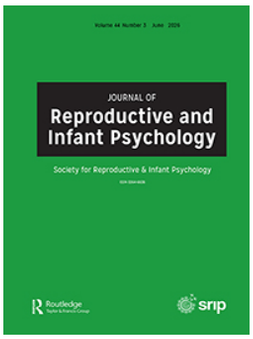

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Discussing sexuality, contraception, family planning, pregnancy and parenthood in mental healthcare

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ABSTRACT

Aim: Individuals with mental health concerns face additional risks in reproductive health. The responsibility of mental healthcare professionals (MHPs) in discussing reproductive health themes – including sexuality, contraception, family planning, pregnancy and parenthood (SCUFPP) – remains underexplored. This study aimed to assess MHPs' opinions, practices, perceived competence and collaboration in discussing SCUFPP with patients.

Methods: Data from 236 Dutch MHPs who completed a 22-item questionnaire on SCUFPP between January 2023 and August 2024 (survey A) were combined with data from 139 Dutch MHPs who completed a nationwide previous survey in May 2022 (survey B) on family planning, to deepen the exploration. Subgroup analyses included gender, age and experience.

Results: In total, 55.5% of MHPs agree that family planning should be discussed with every patient of reproductive age, while 44.5% did not explicitly agree. Sexuality and parenthood were discussed more often than family planning, pregnancy and contraception. Older and more experienced MHPs initiated conversations more often. Most MHPs felt competent to discuss SCUFPP, while a minority (27.3%) was familiar with methods or conversation techniques. Female MHPs more often felt competent and expressed a greater need for education on pregnancy. Most MHPs valued collaboration with integrated and preconception care in mental healthcare.

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Conclusion: These findings point to a gap between MHPs' perceived responsibility and their ability to implement these conversations in practice. Enhanced training and collaboration with expert consultations in SCUFPP may improve MHPs' responsibility in informed reproductive choices, enhancing mental health outcomes for patients.

Introduction

Reproductive health decisions, including family planning and pregnancy intention, are critical yet underexplored, particularly among individuals with psychiatric conditions (J. Coverdale et al., 1997; J. H. Coverdale et al., 1997; Moura et al., 2012). Family planning addresses, among other things, sexual health, childbearing desires, pregnancy intention, contraception and preconception care. Pregnancy intention refers to an individual's or couple's attitudes, plans or desires regarding the timing and occurrence of a pregnancy and is pivotal to reproductive health. An estimated half of all pregnancies worldwide are unintended (Bearak et al., 2020). Unintended pregnancies distinguish between mistimed pregnancies that are wanted but not planned and unwanted pregnancies that are not intended now or in the future (Hall et al., 2017). Implications of unintended pregnancies (UPs) are significant and extend across maternal, obstetric, neonatal and infant health, including adverse outcomes such as low birth weight and preterm births (Hall et al., 2017; Shah et al., 2009), higher rates of neonatal mortality (Hall et al., 2017) and perinatal (chronic) maternal depression or anxiety (Biaggi et al., 2015). Mothers experiencing UPs are also more likely to engage in unhealthy perinatal behaviours, such as not taking folic acid, delayed prenatal care, and use of alcohol, tobacco and other substances (Cheng et al., 2009; Young-Wolff et al., 2022).

General risk factors for UPs include young maternal age, low educational level and a lower socio-economic status (Finer & Zolna, 2016). More recent evidence shows that women with psychiatric conditions are also more likely to experience UPs (Maravilla et al., 2017; Schonewille et al., 2022; Zengin Eroglu & Lus, 2020). This heightened susceptibility to UPs may stem from changes in sexual behaviour and family planning associated with their conditions, such as reduced planning skills, hypersexuality or lack of sexual education (Posada Correa et al., 2020), or misconceptions about fertility due to changes in menstrual cycles (Bulik et al., 2013). Additionally, concerns related to psychopharmacological drugs and their possible effect on their offspring, or antenatal or postpartum alternation of symptoms may impact decision-making in women with psychiatric disorders (Baydar, 1995; Martini et al., 2015). Regardless of pregnancy intention, these concerns related to psychiatric conditions and their implications on psychiatric stability, desire for children, prospect of motherhood and transmission of psychiatric disorder(s) to children may hold large significance for these women (Ahmad et al., 2024).

