Sexual boundary issues in psychiatric settings

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Executive summary and recommendations

Revision of the original College report *Sexual Abuse and Harassment in Psychiatric Settings* (Royal College of Psychiatrists, 1996) led to a review with a wider remit, to take into account major developments in the legal framework in which patients are treated and to encompass a broader discussion on sexuality. Issues of capacity and consent are relevant for all areas of care and psychiatric professionals have to balance principles of autonomy and protection. Particularly relevant in the context are the Human Rights Act 1998, the Sexual Offences Act 2003, the Mental Capacity Act 2003 and additional legislation regarding standards of care for both adults and children.

The area is one of high risk in terms of likelihood and impact because of the vulnerability of the patient group. Recommendations are made in the light of the Kerr/Haslam inquiry (Department of Health, 2005), the Patient Safety Observatory Report 2 (National Patient Safety Agency, 2006) and the government report *Safeguarding Patients* (Department of Health, 2007).

Recommendations

- Wards must have appropriate design and sufficient space to allow patients to be cared for in safety, privacy and a reasonable degree of comfort.
- Sufficient numbers of qualified staff must be on duty at all times.
- All staff should be in regular supervision. This will include discussion of attitudes and behaviour. Supervision may also provide a safe space in which they are able to acknowledge lack of skill and to voice anxieties and concerns about themselves and others.
- Trusts should have evidence bases and protocols for treatments. They should be aware of therapies being undertaken by all staff, through supervision, appraisals and job plans. A register of treatments is a useful mechanism for recording treatments and approved protocols; it could also include chaperone requirements, and specify training and supervision requirements for each treatment.
- Clinical supervisors and managers must develop an understanding of the causes and recognition of sexual abuse and should be aware of the situations in which abuse is more likely to occur.

- Staff induction programmes should include clear instructions about what behaviour is acceptable and what is unacceptable.
- Each psychiatric unit must have developed an accepted philosophy, with ensuing policy and procedures, to cover the appropriate expression of sexuality among in-patients. The policy will address human rights, legality, capacity and consent, contraception and cultural variances.
- Each unit must have a policy with respect to allegations of sexual harassment, sexual abuse and rape, whether this be by another patient, by a staff member or by a visitor to the ward. The policy will address the duties of staff, immediate action, evidence, support to the complainant, when and how to involve the police and/or social services, incident reporting and investigation, and disciplinary procedures.
- There should be regular audit concerning the numbers of incidents, complaints and allegations, patient attitudes to policies, and staff attitudes, knowledge of and adherence to policies.
- Employment policies must ensure that all staff, clinical and non-clinical, permanent or temporary, have no previous record of sexual impropriety.
- Senior management must support training in the prevention, recognition and management of abusive and potentially abusive situations. There should be ongoing multidisciplinary educational programmes for staff, to raise awareness and confidence in dealing with issues related to the expression of sexuality. Staff should receive specific training in the recognition of abuse and the handling of allegations of abuse and harassment.
- Patient information should be readily available, including information about what to expect in assessment and treatment, how to access support and advice, and how to make a complaint.

Introduction

This document is intended to foster awareness of various aspects of sexual boundary issues in psychiatric settings. It also provides guidance for psychiatrists, working in multidisciplinary teams and supported by managers, for dealing with these difficult issues. Nevertheless, locally created policies will be essential. While this report is specific to England and Wales, the principles apply also to other jurisdictions.

Since the publication of the first edition of the College report *Sexual Abuse and Harassment in Psychiatric Settings* (Royal College of Psychiatrists, 1996) a considerable body of articles and reports has been written on these subjects and the wider issue of the sexual rights of psychiatric patients. The Department of Health has published important guidelines, and the last decade has also seen major developments in the legal framework within which patients are treated. Of particular relevance are the report of the Kerr/Haslam inquiry (Department of Health, 2005) and the Sexual Offences Act 2003.

The Kerr/Haslam inquiry looked at the responses of the health service to allegations that two consultant psychiatrists had sexually abused many patients over many years, and commented that the prevailing culture in the hospitals concerned was one where 'patients were routinely disbelieved'. Changes of attitude by staff as to the likelihood and seriousness of impact of sexual abuse, assault and harassment for patients, whether by other patients, visitors or staff, are therefore of primary importance. Formal measures will also be necessary. The Sexual Offences Act 2003 provides a comprehensive new legislative framework for sexual offences. It covers offences against adults (including people with mental disorders), offences against children and familial sexual offences. Currently (July, 2007) recommendations are expected from the Committee of Health Care Regulatory Excellence, which has been commissioned by the Department of Health to develop guidance about sexual boundaries between patients and professionals.

Discussion of sexual relationships should not confuse gender with sexuality. Relationships may be between members of the same or opposite sex. Relationships may also be between patients or between a member of staff and a patient. Sexual abuse and harassment may occur as a spectrum of behaviours. These range from visual or verbal harassment to assault or rape. It is important to recognise that there are wide individual variations, reflecting personal and cultural differences in attitudes to sexuality. For some, for instance, pornography or sex aids would be an acceptable part of sexuality; for others they would be taboo and even discussion of them may be construed as abusive.

