FRONTLINE PERSPECTIVES

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Let's Talk About Sex: Staff Attitudes and Perspectives About Sexual Activity Among Forensic Mental Health Clients

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Abstract

While it is accepted that many people residing in forensic mental health units are sexually active, policies regarding sexual activity are incoherent, if they exist at all, and staff are often reluctant to discuss or support sexual expression with their clients. This study describes staff attitudes and perspectives about sexual activity among forensic mental health clients. With the guiding principles of interpretive phenomenology, a multiple case study method was used to survey two forensic mental health services in Ontario, Canada – one that has a policy in place regarding sexual activity, and one that does not. Findings describe staff perspectives on the permissibility of specific types of sexual activities and types of relationships, and share the importance of specific clinical considerations including staff education needs. Four emergent themes are discussed – consent and capacity to consent, risk of harm, privacy and embarrassment, and professional responsibilities.

Key Words: sexual activity, consent and capacity, risk of harm, professional responsibility

Introduction

It is accepted that many people residing in forensic mental health units are sexually active even when it is expressly forbidden or punished by the institution (Bartlett, Mantovani, Cratsley, Dillon, & Eastman, 2010). International policies in forensic sites show significant variations of views on sexual expression, of screening procedures, of safe sex practices, and of privacy spaces influenced by staff attitudes within a site (Tiawana, McDonald, & Völlm, 2015).

Sexual expression is important to mental health clients, yet staff commonly avoid discussing and providing support related to sexual expression (Quinn & Happel, 2012). The challenge of balancing risk and recovery in forensic mental health settings includes concerns about sexually transmitted infections, pregnancy, sexual coercion, and protecting vulnerable persons (Drennan & Alred, 2012; Quinn & Happell, 2012). Legal and ethical concerns regarding the capacity of forensic mental health clients to consent to sexual activity are gaining increased attention (Perlin & Lynch, 2014; Walker-Renshaw, 2012). While it is recognized that the presence of a mental disorder does not mean a lack of capacity to consent to sex, the criteria for capacity to consent are not clearly defined in Canada (Perlin & Lynch, 2014). Legal and health professionals responsible for drafting policy and making decisions about sexual activity are reliant on criteria within the federal criminal code regarding sexual offenses and provincial legislation regarding capacity to consent to health care decisions for guidance.

In a review of policies across the United Kingdom, Bartlett et al. (2010) found inconsistencies within policies of forensic mental health services and that having a policy, in itself, was not sufficient to provide a clear message for clients. Policies, when they exist, have been shown to carry the assumption that "sex and emotional relationships are clinical matters subject to regulation" (Bartlett et al., 2010, p. 160) and clients experience a lack of support from health care professionals in navigating sexual relationships (Quinn & Happell, 2012). Bartlett et al. (2010) also identified that “the absence of a clear policy increases the probability that staff will be guided by their own moral judgments and personal beliefs, and hence act” (p. 156).

The aim of this study is to describe the attitudes and perspectives about sexual activity among staff responsible for developing and implementing policies, making clinical decisions, and responding to sexual activity among forensic mental health clients in Canada. The findings are intended to help inform the development of policy, changes to current policies and practices, and staff educational needs regarding sexual activity of the clients in their care.

Methods

Following the theoretical foundations of interpretive phenomenology, a multiple case study design was used. Interpretive phenomenology is based on the concept of shedding light on aspects of the human experience that are typically hidden and is ideal for new areas of investigation (Lopez & Willis, 2004). The multiple case study design (Stake, 2006) focused on two forensic mental health services in Ontario, Canada. Both sites were subject to the same provincial legislation for regulated health professions and mental health care as well as the provisions of the Criminal Code of Canada (Government of Canada, 1985) through which individuals are subject to the jurisdiction of the Ontario Review Board. The sites were also purposively selected to include one site that has an existing policy regarding sexual activity among clients and one site that does not have a policy in place. Approval for the project was granted by the Health Science Research Ethics Board at Dalhousie University as well as the research ethics boards at the two forensic mental health services where the research took place.

Data collection

Consistent with the theory of interpretive phenomenology, the authors adapted (with permissions) an existing survey tool (Talbot, 2015) using Opinio®, a web-based survey service hosted on secure servers at the first author's post-secondary institution. The survey was piloted with three researchers and three occupational therapists with survey design expertise and/or forensic clinical experience. Changes were made to clarify answer options and to correct technical issues with the electronic format. Pilot responses were not included in the analysis. The final survey had a total of 47 questions: 6 multiple choice, 36 multiple choice with the option of adding comments, and 4 short-answer questions. Respondents were not asked to disclose any identifying information (name, IP address, etc.), providing an initial level of anonymity. All potentially identifiable data was analyzed in relation to common themes and incorporated as aggregate data.