For women with psychiatric disorders, access to appropriate preconception care is essential to support informed decision-making about family planning, pregnancy and parenthood. Mental health professionals (MHPs) play a crucial role in actively discussing reproductive health with their patients, ensuring that family planning conversations take place within regular mental healthcare settings. The preconception phase offers a window of opportunity to address and minimise disease-specific risks while optimising

physical and mental health before conception and during the perinatal period. When needed, MHPs can refer patients with more complex needs to integrated care clinics that combine psychiatric, obstetric and paediatric expertise. These specialised consultations help patients evaluate potential risks related to perinatal mental health and provide tailored guidance on available treatment options (Lambregtse - van den Berg et al., 2015). While referrals to such clinics should be considered when additional expertise is required to optimise both physical and mental health before conception and during the perinatal period, MHPs remain central in addressing reproductive health within their own practice, ensuring continuity of care.

The patients' reproductive health desires can be discussed with MHPs in any therapeutic relationship, especially during the reproductive years. However, a study previously reported that these conversations rarely occur between MHPs and patients, with MHPs often facing conflicts between their own norms and their patients' desire for children (Krumm et al., 2014). The MoMentUM study explored barriers and facilitators for discussing family planning from the perspectives of MHPs, (former) patients and close ones (Schonewille et al., 2024). While most (former) patients and MHPs recognise the importance of discussing the desire for children and family planning during the reproductive phase of life, barriers like fear of judgement, time constraints, limited knowledge and the absence of opportunities for thorough exploration of life themes often prevented such conversations. Therefore, MHPs may not discuss family planning with their patients, even though they recognise the importance of discussing this topic (Krumm et al., 2014).

In the present study, we aimed to further explore the experiences of MHPs in discussing reproductive health decisions with their patients. Previous research focused on the perspectives of (former) patients, their close ones and MHPs primarily about family planning, while other relevant topics related to sexuality, contraception, family planning, pregnancy and parenthood (SCUFFP) were not covered. Specifically, we seek to better understand MHPs' opinions, practices, perceived competence and collaboration with integrated care clinics regarding discussions about SCUFFP. Building on Schonewille et al. (2024), family planning encompasses both the prevention of unwanted pregnancies and the achievement of wanted pregnancies, which may or may not include contraception. Pregnancy refers to the state of being pregnant and to emotional factors involved such as fears, past trauma and postpartum mental health. With these insights, we can better identify possibilities for improving discussions about family planning.

Materials and methods

Study design

We conducted a cross-sectional study with data from a new survey (A) and data from a previous survey (B). Survey A comprised 22 items to investigate MHPs' experiences with discussing SCUFPP. Survey A built on a previously conducted questionnaire distributed to MHPs recruited at the annual conference of the Dutch Psychiatry Association (survey B), which focused on family planning (Schonewille et al., 2024). While retaining eight identical questions to enable combined analysis, survey A expanded the scope of survey B to include inquiries about professionals' discussions of sexuality, contraception, pregnancy and

parenthood with their patients and their close ones. Further details about survey B are available in Schonewille et al. (2024). The full list of questions from both surveys is provided in Supplementary file 1. This study received approval from the Medical Ethics Committee board (METc) of the University Medical Centre Groningen (UMCG), with a waiver obtained as there was no infringement of participants' physical or psychological integrity (METc 2023/084). All participants provided informed consent. They were ensured data were processed anonymously and could withdraw at any moment without consequence.

Participant recruitment and data collection

MHPs were recruited in two large mental health organisations in the north of the Netherlands (Lentis Psychiatric Institute and Friesland Mental Health Services). Between January 2023 and August 2024, MHPs were approached via email or via a newsletter. After providing informed consent, participants completed survey A. Exclusion criteria included age ≤18 years or not being an MHP. MHPs specialising exclusively in geriatric psychiatry were excluded from survey A, as discussing contraception and pregnancy is mostly irrelevant for patients beyond the reproductive phase. However, these MHPs were included in the combined survey analyses for family planning (survey A + B), as distinction based on field of speciality was not made in the survey B (Schonewille et al., 2024).

Instrument

The web-based survey was developed specifically for this study and underwent pre-testing to ensure usability and technical functionality. Participants were provided a link to Routine Outcome and Quality Assessment (RoQua), a secured online questionnaire application environment (Sytema & Van Der Krieke, 2013). The survey was provided in Dutch and took approximately 15 minutes to complete. The survey contained 19 items across seven pages, incorporating adaptive questioning to reduce respondent burden. Nineteen questions were closed-ended, with three open-text questions. Completion of the questionnaire occurred in a single session without intermediate saving, allowing respondents to modify answers within the session. Incomplete questionnaires were excluded from the analysis. Results from the open-ended questions are not integrated in the current report. All data were stored securely following GDPR regulations.

Data analysis

First, data from survey A were analysed, followed by combining data from the eight shared questions on family planning from surveys A and B to explore family planning in greater depth across a larger cohort. Data from survey A was pseudonymised and then shared with the research team. The data underwent cleaning and analysis using SPSS (version 28.0). Descriptive data were presented in frequencies and proportions. In cases of zero or low cell counts, outcomes were combined. Subgroup analyses compared females and males, age groups and years of experience. Chi-square tests or Fisher exact tests assessed outcome distributions among demographic subgroups. A significance level of $p < 0.01$ was employed to account for multiple comparisons.