The range of psychiatric settings also makes matters complex. Importantly, with the increase in community-based psychiatric care, abuse may occur in non-hospital environments. Monitoring and other aspects of

prevention may be more difficult in isolated units. Psychiatric longer-term care in a variety of settings raises issues of the rights of patients in relation to sexual expression and contraception, and their conjugal rights. Policies for in-patient settings may seem easier to put in place but consideration should also be given to policies in other environments, such as day hospitals, community care settings, hostels and out-patient clinics.

Legal considerations

The legal framework

Since the publication of the first edition of this document, various legal developments have taken place. The introduction of several policies by the government has also informed and affected issues related to sexual boundaries in psychiatric settings.

Of considerable significance was the passing of the Human Rights Act 1998. The right of the individual to respect for private and family life (Article 8) may be relevant with regard to sexual expression when in psychiatric care, and the right to marry and found a family may be relevant to requests for conjugal rights for hospitalised patients with mental disorders.

The Department of Health & Home Office (2000) published *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse* in March 2000. The document *Children's Homes. National Minimum Standards. Children's Homes Regulations* (Department of Health, 2002) gives clear indications of the standards of care that apply to psychiatric in-patient units for children and adolescents. While the possibility of abuse in social care (e.g. fostering and children's homes) is now well recognised, it is only recently, with the publication of the Carlile report (National Assembly for Wales, 2002), that the similar issues for children in National Health Service (NHS) care have begun to be systematically addressed. Many of the issues for children and young people are relevant to adults also.

The Sexual Offences Act 2003 came into force in May 2004, although case law has not yet clarified its full implications. This Act provides a comprehensive new legislative framework for sexual offences. It covers offences against adults (including people with mental disorders), offences against children and familial sexual offences. It also sets clear new parameters for people working with children, and for those working with people with mental disorders. Section 74 of the Act states that 'A person consents if s/he agrees by choice and has the freedom and capacity to make that choice'. The Sexual Offences Act 'sets down – for the first time – a clear definition and new responsibilities surrounding consent' (Home Office, 2004). The Act sets out clear boundaries about what is and what is not acceptable. It ensures that people of all sexual orientations are equally protected from sexual crime. Guidance on the Act from the Crown Prosecution Service (2005) clarifies that there are three categories of offence against people with a mental disorder. They are:

- offences against persons with a mental disorder who are 'unable to refuse' (e.g. they cannot make or convey a decision)

- offences against persons who have a capacity to consent to sexual activity but who have a mental disorder that makes them vulnerable to inducement, threat or deception
- offences by care workers against persons with a mental disorder.

In all these offences, mental disorder has the same definition as in section 1 of the Mental Health Act 1983 (Crown Prosecution Service, 2005).

Capacity and consent

The common law test of capacity to consent to sexual relations is that the person concerned must be capable of understanding what is proposed and its implications, and must be able to exercise choice. Doctors may be asked to give a view on the capacity of patients to embark on a close relationship. Under these circumstances, each person should be seen privately for assessment and advice. The implementation during 2007 of the Mental Capacity Act 2005 will have implications for decisions about capacity for consent.

The issue of capacity and consent is relevant for all areas of care. There is a presumption in law against lack of capacity, which therefore needs to be proved in an examination of the conduct and level of understanding of the individual. In Scotland, the legal framework has been clearer than in England and Wales. The Mental Capacity Act gives a new statutory definition of capacity, which may be summarised as follows: individuals are without capacity if: (i) they are unable by reason of mental disability to make a decision; and/or (ii) they are unable to communicate a decision. The emphasis on mental disability (permanent or temporary) suggests the importance of psychiatric expertise in such assessments. The ability to make a decision requires the understanding and retention of the relevant information, including information about the reasonably foreseeable consequences of that decision, and the capability of judging that information.

Until recently there was a paucity of research into and debate about the assessment of capacity to consent to sexual activity (in contrast to consent to medical treatment) in people who are mentally disordered or incapable. It may be that most sexual abuse in psychiatric settings is chronically exploitative rather than sudden, dramatic and clearly classifiable as sexual assault.

Relatives often think and say that because patients are unwell they are able to make decisions on their behalf. For adults this is not correct and is no more correct for matters of sexuality than other aspects of life. It may be good practice to involve relatives in a patient’s care but only with permission of the patient and with due regard for confidentiality. Having ‘enduring power of attorney’ currently does not confer on the attorney any rights or obligations in decision-making other than specifically about property and affairs. ‘Lasting power of attorney’, introduced in 2007, can allow decisions on health and welfare.

The psychiatric team is always balancing principles of autonomy and protection. At the same time as recognising patients’ autonomy and encouraging independence, they must endeavour to shield the vulnerable from violence, intimidation, abuse and sexual assault. Mental health professionals may be tempted to judge behaviour based on conventional

social norms and prejudices. Instead, they need to be precise, clinically and legally. Anyone with capacity may make decisions which the more prudent may not make, or which defy convention.