Recruitment

All staff at both sites were invited to participate in the study by e-mail, which included a description of the project and that consent to participate was implied by clicking on the survey link and submitting responses to the questions. Respondents were recruited from the entire staff

complement of full- and part-time employees, as well as contract staff, at both sites. This included all regulated and non-regulated health professionals, program staff, security, administrative and custodial staff, and managers. All employees of both sites are required to be fluent in written English, therefore there was no anticipated language barrier.

Respondents

Overall, there was a 16.7% (n=75) response rate between the two sites. This is a modest response rate that averages a stronger response rate (31.3%; n=47) from the site that does not have a policy about sexual activity with a poor response rate (9%; n=28) from the site that does have a policy. This difference in response rates is not likely attributable to having a policy in place since 43% (12/28) of respondents from the site with a policy did not know that the policy existed. Respondent characteristics are summarized in Table 1.

Data analysis

Descriptive analysis of multiple choice responses was done through the Opinio® survey software. Inductive content analysis was used for analysing comments and short answer questions, which is an appropriate approach to investigate underexplored phenomena (Vaismoradi, Turunen, & Bondas, 2013). This approach required open coding of the data into multiple categories then collapsing these categories into broad themes. It was an iterative process that went back and forth between the categories and the data to ensure that the data illustrated the themes. All three authors were actively involved in analysing and interpreting the data, as well as engaging in discussions to obtain consensus on the final themes.

Findings

Staff perspectives about the permissibility of specific types of sexual activities and types of relationships and the importance of specific clinical considerations are described, and four emergent themes are discussed: consent and capacity to consent, risk of harm, privacy and embarrassment, and professional responsibilities. Staff educational needs are also discussed.

Sexual activities and relationships

Most respondents (69.3%) agree or strongly agree that forensic mental health clients should be able to engage in sexual activity. While a small percentage (6.7%) of respondents disagreed or strongly disagreed, the more curious finding was that 18.7% of respondents neither agreed nor disagreed. This could be an indication of ambivalence towards sexual activities among clients, however numerous comments throughout the survey overtly expressed uncertainty or a sense of being unprepared to address this issue. The responses "*unsure*", "*I don't know*", "*beyond my clinical knowledge*", "*???*", and "*not that I'm aware of*" were provided by many respondents for several of the questions, particularly those related to professional responsibilities. Despite uncertainty on many aspects of this issue, most respondents acknowledged that clients are having sex at their sites, primarily in common spaces such as bathrooms, stairwells, and outdoors. Estimates of how many clients at their sites are engaging in sexual activities ranged from 5% to 75%, with most estimates being 40% or higher.

Respondents were asked a series of questions about whether or not clients should be permitted or prohibited from engaging in specific sexual activities, and within what relationships these activities might be supported (see Table 2). At least two thirds of respondents indicated that most types of sexual activity should be expressly permitted or permitted under certain circumstances. Across the types of sexual activity, the concerns expressed remained consistent: consent and both partners' capacity to consent, privacy, the risk of a client being harmed, as well as the risk of a client causing harm to another person. The question about access to pornographic materials generated comments and questions about the legality of certain materials, the innate victimization and dehumanization of people represented in pornographic materials, staff comfort with some forms of pornography (magazines) over other forms (videos), and the principle of equivalence which asserts that "*if clients are living here, they should be afforded the same privileges as they would if they were living in the community*".

Almost all respondents indicated support for clients engaging in sexual activities with their spouses or long-term partners. Most staff indicated support for sexual activities with new partners from outside the hospital (69.4%) or with fellow clients (76%). There was significant opposition to clients paying for sex with 84% of respondents indicating that it should be discouraged or prohibited. The primary objection expressed was that it is illegal in their jurisdiction and that "*clients should have to adhere to the same laws as the rest of society*". Of note, given that in this jurisdiction it is illegal to

discriminate based on sexual orientation, was the finding that 14.7% of respondents disagree or strongly disagree that opportunities for sexual activity should be afforded equally to heterosexual and homosexual relationships.