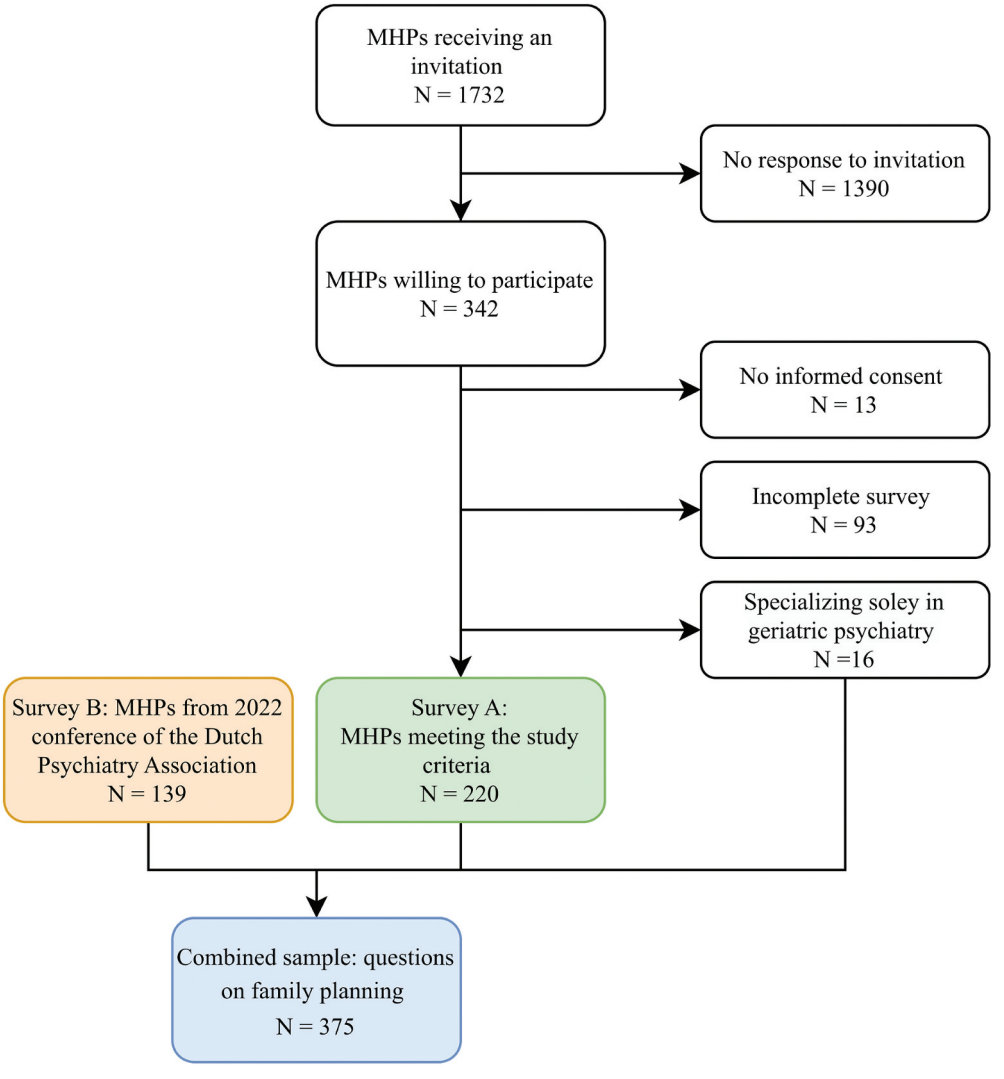

Figure 1. Inclusion process of the study. Abbreviation: MHPs, mental healthcare professionals.

Results

A total of 236 MHPs provided consent and completed survey A (response rate: 13.6%). Sixteen MHPs (6.8%) specialised solely in geriatric psychiatry and were subsequently removed from survey A but still included in the larger cohort analyses (survey A + B; see Figure 1). Baseline characteristics of 220 MHPs are summarised in Table 1. The majority of the MHPs identified as female (76.4%), and most worked in adult psychiatry (80.9%). Survey B of Schonewille et al. (2024) consisted of 139 MHPs (response rate: 6.5%). Compared to survey A, survey B had a higher representation of psychiatrists (66.2% versus 10.5%) and junior or resident doctors (29.5% versus 8.2%) but fewer psychologists (1.4% versus 20.0%) and (psychiatric) nurses (0.7% versus 41.8%). Additionally, survey A included MHPs with professions not described in survey B,

Table 1. Demographic features of participants from survey A, survey B and combined.