Doctors are most used to making assessments about capacity to consent to treatment. Consent to a sexual relationship or behaviour is perhaps more complex, as two people are involved, but it presents similar conceptual questions. Sexual relationships should be entered into only in a situation of free personal choice. The common law test of capacity to consent to sexual relations is that the person concerned must be capable of understanding what is proposed and the implications of sexual activity, and be able to exercise choice and resist coercion in the matter. A doctor may be asked either for advice before the proposed act or for an opinion subsequently. The patient should be interviewed privately and sensitively, although the doctor may need to use language explicitly. Does the patient understand what is proposed to be done (e.g. the physical act of penetration of the female body by the male organ)? Does the patient understand that the act is one of sexual connection, as distinct from an act of a totally different character? Would the patient be capable of exercising any judgement in the matter? Consent is not mere assent or lack of dissent. Expressions of the human need for tenderness and warmth may be misinterpreted as sexual, with non-verbal communications being more likely to be misunderstood than spoken ones. Of course, the ability to give consent does not mean that consent has been given.

Capacity to consent may vary according to the mental state of the patient and should be addressed in the preparation of individual care plans. Assessment of capacity to consent involves clinical and legal aspects and must be undertaken in a language in which patients and carers are able to communicate.

An imbalance of power in a relationship interferes with the ability to consent. Examples of such situations are staff–patient relationships, adult–child relationships and relationships involving an adult with severe mental illness or intellectual disability.

Prevention

The quality of the environment and the vigilance of all staff members, as well as physical boundaries, are crucial factors in preventing unacceptable behaviour. All psychiatrists, clinical staff and managers have a duty to ensure that the ward environment is as pleasant, peaceful and therapeutic as possible, that all patients and staff are treated with dignity and respect, and that their cultural needs are met.

Staff numbers can affect the risk of sexual abuse or harassment. It is essential that there are always sufficient qualified staff on duty. Where units are understaffed, there is likely to be inadequate supervision of vulnerable patients. The opportunity for abuse or harassment to occur undetected will therefore arise, as pointed out by Tonks (1992).

Physical design of the ward

The physical design of the ward is part of ensuring an environment for patients in which they feel they are being cared for in dignity and safety. All patients need adequate privacy and space to retreat from those who are perceived as threatening. Subotsky (1991) emphasised the significance of changes in acute psychiatric facilities: the higher turnover of a younger, more disturbed population in acute wards, which are often cramped and old fashioned with few single rooms, contributes to increased sexual harassment. All wards should strive to provide an environment that combines safety, privacy and reasonable comfort.

The good practice guidance entitled *Safety, Privacy and Dignity in Mental Health Units* (NHS Executive, 1999) makes suggestions on ward design which take these issues into account. The guidelines state that NHS trusts need to ensure that all patients are protected from physical, psychological or sexual harm while in hospital and to recognise that the needs of male and female patients may differ. The government was committed to phasing out mixed-sex hospital accommodation, with the objective of eliminating it in 95% of health authority areas by the year 2002. Unfortunately, this has not been achieved. Standard 5 of the National Service Framework for Mental Health (Department of Health, 1999) included access to single-sex accommodation in hospital. However, separating the sexes into single-sex wards does not necessarily prevent unacceptable behaviour and is not necessarily preferred by patients (Mezey *et al*, 2005). Verbal and physical as well as homosexual abuse can occur on single-sex wards and patients will meet the opposite sex as visitors and healthcare personnel.

Staff and patients

The prevention of any boundary crossing or abuse in care settings is founded on an understanding of its causes and recognition of incidents. Understanding the multiple factors which play a part in the aetiology of inappropriate sexual behaviour is necessary to devise principles of good practice, training, supervision and other solutions to prevent it. Personal factors in individual members of staff and patients will play a part but individual psychopathology (although it cannot be ignored) is not an adequate explanation for abuse in an institution. Multiple factors, including ones within the organisation, need to be considered.

Patients may behave in ways which do not correspond to social norms. They may be more aggressive, more passive or more disinhibited than usual and approach others, including staff, inappropriately. However, generally staff are in a position of power in relation to the patient and need to exercise this with care, always being thoughtful about the possible consequences of attitudes, words and actions. More than in other medical settings, the psychological relationship between staff and the patient is an essential part of the treatment in psychiatry. The staff member needs to be emotionally close enough to patients to allow disclosure of intimate personal material and for patients to feel they have been listened to and understood; however, at the same time, staff need to retain the skill of clinical detachment and the ability to recognise and examine their own feelings in the interaction.

Staff working with people with a history of being sexually abused may have particular difficulties. The work itself can become abusive or voyeuristic. Staff need to examine their motives for choosing this type of work and always to consider their responses to patients, including monitoring the intention behind their questions. Questions should be motivated by clinical concern, not personal curiosity.

Supervision and training must be made accessible and available to all staff. They need a safe and containing space in which they are able to acknowledge possible lack of skills or knowledge, and to voice anxieties and concerns about their own feelings and potential behaviour, the behaviour of patients and, if necessary, the behaviour of other staff members. To help ensure an ‘open system’ and reflective practice, a staff discussion forum can be useful, especially with a facilitator who is specifically trained in cultural competency and who works in a culturally sensitive way.