Clinical concerns

Respondents were asked about the importance of a series of specific clinical considerations regarding engagement in sexual activity (see Table 3). The greatest importance was placed on the clients' capacity to consent to sexual activity (96%), the risk of spreading sexually transmitted infections (94.7%), vulnerability of clients (93.3%), and clients having a history of being victimized (82.7%). The importance of client education regarding matters of sexual health was identified, as well as the availability and use of condoms to prevent unwanted pregnancies and the spread of sexually transmitted infections. The majority of the responses were qualified in relation to the dynamic nature of the illness experience: *"the level of wellness impacts one's ability to consent and understand the risks verses benefits"*.

Consent & capacity

The majority of the respondents focused on a client's capacity to consent to sexual activity and equated this with the capacity to consent to health care. Many respondents felt that if a client was capable to consent to health care then they should be capable to consent to sex. Conversely, *"...I would say anyone incapable to consenting to treatment would be out of the question"*. While legislation on capacity to consent to health care provides some principles for decision-making, it presents particular legal and ethical dilemmas in decision-making regarding sexual activity. Despite the Criminal Code of Canada (Government of Canada, 1985) being clear that consent to sexual activity cannot be given on another person's behalf, several respondents suggested, for a client who does not have capacity to make health care decisions, that the substitute decision maker be involved in decisions regarding sexual activity.

All respondents agreed that at times an assessment of the client is required before engagement in sexual activities. Suggestions included assessing the client's ability to engage or not engage in sexual activity without fear of harm, without being victimized, without coercion, and to prevent sexual activities being used as a form of bartering, as well as assessing the client's ability to know how to protect oneself, know what consent is and what it is not, know how to give consent, and

know how to "*understand the ramifications of the intimate act".* Participants did not identify existing frameworks for assessing capacity to consent to sexual activities or in whose professional scope of practice such an assessment can be conducted.

Risk of being harmed vs. risk of causing harm

The concept of risk was prevalent in the responses, and staff concerns of clients at risk of being harmed were juxtaposed with staff concerns of clients at risk of harming others. Staff expressed significant sense of responsibility for protecting their clients: *"we need to protect the vulnerable from the predators on the unit*". Past behaviour was deemed important for consideration, in particular the *"index offence needs to be taken into consideration, especially if (it is) a sexual charge"* and *"it should be part of the assessment to determine if that person can be victimized or a predator."*

Privacy & embarrassment

Both sites had a privacy or conjugal room for client use, though many noted *"the process to access it can be embarrassing and discourage its use".* Other staff members commented on the fact that the room itself is not sufficiently isolated and noises from inside the room could be heard. *"It's in the hallway so if you go in everyone knows what you are doing. It should be a bit more private."* Staff members identified that these barriers could discourage the use of the private room and instead alternative venues, such as common spaces, may be preferred for sexual activity. *"It is not a very welcoming site. It has to be booked, which takes away from a private sexual life"*.

The availability of condoms was largely supported in relation to client safety, but staff lacked strategies for providing condoms that provide privacy and minimize embarrassment which might prevent clients from obtaining them.

Professional responsibility

Responses from both sites commented on the inevitability of client engagement in sexual activities as well as staff unease and a lack of professional direction in terms of the appropriate professional response to sexual activities in common spaces (see Tables 4 & 5).

When asked what staff would do if they observed clients engaging in sexual activities, the most common response from staff was to leave and report it to a nurse, security personnel, or

supervisor. A small number of respondents indicated that they would ask the clients to stop and then report it. However, several respondents said "*it depends on the situation*", including who the clients were and where they were engaging in sexual activity. Only one respondent indicated a professional responsibility to educate and support clients saying that they would "*establish that both wanted to be there…*", balancing the concern about consent with the clients' right to self-determination, then "*…discuss consent and sexual health at a later time*".

The vast majority (88%) of respondents indicated that sexual activities should be documented always or under certain circumstances, such as, "*if they have been diagnosed with a communicable disease – HIV*", "*if the sexual activity was not consensual*", and "*if it was deemed inappropriate*". Some respondents indicated that sexual activity should only be documented in specific cases when it is clinically relevant, such as "*excessive/impulsive sexual activity… may be indication of manic symptoms*" or if "*they choose to discuss it with staff*", while others expressed that it is always clinically relevant "*like any daily activity we document on (i.e.: nutrition, hygiene, [mental status])*". One respondent also expressed that it is useful "*to document informed consent and to highlight the role of relationship in [the] person's recovery*". These findings highlight that personal factors, such as a clinician's own view of what is appropriate or clinically relevant, could lead to differences in practice. Just one respondent expressed a need for *"documentation to remain unbiased. Documenting facts, statements, diagnostic tests related to sexual health. Clinicians have to be mindful not to impose [their] own values and beliefs".*

Only a third of respondents expressed concerns related to professional liability, repercussions from their professional college, or lawsuits. Specific concerns related to pregnancy, rape, or sexually transmitted infections were mentioned: *"Someone could come back and say they were not capable at that time to consent but were deemed capable by staff so now they are going to sue us"*.