Demographic characteristic	Category	Survey A (n = 220)		Survey B (n = 139)		Total (n = 375)	
		N	%	N	%	N	%
Professional role	Psychiatrist	23	10.5	92	66.2	117	31.2
	Junior or resident doctor	18	8.2	40	28.8	58	15.5
	Psychologist	44	20.0	2	1.4	56	14.9
	(Psychiatric) nurse	92	41.8	2	1.4	107	28.5
	Social (pedagogical) worker	27	12.3	0	0	19	5.0
	Other[a, b]	16	7.3	3	2.2	18	4.8
Workplace[c]	Mental healthcare institution, adult psychiatry	184	83.6	–	–	–	–
	Mental healthcare institution, child and adolescent psychiatry	32	14.5	–	–	–	–
	Mental healthcare institution, geriatric psychiatry[d]	7	3.2	–	–	–	–
	Other[e]	9	4.1	–	–	–	–
	Psychiatric institution	–	–	103	74.1	–	–
	Hospital	–	–	25	18.0	–	–
	Forensic psychiatric clinic	–	–	3	2.2	–	–
	Private practice	–	–	5	3.6	–	–
	Outreaching team	–	–	1	0.7	–	–
	Care centre for mentally disabled persons	–	–	1	0.7	–	–
	Missing	–	–	1	0.7	–	–
Years of experience	<5 years	47	21.4	38	27.3	87	23.2
	5–10 years	33	15.0	20	14.3	56	14.9
	10–20 years	67	30.5	40	28.8	111	29.6
	>20 years	73	33.2	40	28.8	120	32
	Missing	0	0	1	0.7	1	0.3
Age	<25 years	7	3.2	0	0	7	1.9
	25–35 years	61	27.7	44	31.7	108	22.4
	36–45 years	58	26.4	30	21.6	93	24.8
	46–55 years	45	20.5	32	23.0	82	21.9
	>55 years	49	22.3	32	23.0	84	22.4
	Missing	0	0	1	0.7	1	0.3
Gender	Female	168	76.4	95	68.3	275	73.3
	Male	50	22.7	44	31.7	97	25.9
	Other/prefer not to disclose	2	0.9	0	0	2	0.5

[a]Other functions of MHPs in survey A included: social worker, educational therapist, psychomotor therapist, mental health nurse practitioner (primary care), project assistant, socio-therapist and sexologist.
[b]Other functions of MHPs in survey B included: physician assistant, psychiatrist-director and addiction specialist.
[c]Multiple answers possible for survey A.
[d]MHPs worked in geriatric psychiatry as well as in adult psychiatry, or child and adolescent psychiatry.
[e]Other workplaces within mental healthcare included: adolescent/young adult psychiatry (age 15–25), neuropsychiatry or care for individuals with intellectual disabilities (all ages).

such as social (pedagogical) workers, educational or psychomotor therapists, mental health nurse practitioners, project assistants, socio-therapists or sexologists (19.6%). Gender distribution, age and years of experience were comparable between the two surveys.

Below we report the main findings per subject:

(1) **MHPs opinions about discussing reproductive topics**. The results of survey A are available in Table 2. Approximately half of MHPs (55.5%) agreed that family planning should be discussed with every patient (and close ones) of reproductive age, while 44.5% did not explicitly support this. MHPs seemed to agree that the topic should always be discussed if it is introduced by the patient. When asked whether MHPs consider it their role to discuss family planning with all patients, 47.3% of

Table 2. Results of survey a amongst mental health professionals on the topics of sexuality, contraception, family planning, pregnancy and being pregnant, and parenthood.