Types of treatment

Clearly, some treatments provide more opportunity for abuse than others. Risky situations include the use of frequent one-to-one sessions in isolated places or times, the use of benzodiazepines and other sedatives, hypnotherapy, and ‘touching’ treatments such as massage or aromatherapy. The Kerr/Haslam inquiry (Department of Health, 2005) warned against the use of ‘unorthodox’ treatments without good explanation, consent and monitoring. It is recommended that trusts should have evidence bases and protocols for treatments and that they should be aware of therapies being undertaken by all staff, through supervision, appraisals and job plans. A register of treatments is a useful mechanism for recording treatments and approved protocols; it could also include chaperone requirements, and specify levels of training and supervision requirements for each treatment.

Policies and procedures

While policies in and of themselves cannot protect against every eventuality, their development, monitoring and review at the very least promote awareness, identify risks and difficulties, and clarify priorities.

Developing policies

Each unit should have a clear written policy which covers acceptable, consenting activity and issues such as harassment, sexual assault and sexual abuse. The policy should ensure that sexuality and sexual issues are considered as part of individual care plans. Such policies are likely to vary in different settings – policies on short-term acute admission wards will necessarily be different from those in settings where patients are admitted for more prolonged periods. In child and adolescent units, such a policy will have a quite different emphasis from that in an adult ward.

Policies should include full consideration of wider unit or trust policies, including issues of culture, ethnicity and patients' views. There should be well documented procedures for responding to untoward incidents, including how the issue of police investigation and charging should be discussed and pursued in the case of a patient perpetrator of a sexual assault. Subotsky (1993) outlined a simple policy as an example of good practice.

Such policies should be drawn up by multidisciplinary groups with patient and carer representation. Other agencies will need to be involved in the formulation of sexual abuse policies, especially the police, social services and the local sexual health services, so that their response capacity is understood. The trust's legal department will need to be consulted also. For children, the local child protection personnel will need to be involved, such as the area child protection committee, the health authority's designated doctor and the trust's named doctor and nurse.

Staff should be properly trained in implementing the policy, and training should be part of induction.

Recognition, management and monitoring

It is difficult for patients to complain, especially about potentially embarrassing issues and when they do not feel safe to do so. Complaints procedures therefore must be as accessible as possible, with support available from both staff, such as a patient advice and liaison service (PALS), and independent advocates. Psychiatric patients raising complaints should be treated with care and consideration.

It is very likely that sexual incidents, like many others, are under-reported currently, as staff are unclear what good it will do and may wish to avoid further difficulties. At present trusts are revising their reporting systems of serious and untoward incidents, and sexual incidents should, clearly, be part of these, so that figures can be collected and investigations made as to the possibilities of prevention and the appropriate handling. 'No blame' policies should help encourage reporting.

It is vital that adequate procedures are in place to ensure that incidents cannot be 'hushed up', but can be dealt with sensitively and professionally by senior members of staff. The police should become involved quickly where appropriate. Regular review of staff attitudes is also important, probably through in-service training and continuing education.

There should be well established procedures for monitoring and auditing ward philosophy and policies, as well as untoward incidents or allegations and their management. Quality checklists could be helpful in this area and could be drawn up at the time of drafting the policies.

Abuse by staff

The Kerr/Haslam inquiry (Department of Health, 2005) highlighted abuse by staff as an issue and commented that the culture of the hospitals concerned was such that 'patients were routinely disbelieved'. While false allegations do occur, the possibility of staff abuse, including by senior doctors, must be borne in mind.

Sexual harassment and abuse of patients by staff may fall for doctors into any or all of the following categories of transgression:

- against trust disciplinary codes and policies
- against guidelines from the General Medical Council (GMC)
- against guidelines from the Royal College of Psychiatrists
- against the law.

All have their own associated methods of investigation and sanctions, which unfortunately may be at cross-purposes with each other, as repeated questioning of complainants is clearly undesirable. Revised policies could indicate the standards clearly, but the role of the employer must be emphasised as the primary 'enforcer'. Trust policies should apply to all staff and be as explicit as possible about what sorts of behaviour are acceptable and not acceptable, including what sorts of 'touch'. Other boundary issues, which are not at this level, such as socialising or financial transactions, also need discussion, as they can be part of a 'slippery slope'. College Report CR146, *Vulnerable Patients, Safe Doctors*, recently revised, clarifies that 'sexual relationships with patients or former patients are unethical' (Royal College of Psychiatrists, 2007). Recent GMC guidance on this issue is recommended (General Medical Council, 2006). In addition, supportive 'whistle-blowing policies' are essential so that staff, regardless of their status, can safely report concerns about other staff's behaviour.

Different services should have unambiguous protocols about what level of physical examination is required under different circumstances (e.g. admission, first out-patient attendance, emergency, home visits). In the development of such policies, consideration should be given to the possible interpretation of standard examination as intrusive, because of either cultural

beliefs or mental state. Patients need to have a clear understanding of the nature of the examination being undertaken, its implications and their rights to a chaperone in all circumstances, not just where an intimate examination is being undertaken. For intimate examination, ideally the examiner should be of the same gender as the patient, although this may not always be possible. However, a chaperone should always be available and offered (see also NHS Clinical Governance Support Team, 2005).