Question	Answer category	N	%
		220	100
(1) **MHPs[a] opinions about discussing reproductive topics**			
The psychiatrist should discuss family planning/formation[b] with every patient (and close one) of reproductive age.			
	Disagree	46	20.9
	Neutral	52	23.6
	Agree	122	55.5
I believe it is part of my role to discuss . . . with all patients.			
Sexuality	Disagree	34	15.5
	Neither agree nor disagree	38	17.3
	Agree	148	67.3
Contraception	Disagree	60	27.3
	Neither agree nor disagree	59	26.8
	Agree	101	45.9
Family planning	Disagree	44	20.0
	Neither agree nor disagree	72	32.7
	Agree	104	47.3
Pregnancy and being pregnant	Disagree	38	17.3
	Neither agree nor disagree	71	32.3
	Agree	111	50.5
Parenthood	Disagree	29	13.2
	Neither agree nor disagree	47	21.4
	Agree	144	65.5
(2) MHPs practices in discussing SCUFPP			
Do you discuss contraception with your patients (and close ones)?			
	Yes	136	61.8
	No	68	30.9
	Not applicable	16	7.3
Have you ever initiated a discussion with your patients (and close ones) about . . .?			
Sexuality	With no patients/ close ones	16	7.3
	With some patients/ close ones	116	52.7
	With many or all patients/ close ones	88	40.0
Contraception	With no patients/ close ones	28	12.7
	With some patients/ close ones	144	65.5
	With many or all patients/ close ones	48	21.8
Family planning	With no patients/ close ones	33	15.0
	With some patients/ close ones	134	60.9
	With many or all patients/ close ones	51	23.2
	Missing	2	0.9
Pregnancy and being pregnant	With no patients/ close ones	22	10.0
	With some patients/ close ones	155	70.5
	With many or all patients/ close ones	41	18.6
	Missing	2	0.9
Parenthood	With no patients/ close ones	9	4.1
	With some patients/ close ones	73	33.2
	With many or all patients/ close ones	138	62.7
Do you receive questions about . . . from your patients (and close ones)?			
Sexuality	From no patients/ close ones	23	10.5
	From some patients/ close ones	172	78.2
	From many or all patients/ close ones	24	10.9
	Missing	1	0.5
Contraception	From no patients/ close ones	87	39.5
	From some patients/ close ones	122	55.5
	From many or all patients/ close ones	10	4.5
	Missing	1	0.4
Family planning	From no patients/ close ones	53	24.1
	From some patients/ close ones	149	67.7
	From many or all patients/ close ones	16	7.3
	Missing	2	0.9

(*Continued*)

Table 2. (Continued).

Question	Answer category	N	%
Pregnancy and being pregnant	From no patients/ close ones	47	21.4
	From some patients/ close ones	160	72.7
	From many or all patients/ close ones	11	5.0
	Missing	2	0.9
Parenthood	From no patients/ close ones	22	10.0
	From some patients/ close ones	119	54.1
	From many or all patients/ close ones	79	35.9
(3)C ompetence, training and organisational support			
Do you feel competent enough to discuss . . . in relation to psychiatric vulnerability with patients (and close ones)?			
Sexuality	Yes	141	64.1
	I find it difficult to say if I feel competent enough	68	30.9
	No	11	5.0
Contraception	Yes	150	68.2
	I find it difficult to say if I feel competent enough	46	20.9
	No	24	10.9
Family planning	Yes	132	60.0
	I find it difficult to say if I feel competent enough	74	33.6
	No	14	6.4
Pregnancy and being pregnant	Yes	135	61.4
	I find it difficult to say if I feel competent enough	71	32.3
	No	14	6.4
Parenthood	Yes	166	75.5
	I find it difficult to say if I feel competent enough	44	20.0
	No	10	4.5
Did you receive education during your training as a professional in mental healthcare about . . . in relation to psychiatric vulnerability?			
Sexuality	Yes	130	59.1
	No	90	40.9
Contraception	Yes	65	29.5
	No	155	70.5
Family planning	Yes	72	32.7
	No	148	67.3
Pregnancy and being pregnant	Yes	90	40.9
	No	130	59.1
Parenthood	Yes	109	49.5
	No	111	50.5
Do you feel the need for further education/training on the topic of . . . in relation to psychiatric vulnerability?			
Sexuality	Yes	130	59.1
	No	90	40.9
Contraception	Yes	92	41.8
	No	128	58.2
Family planning	Yes	129	58.6
	No	91	41.1
Pregnancy and being pregnant	Yes	121	55.0
	No	99	45.0
Parenthood	Yes	127	57.7
	No	93	42.3
Are there protocols or instructions in the organization where you work regarding discussing . . .?			
Sexuality	Yes	45	20.5
	No	175	79.5
Contraception	Yes	27	12.3
	No	193	87.7
Family planning	Yes	24	10.9
	No	196	89.1
Pregnancy and being pregnant	Yes	38	17.3
	No	182	82.7
Parenthood	Yes	59	26.8
	No	161	73.2

(*Continued*)

Table 2. (Continued).

Question	Answer category	N	%
Are you familiar with methods or conversation techniques to make topics such as sexuality, contraception, family planning, pregnancy, and parenting easier to discuss in relation to psychiatric vulnerability?			
	Yes	60	27.3
	No	160	72.7
(4) Collaboration and expert consultation			
In order to improve care for patients with pregnancy and to best prepare them for parenthood, every mental healthcare institution should collaborate effectively with POP[3] clinics [integrated care clinic].[f]			
	Yes, I find that important	192	87.3
	Yes, because …	28	12.7
	No, because …	17	7.7
To improve care for patients with a desire to have children, every mental healthcare institution (for adult psychiatry) should have a preconception care clinic.[f]			
	Yes, I think it's a good idea to have a central point with a lot of expertise on this matter, to which I can refer patients.	60	27.3
	Yes, I think it's a good idea to have a central point with a lot of expertise on this matter, which can be consulted.	84	38.2
	No, it's better to train all healthcare providers in this area so that discussing the desire to have children can be addressed with every therapeutic relationship.	96	43.6
	Other, namely:	30	13.6
If you are in favour of a preconception care clinic, what should be the composition of a preconception care clinic? [d,e]			
	Medical social worker	92	76.0
	Psychiatrist	73	60.3
	(Specialised) nurse	112	92.6
	Psychologist	89	73.6
	Other, namely … [f]	19	15.7

[a]MHPs = mental healthcare professionals.
[b]By family planning, we mean whether there is a desire for children or expanding the family.
[c]POP = Psychiatry Obstetrics Paediatrics.
[d]Multiple answers possible.
[e]Filled in by $N = 121$ that were in favour of a preconception care clinic.
[f]Other = expert by experience, mental health social worker, infant mental health specialist, paediatrician, pedagogue, sexologist or sexual health consultant, social worker, systemic therapist or midwife.

MHPs affirmed that they do, similar to contraception (45.9%), and pregnancy (50.5%). In contrast, MHPs consider discussing sexuality (67.3%) and parenthood (65.5%) more often as part of their professional responsibility.

(2) **MHPs' practices in discussing SCUFPP**. Compared to the other four topics, MHPs were more likely to initiate a discussion about parenthood with their patients (or close ones) (Table 2). Nearly two-thirds (62.7%) reported to initiate discussions on parenthood with most or all their patients. MHPs also received most questions about parenthood, with 35.9% of MHPs receiving questions about parenthood from many or all of their patients.

MHPs with over 20 years of experience were most likely to discuss sexuality with their patients, and older MHPs were most likely to initiate conversations about family planning (Table S1 and S2). Older and more experienced MHPs also received more questions from their patients.

(3) **Competence, training and organisational support**. More MHPs felt competent discussing parenthood (75.5%) than contraception (68.2%), sexuality (64.1%), pregnancy (61.4%) and family planning (60.0%) (Table 2). MHPs reported to have

received most education in sexuality (59.1%) and parenthood (49.5%), and the least on family planning (32.7%) and contraception (29.5%). Contraception was also the least requested topic for further training (41.8%).

Of all MHPs, 27.3% reported being familiar with methods or conversation techniques for discussing SCUFPP related to psychiatric vulnerability. Within the organisations where MHPs work, protocols or instructions were more frequently available for discussing parenthood (26.8%) compared to other topics. Family planning was the least frequently instructed area, with only 10.9% of organisations providing protocols to discuss this topic.

More female MHPs felt competent enough to discuss pregnancy in the context of psychiatric vulnerability and female MHPs also expressed a greater need for further training in this area (Table S3). Older and more experienced MHPs felt more competent discussing family planning and parenthood and had received more training on sexuality, contraception, pregnancy and parenthood in relation to psychiatric vulnerability compared to younger and less experienced MHPs (Table S1 and S2).

(4) **Collaboration and expert consultation**. A majority (87.3%) of MHPs stated to find it important for mental healthcare institutions to collaborate with integrated care clinics for the optimal preparation of pregnant women for parenthood (Table 2, section 4). Only a small minority (7.7%) disagreed, as they see no added value in those clinics, or find them unnecessarily expensive or inadequate. Opinions were more divided regarding preconception care clinics within mental healthcare institutions. While 65.5% preferred a central point for expertise to which patients can either be referred to (27.3%) or can get consultations (38.2%), a substantial proportion (43.6%) believed it is better to train all healthcare professionals in this area, ensuring that discussions about the desire to have children are integrated into every clinical practice. Regarding the ideal composition of a preconception care clinic, the most suggested MHPs were (specialised) nurses (92.6%), followed by medical social workers (76.0%) and psychologists (73.6%). Psychiatrists were also considered important (60.3%).

Combined sample on family planning

Analyses were performed on the combined data from both survey A and B ($N = 375$) on family planning (Table 1). Combined survey results are summarised in Table 3. Compared to male MHPs, female MHPs reported to receive more questions about family planning (79.8% versus 69.8%, $p < 0.001$, Table S4). Older and more experienced MHPs felt more competent addressing family planning in the context of psychiatric vulnerability and reported a lower need for further training in this area compared to younger and less experienced MHPs (Table S5 and S6).