Staff issues

Recruitment

Formal inquiries have suggested that a number of sexual abuse incidents could be prevented if good recruitment practices were followed. Pre-employment police vetting should be undertaken to the highest possible level (such as via the Criminal Records Bureau disclosure system), as all psychiatric patients can considered vulnerable. All staff – whether permanent, non-clinical, temporary or volunteer – should be checked if they have potential access to patients. If it is necessary to use agencies, only those that have police-checked their workers should be used. These agencies must comply with the Race Relations (Amendment) Act 2000.

The Kerr/Haslam inquiry (Department of Health, 2005) recommended that one of the referees in any job application should be the consultant who conducts the applicant's appraisal, or the applicant's clinical director or medical director, and that references should be obtained from the three most recent employers and 'properly checked'. The Royal College of Psychiatrists should ensure that this is part of training and advice to College appointments advisers.

Medical staff have to be on the GMC register as a condition of employment, and it is recommended that other professional staff also should be required to have appropriate affiliation to ensure regulation, even if the recruitment to a mental health post is 'generic'.

Staff performance

Supervision, appraisal and job planning systems must be systematically and effectively used for all clinical staff, irrespective of status. For senior practitioners, whose work may often be independent, '360 degree' appraisals could be helpful. 'Clinical supervision' is an ambiguous term but supervision systems for senior clinicians should be seriously considered. Some trusts do this through peer groups for continuing professional development (CPD), but other models would be possible. Recent government guidance takes the view that poor practice or deliberate abuse should be picked up by 'strengthened clinical governance, a robust system of revalidation, and closer links between local clinical management and national regulators' (Department of Health, 2007).

Staff training

Training is an essential part of any policy for dealing with abuse. All staff receive 'risk training' with an emphasis on self-harm and violence. Issues around sexual and other abuse could be incorporated into this.

Staff members who spend the most time in direct contact with patients and therefore exposed to serious psychopathologies for the longest are those who need to be highly trained and to be the most experienced. This must be supported by senior management, so that priority may be given to training in the prevention, recognition and management of abusive and potentially abusive situations. Professional bodies, in consultation with the Council for Healthcare Regulatory Excellence, are aware of the issues around appropriate boundary keeping and are producing policies and guidance that will be of use in training. Training needs to address staff attitudes and behaviour in addition to the use of policies.

If the possibility of abuse in a psychiatric setting has not been considered, then staff will be more likely to miss or dismiss the signs that an abusive situation has arisen. Complaints by patients of sexual abuse or harassment can easily be dismissed as delusions or exaggerated fears. Staff need to listen to their patients and to be vigilant.

Those who develop curricula for healthcare workers should ensure that information is provided on boundary issues, reporting responsibilities and clinical governance. Boundary and other ethical issues should be part of all levels of psychiatric training.

As incidents are reported, internal inquiries should identify and address outstanding policy and training needs in the area of sexual abuse. Personal development plans could promote training in this area. Training packages, also involving cultural competency and sensitivity, should be appropriate for use in both community settings and hospital environments.

A training package may usefully include the following:

- how to recognise and acknowledge personal feelings, both to oneself and also to one's supervisor, while behaving entirely appropriately and professionally (healthcare workers should be able to discuss feelings of sexual attraction 'without the automatic risk of disciplinary action' – Department of Health, 2005)
- awareness of psychodynamic processes, interpersonal and institutional
- recognition of inappropriate behaviour in self and others
- how to speak clearly, comprehensively and explicitly about sexual matters in an unsexualised way
- assessment of competence and decision-making capacity
- how to treat patients in a gendered but unsexualised way
- management of sexuality in different healthcare settings
- how to manage the patient with overtly sexual manners and behaviour
- the management of staff–patient conflict over sexual issues
- recognition of signs of sexual abuse in different patient groups
- an understanding of different religious and cultural mores

- management and support of the patient who has been abused or harassed
- ethical and legal issues in relation to sexuality, including the power differential between staff and patients, and factors to do with control and detention
- knowledge of trust/unit policies
- knowledge, skills and confidence to act when necessary, for example by preventing a patient acting out sexual feelings, by reporting an incident or by contacting the police.

Support to patients

Service user involvement

Patients and their carers should be actively involved in the setting up and review of policies and procedures. Regular opportunity for debate, involving patients, staff and concerned outsiders such as women's groups, may help raise consciousness and contribute to the development or modification of policies.

Information and education

New patients should be provided with information in a language they can understand on what to expect in assessment and treatment, and admission. Appropriate leaflets could be developed and used to help ensure good practice in obtaining informed consent. Patients should be given the opportunity to discuss this information face to face with a staff member. Interpreters should be available if required. Note that it is not always appropriate for a family member to act as an interpreter.