Discussion

We aimed to explore MHPs' opinions, practices, perceived competence and collaboration with specialised care clinics in discussing SCUFPP with their patients. Our findings show

Table 3. Combined results of surveys (survey S + B) amongst mental health professionals on the topic of family planning.

Question	Answer category	N	%
		375	100
The psychiatrist should discuss family planning/formation[a] with every patient (and close one) of reproductive age.	Disagree	73	19.5
	Neutral	83	22.1
	Agree	219	58.4
Do you discuss contraception with your patients (and close ones)?	Yes	218	58.1
	No	118	31.5
	Not applicable	36	9.6
	Missing	3	0.8
Have you ever initiated a discussion with your patients (and close ones) about family planning?	With no patients/ close ones	61	16.3
	With some patients/ close ones	214	57.1
	With many or all patients/ close ones	94	25.1
	Missing	6	1.6
Do you receive questions about family planning from your patients (and close ones)?	From no patients/ close ones	84	22.4
	From some patients/ close ones	248	66.1
	From many or all patients/ close ones	38	10.2
	Missing	5	1.3
Do you feel competent enough to discuss family planning in relation to psychiatric vulnerability with patients (and close ones)?	Yes	223	59.5
	I find it difficult to say if I feel competent enough	127	33.9
	No	24	6.4
	I don't know / missing	1	0.3
Did you receive education during your training as a professional in mental healthcare about family planning in relation to psychiatric vulnerability?	Yes	109	29.1
	No	248	66.1
	I don't remember	16	4.3
	I don't know / missing	2	0.5
Do you feel the need for further education/training on the topic of family planning. in relation to psychiatric vulnerability?	Yes	224	59.7
	No	149	39.7
	Missing	2	0.5
Are there protocols or instructions in the organisation where you work regarding discussing family planning?	Yes	42	11.2
	No	328	87.5
	Missing	5	1.3

[a]By family planning, we mean whether there is a desire for children or expanding the family.

that nearly half of MHPs do not explicitly support discussing family planning with reproductive-age patients. MHPs reported that they more often consider discussing sexuality and parenthood as part of their professional responsibility. Conversations about family planning, pregnancy and contraception occurred less frequently. Older and more experienced MHPs initiated conversations more often than younger and less experienced MHPs and also received more questions from patients. Regarding perceived competence, most MHPs reported feeling competent discussing SCUFPP. Few MHPs were familiar with specific methods or conversation techniques to initiate these topics in relation to psychiatric vulnerability. Older and more experienced MHPs more often felt competent, particularly in discussing parenthood and sexuality. Females MHPs more often reported feeling competent discussing pregnancy and at the same time expressed a greater need for further education or training on this topic. Finally, most MHPs valued collaboration with a centralised resource for integrated and preconception care in mental healthcare.

Despite acknowledging the relevance of SCUFPP, nearly half of MHPs do not initiate these conversations. Similarly, Goodsmith et al. (2023) found that most MHPs are open to

discussing reproductive topics with patients but emphasise the importance of patient consent to avoid discomfort or ambivalence, underlining the need for respect and sensitivity in these discussions. Underwood et al. (2024) also noted the substantial need for education and confidential support on contraception for adolescents with mental health vulnerabilities. Although most MHPs view discussing sexuality and parenthood as part of their professional responsibility, a smaller proportion consider family planning and contraception within their scope of responsibility. This indicates a need for greater clarity or consensus on this responsibility within mental healthcare. Given that patients are unlikely to initiate these conversations themselves, it is essential that MHPs take the lead in addressing these topics or at least create an open environment and asking and giving permission to talk about these topics (Taylor & Davis, 2007). While D'Angelo et al. (2020) highlighted the role of midwives in providing counselling on contraception and reproductive health, our findings suggest that MHPs can and should also take on this responsibility, especially since SCUFPP topics are already relevant before midwives are involved.

When MHPs did discuss SCUFPP, sexuality and parenthood were discussed most frequently. This indicates that only a subset of SCUFPP topics is routinely addressed. Maybery and Reupert (2009) similarly reported that MHPs recognise the importance of family and relational dynamics, particularly parenting. However, they also found there are persistent barriers, such as taboos and lack of training, which hinder open discussion. Similarly, Traumer et al. (2019) reported that patients and MHPs consider discussing sexuality as taboo, which negatively impacts the likelihood that these topics are addressed. For MHPs who avoid these topics, taboos and cultural barriers could remain a challenge. Although most professionals agree that sexuality should be addressed, they hesitate due to lack of awareness, time constraints, presumed patient shame or their own discomfort (Bungener et al., 2022). This may explain why some SCUFPP topics are still rarely discussed in mental healthcare.