If a physical examination is intended, patients should be given information and offered a chaperone. Patients need to have a clear understanding of the nature of the examination being undertaken, the implications and their rights to a chaperone in all circumstances, not just where an intimate examination is being undertaken.

Patient education, particularly in longer-term treatment settings, has an important part to play in the prevention of inappropriate sexual behaviour. Information and advice on sexual and relationship issues should attempt to meet the needs of individual patients. There may be a need for specific sex education, and health promotion should be part of any education offered to patients.

Patients and carers should be told about how they can:

- comment on the service
- raise a concern
- make a formal complaint
- access advocacy services and other agencies offering assistance.

With children and adolescents, access to social services should be ensured.

Support and counselling

In the event of an allegation of sexual harassment or assault, staff should appropriately support the complainant while investigating the allegation. Patients should be made aware of complaints procedures and be able to access independent advocacy and support, as making reports about sexual matters is difficult in itself and may lead to further demands for 'written evidence', reporting to the police and further interviewing or even cross-examination.

While practical, immediate steps may be the priority, subsequently patients who have been subject to sexual abuse, perhaps especially if by staff, may need access to psychotherapeutic treatment. The voluntary agency Witness (previously named POPAN) is a useful advisory source on this (see http://www.popan.org.uk).

Staff should be alert to the needs of other patients on a unit when there is a serious untoward incident, while respecting confidentiality. Separation of the two parties concerned is likely to be necessary.

Settings and specialty issues

Various specific issues arise in relation to the function of the ward or unit and also as particular problems with specific patient groups. Issues which merit special consideration are discussed here.

Acute wards

Perhaps the most important specific issue that arises on acute general psychiatric wards is the fact that the intake is non-specific. On a ward, at any time, there may be an adolescent as young as 15 and often patients over 65.

Patients with diagnoses across the range of mental conditions may be admitted. Some will be acutely disturbed and others may be waiting to be discharged. Acutely ill patients may be sexually disinhibited and invite from another, or propose to another, inappropriate sexual activity. Others may, by virtue of mental illness or personality, be vulnerable to the sexual approaches of others. This risk must be assessed and care planned, taking religious and cultural needs into account.

Many patients will have their competence to handle personal relationships affected by having had abusive experiences. On occasion, patients with a specific history of a sexual offence may be accommodated on a general psychotic ward for assessment, treatment and reports.

The multidisciplinary team must be aware not only of the care plan for each individual, but also of the potential adverse interactions with other in-patients. For patients who are likely to have only a short stay, it may be appropriate to deny sexual contact altogether. Many patients have periods of leave from the ward and staff should be aware not only of the likely interactions on the ward but also of likely behaviours while on leave.

In dealing with acutely disturbed and possibly vulnerable patients, staff need to consider procedures that relate to intimate contact, particularly during physical examination and restraint. Staff expected to do this must be properly trained in these procedures and must ensure that they regularly update their skills.

The move towards single-sex accommodation is not a panacea, but service users report a perceived improvement in safety, particularly when the option of single-sex day areas is available. It remains the case that many localities are struggling to deliver a modern service in outdated facilities.

The maintenance of an informed, aware and safe ward culture depends not only on the patient mix and the facilities but also, crucially, on the staff. Problems are encountered on acute wards where there is persistent staff shortage and heavy use of locum/agency personnel.

The ability of patients to make their views known should be actively encouraged through patients' fora and advocacy. Policies should be clear and developed with the involvement of patient representatives. Patients should be informed about how to make concerns known, both informally and through formal trust complaints procedures.

Long-term care settings

People who are more chronically mentally ill present some different problems. There is a fine line to be drawn between protection of those who are vulnerable from exploitation and abuse but at the same time preservation of their rights to fulfilment of their sexuality.

Many vulnerable adults, including those with a chronic mental illness, intellectual disability or dementia, are now looked after in group homes and hostels in the community where people from Black and minority ethnic groups in particular could feel that their needs are not being met. The opportunities for abuse and ill-treatment of these people may be even greater than in hospital settings. Many homes are isolated, with only infrequent visits from managers, registration inspectors or social workers. In the intellectual disability service, the emphasis on 'normalisation' has meant that all home visits by psychiatrists are by prior appointment, so it is easy for abusive situations to go undetected.

Large-scale investigations in recent years have highlighted common themes, which could be used as indicators of situations where abuse is more likely to occur. These include:

- one dominant member of staff (usually male) who is older and longer-serving than the rest of the staff
- sexual harassment of female staff
- misuse of alcohol
- isolation from other services
- lack of monitoring of procedures (e.g. for bathing)
- financial irregularities
- low staff morale
- poor record-keeping
- feelings of powerlessness in staff
- lack of respect for service users.

Awareness of these indicators may enable managers, professionals and registration authorities to detect abuse or to prevent it before it occurs.

Out-patients and psychotherapy

The main sexual boundary risk in out-patient sessions is between staff and patient because of the one-to-one, continued, unobserved nature of the sessions, although patient-to-patient hazards can also occur in waiting areas. This issue has been particularly highlighted in the literature from the

United States (see for instance Gabbard, 1999) and has been reviewed by Sarkar (2004).

At assessment, detailed questioning about sexual issues and physical examination that is unexpected, unchaperoned and not perceived as relevant by the patient can be a source of concern. Even very experienced professionals have been known to justify aberrant moves to sexualise a relationship with a patient as being in the patient's best interests.

Experience of providing psychotherapeutic treatment under clinical supervision during training can help psychiatrists become more aware of transference and countertransference possibilities, including the nature of power imbalance and potential vulnerabilities to act out on both sides. Boundary 'transgressions' may be non-sexual and apparently minor, but may lead on to serious violations – a process often described as 'the slippery slope' (for a fuller account of this, see Gabbard, 1999).

The emotional intensity and intimacy of psychotherapeutic treatments also pose dangers in themselves. Generally, out-of-hours and unsupervised treatments should be discouraged because of risk to both patient and therapist. Special techniques, especially if they require any form of touch (such as some forms of psychosexual counselling), should not be undertaken without rigorous training and supervision.

Special care units/secure units

In secure settings, there are particular issues concerning privacy. For example, patients who are self-harming should always be provided with appropriate clothing, even if this needs to be tear-resistant in order to minimise the risk of self-harm. There is no excuse for stripping patients in the presence of staff of the opposite sex, and changing patients from their ordinary clothes into such strong clothing needs to be done with due attention to the dignity and privacy of the patient. These issues are likely to be relevant in other settings as well as special care units, psychiatric intensive care units (PICUs) and secure units.

Special care units are designed for observation and security rather than privacy. This can cause difficulties in provision of adequate facilities for women to feel safe on a mixed-sex ward. Perpetrators and victims may be on the same ward. This may give rise to the feeling in victims that they may be used as a means of assessing the perpetrator's potential for reoffending.

The situation concerning patients in special hospitals and, to a lesser extent, regional secure units needs recognition. Many patients are now admitted to private medium- and low-security settings. These are places where people may be living for many years without free access to sexual relationships. In regional secure units, in particular, the patients are often young adults at the peak of their sexual interest, who may be in care over a prolonged period.

Women in these settings may have been victims of sexual abuse or violence. Some of the men may be known sex offenders. It is important to consider the staff responses to emerging sexual relationships between patients, the provision of privacy, sex education and condoms. Sexual vulnerability or exploitativeness must be recognised and addressed by the multidisciplinary team in individual patient care plans. It may not be

appropriate to deny patients all modes of sexual expression over a prolonged period unless this has been carefully considered as part of a detailed care plan agreed with the patient as far as possible.

Older patients

It is not merely increasing age which makes people vulnerable. There is evidence that older people with mental and physical disabilities are the most likely to be abused (Royal College of Psychiatrists, 2000). Abuse of such people is under-recognised and under-reported. Probably this is most true of sexual abuse, because of the nature of the acts.

In institutions, older people are in a position of dependency and so may represent easily targeted victims who will not cause much trouble. In the younger staff, this situation of unequal power may stimulate sexual or sadistic responses. As in all situations of abuse, there may be collusive aspects, with the victim seeming to invite a sexual approach from the younger staff. Whatever the provocation, there are no circumstances in which a sexual response is appropriate.

In the event of abuse, patients may well be able to say and describe exactly what has happened to them but choose not to owing to embarrassment or shame. Because of language and cognitive problems, patients with a dementing illness will have greater difficulty relating events. Descriptions of previous experiences may be conflated with current ones and it is easy for the listener to dismiss a patient's report merely as 'evidence of confusion'. Any suggestion or accusation of sexual impropriety with a patient must be taken seriously, and staff supported appropriately through an investigation, which may or may not find evidence of wrong-doing.

Staff may need to be involved in the most intimate of personal care for some patients. This always needs to be carefully explained and talked through, approached with sensitivity and kept firmly within boundaries. The potential for misinterpretation of staff actions is enormous. Where possible, same-sex carers should undertake this type of personal care. Religious and cultural expectations must be taken into account.

Sexual abuse should be considered if a patient has bruising on the inner thighs, blood on underwear, sexually transmitted disease, frequent infections or genital or urinary irritation. The patient may try to hide part of the body on examination or show fearfulness with a particular member of staff, unusual clinging, weeping or sobbing, seeking attention or protection, or a change in behaviour or attitude to sex.

Patients may abuse staff – grabbing and touching – when they are engaged in care tasks. For patients who are in control of their behaviour, it may be appropriate, after warning, to discharge them – there is no reason why staff should tolerate this. For others, careful but firm management by experienced staff can contain a difficult situation.

Sexuality is important throughout life. Patients in long-stay institutions may not choose to end their days in sexless isolation. Some homes or wards, through sensible policies and congenial architecture, allow contact between patients and spouses or for patients to masturbate in private. It is more complex when two patients start a relationship. For patients suffering from a dementing illness or following a stroke with cognitive impairment, issues of capacity and consent need to be determined by the staff. Patients may

mis-recognise a fellow patient as a partner, often causing pain to the spouse, or they may wander with one another throughout the day, throughout the building, with no more than hand-holding and the knowledge that someone sympathetic is with them.