Although many MHPs reported feeling competent discussing SCUFPP in relation to psychiatric vulnerability, a substantial proportion expressed a need for further training. SCUFPP topics are still not systematically embedded in all MHP training programmes, and their presence in clinical protocols and institutional guidelines remains limited and inconsistent. This highlights an opportunity for educational initiatives to increase awareness of the relevance of SCUFPP topics to mental health, particularly for MHPs who may not yet see it as an integral and essential part of patient support. MHPs could benefit from more specialised knowledge and skills, aligning with research among nurses, where a lack of training was one of the key factors contributing to not discussing sexuality (Fennell & Grant, 2019). Discrepancies between reported discussions on SCUFPP topics, MHPs reported competence, formal education that MHPs received and their reported need for further training suggest that perceived competence may not always reflect actual knowledge or skill. By equipping MHPs with relevant knowledge and communication techniques, patients can be supported in making informed reproductive decisions that align with their mental health and life goals, receiving adequate support when needed.

Our study also revealed differences in gender, age and work experience. Female MHPs reported higher competence in discussing SCUFPP compared to male MHPs, possibly due to varying personal or professional interests and work settings (Dial et al., 1994). However, our sample includes an overrepresentation of women, which may impact the results.

While limited research examined age and experience effects on MHPs' competence, earlier studies suggest clinical experience boosts confidence rather than competence (Garb, 1989). Additionally, with age, MHPs may gain personal experience with these topics. Our findings suggest that more experienced MHPs feel more competent in discussing sensitive topics, such as family planning, with their patients, although this perceived competence may reflect confidence gained through experience rather than skills.

Well-informed reproductive health choices of people with psychiatric disorders may positively impact their mental health outcomes and that of their offspring. As these patients may not easily seek (prenatal) healthcare elsewhere, it is important that MHPs discuss these topics with their patients. From a public health perspective, maternal mental health is a key determinant of preventable morbidity and mortality, highlighting the need for tailored clinical support and informed policy (Wisner et al., 2024). MHPs indicated they needed more structural support for reproductive healthcare within mental healthcare. A central point of expertise for preconception care could enhance direct patient guidance, reducing the need for referrals and ensuring more accessible and integrated support within mental healthcare.

This study has several strengths, including the use of a demographically diverse sample in terms of age, function and employment location across the Netherlands, which enhances the generalisability of the findings. The use of multiple data sources increased the overall sample size and improved data robustness. However, several limitations should be acknowledged. First, selection bias may have occurred in this sample. It is likely that we mainly received responses from MHPs who are interested in the topic. This limits the generalisability of the results and may have led to an overestimation of the actual conversations about SCUFPP and the self-reported competence of MHPs. Second, the sample size was relatively small and included a low proportion of male MHPs, although this reflects the actual gender distribution of MHPs in mental healthcare (Langenberg et al., 2023). Lastly, while the survey format enabled broad data collection, it may not have captured the nuanced motivations behind MHPs' responses. Future research should include a larger, more diverse sample to examine barriers such as cultural differences and taboos in discussions of SCUFPP. Also, our data do not show the specific context of what is discussed, when MHPs indicate to have these conversations. Qualitative methods such as interviews may yield a more thorough understanding of MHP's views on these topics and their needs to better reinforce and integrate this into clinical practice.

Our study shows that MHPs' initiative-taking in family planning and reproductive health discussions should be improved. MHPs first need to recognise the importance of initiating discussions on reproductive health topics as part of their professional role, which highlights the need for greater integration of these topics within training programmes for MHPs. In addition, strengthening MHPs' competence through ongoing professional development and organisational support is essential to embed these responsibilities into actual routine practice. Furthermore, collaboration with integrated care clinics can help facilitate these conversations in daily practice, further underscoring the importance of interdisciplinary collaboration (Auerbach et al., 2023). By addressing the identified gaps, mental healthcare can better serve patients in making informed and supported reproductive choices, contributing to

improved mental health outcomes in themselves, their family and their (possible) offspring.

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Author contributions

Conceptualisation, BB, FJ, JE, LQ; NS; original idea for questionnaire: BB, NS; methodology, FJ, JE & LQ; formal analysis, JE, JH; writing – original draft preparation, JH; writing – review and editing, JH, LQ, BB, JE, FJ, NS; visualisation, JH; supervision, FJ, JE; project administration, LQ, JE; funding acquisition, BB, NS. All authors have read and agreed to the published version of the manuscript.

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Ethics approval

The study was conducted in compliance with the ethical standards of the Medical Ethical Review Board of University Medical Center Groningen.

Consent for publication

All participants in this study have provided consent for publication.

Availability of data and materials

The dataset(s) supporting the conclusions of this article are included within the article and the supplementary files. The original data are available upon reasonable request.

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