A sexually disinhibited patient can cause havoc in an otherwise smoothly functioning home. We prefer to think of older people as sexless and staff are sometimes rendered panicky and impotent by an obvious demonstration of the reverse. It is rarely appropriate to use medication. Other patients may need to be protected, although the main issue may be calming angry relatives. The situation can usually be managed by understanding, distraction, a low-key approach to management and a private space for the patient.

Behaviour is often better in mixed-sex settings. It seems unreasonable to segregate the sexes when they have spent a lifetime living together in a normal society. However, sensitive, skilled nursing and a well designed ward should allow flexible use of areas, if necessary with temporary segregation of individuals or groups, especially at night and in bathing areas, while overall maintaining the ethos of a community of a mixed-sex nature.

The sexual relationship between husband and wife or long-term partners raises difficult issues for psychiatrists. Some male partners of female patients with a dementing illness have given up sexual intimacy because the wife behaves more like a compliant child than an adult woman (Garner, 1997). Others continue the sexual side of the relationship and in the context of an apparently content long-term relationship it may not be helpful for doctors to be proactive in policing the situation. Nonetheless, the possibility of abuse may arise.

Intellectual disability

As with the elderly, people with intellectual disability who require care from professionals are in a relationship with carers which involves an imbalance of power. This makes it more likely both that abuse will occur and that it will go unreported. Many require help with personal care, such as bathing, which may give opportunities for physical and sexual abuse. Difficulties with communication may hinder the reporting of abuse and also result in allegations not being taken seriously (Cooke, 1990).

Another issue in relation to people with intellectual disability is the fine line to be drawn between the protection of those who are vulnerable to exploitation and abuse and the protection of their right to fulfilment of their sexuality. This issue is well presented by Tharinger *et al* (1990), who point out that those with intellectual disability show sexual development and interest at approximately the same age as the normal population. Where there is little opportunity to understand and explore their sexuality, they can easily become the target of abuse and exploitation. This is compounded by a desire to fit in with what is perceived by them as normal behaviour. Brown & Craft (1989), in their book *Thinking the Unthinkable,* outline clearly the tension created between enabling people to live as independently as possible while protecting them from abuse or exploitation. This requires structures and training within the organisation.

The emphasis in *Valuing People* (Department of Health, 2001) on the use of generic psychiatric services for people with intellectual disabilities

means that many of those who also have mental health problems will be admitted to acute adult psychiatric in-patient units. They may be particularly vulnerable to unwanted sexual advances from other patients on the unit.

Children and adolescents

While the possibility of abuse in social care (e.g. fostering and children's homes) is now well recognised, it is only recently, with the publication of the Carlile review (National Assembly for Wales, 2002), that the similar issues for children in NHS care have begun to be systematically addressed. Many of the issues for children and young people are also relevant to adults.

Among the many recommendations of the Carlile report, some of the most relevant are that children should be placed on children's wards in the NHS as a whole and that separate adolescent provision should be considered. If, in mental health services, children or young people are placed on adult wards, then they should still be dealt with only by child and adolescent mental health staff. All NHS staff who have access to children in their work should be police checked and trained in child protection. Special care in terms of checking of police records, references and supervision should be taken with agency staff, locums and those newly recruited from abroad.

Other preventive measures include ensuring that child and adolescent psychiatric residential units are not professionally isolated and do not have a lone consultant in charge for long periods. All in-patient and adolescent mental health units should be regulated and inspected following the same principles as those for the regulation of residential child care facilities.

As allegations are likely to arise, human resources policies concerned with allegations of abuse should promote timeliness, efficiency and proportionality.

Complaints procedures should be developed suitable for children, young people and their families, and advocates should be available for children. Procedures on child protection, untoward incidents, clinical governance and discipline in cases of alleged abuse should be reviewed and harmonised. Whistle-blowers should be protected. Therapeutic services for sufferers of abuse should be developed.

In addition, further thought should be given to safety and privacy for young people in terms of sleeping and bathroom accommodation. There is a shortage of appropriate care and treatment facilities for the most seriously disturbed young people with antisocial behaviour, which may well include sexually disinhibited or abusive behaviour.

Children may also be at risk in other settings, for instance when visiting adult psychiatric wards. One suggestion is to have 'child safe' areas in adult wards, and to provide appropriate training for the staff in child protection issues.

Substance misuse patients

Facilities for the care of patients with substance misuse problems will have similar problems to those of facilities for people with acute mental illness. The disinhibiting and other effects of alcohol and certain drugs may contribute to sexual abuse, and this may be a problem also in acute

admission areas and out-patient departments. Positions of power may be abused in substance misuse settings just as much as in other areas.

Forensic patients

The forensic population is a particularly vulnerable group, who frequently have a history of abuse. Those (the majority) who are detained, usually without limit of time, are also disempowered and dislocated from their support systems.

Given the nature of the population in forensic psychiatry, there could be a tendency to dismiss allegations made by them against staff. It is important, therefore, that systems are in place which enable patients to have a voice, access to advocates and a complaints system which is user-friendly.

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