Staff expressed a desire for a clear policy they could follow, however at the site where a policy was in place to govern the use of the private room, multiple respondents were unaware this policy existed. At both sites there were respondents who did not know there was a private room at their site. For those that did respond that their site had a policy, there were multiple respondents who stated they do not agree with the policy, reporting that it did not address consent and was out of date regarding disclosure of sexually transmitted infections.

Staff education

Many respondents wrote about educational needs. A willingness to learn was expressed by many and respondents requested support for professional development in: assessing consent and capacity to consent; how and when to assess capacity; knowledge of, and teaching of, contraception options and infectious disease management, how to talk about sex with clients, and client rights vs. staff responsibilities.

One response seemed to represent the overall attitude of the survey respondents: *"Let's educate ourselves so we can be prepared to appropriately respond when sexually related situations arise."*

Discussion/Conclusion

The majority of respondents were generally supportive of clients in forensic mental health settings engaging in sexual activities. First and foremost, they indicated concern for the safety and health of clients in their care. Factors confounding practice include limited knowledge of current best practices, legal standards regarding consent and capacity to consent to sexual activity, and how to balance respect for clients' privacy with responsibilities for client safety and reporting.

Of notable concern are the responses that researchers would typically define as 'outliers'. This would include the 7 respondents who disagree with informing clients about sexual side effects of medication, the 7 respondents who strongly disagree with opportunities for sexual activity being afforded equally to heterosexual and homosexual partners, the one respondent who stated that sexual activity between a client and a new partner from outside the hospital is not legal, the one respondent who indicated that paying for sex should be expressly permitted, the one respondent who indicated that condoms should not be provided at all, and the 10 respondents who do not agree that staff should help clients identify appropriate ways to meet their sexual needs. While these staff may not hold the majority view, the reality presented by Bartlett et al. (2010) that, without a policy in effect, staff will make decisions based on their own personal views and beliefs, raises both clinical and legal concerns about decisions being made by staff with 'outlying' views. The varied responses on what to do when encountering a client actively engaged in sexual activity demonstrated that the majority of staff did not have a plan for responding to such a situation and, by their own standards, the responses were largely inadequate.

Amidst all of these staff perspectives related to clinical care, policy, and decision making, it is

important to acknowledge the inevitability of people having sex and the need for staff to be more adequately prepared to provide the support required.

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Table 1
Participant Characteristics

		Site with a policy n=28 (37.3%)	Site without a policy n=47 (63.7%)	Total N=75 (100%)
Gender	Women	22	36	58 (77.3%)
	Men	5	11	16 (21.3%)
	Other Gender Identity	1	0	1 (.01%)
Age	20-29 years	5	6	11 (14.7%)
	30-39 years	8	12	20 (26.7%)
	40-49 years	4	16	20 (26.7%)
	50-59 years	9	11	20 (26.7%)
	60 < years	2	2	4 (5.3%)
Professional Role	Nursing	12	17	29 (38.7%)
	Allied Health/Psychology	10	10	20 (26.7%)
	Manager	2	4	6 (8%)
	Psychiatry / General Medicine	2	2	4 (5.3%)
	Security	0	2	2 (2.7%)
	Other (personal care worker, clerical, physician assistant, etc.)	2	12	14 (18.7%)
Experience in forensic mental health	< 5 years	13	21	34 (45.3%)
	6-10 years	4	15	19 (25.3%)
	11-15 years	5	5	10 (13.3%)
	16 -20 years	2	3	5 (6.7%)
	21-25 years	1	1	2 (2.7%)
	26 < years	3	1	4 (5.3%)

Table 2
Types of sexual activities and relationships

	Expressly permitted	Permitted in certain circumstances	Discouraged	Prohibited
Intimate touching	9 (12%)	40 (53.3%)	15 (20%)	9 (12%)
Kissing (open mouth)	8 (10.7%)	43 (57.3%)	13 (17.3%)	6 (8%)
Kissing (closed mouth)	14 (18.7%)	36 (48%)	17 (22.7%)	6 (8%)
Hugging	24 (32%)	37 (49.3%)	11 (14.7%)	4 (5.3%)
Holding hands	28 (37.3%)	28 (37.3%)	12 (16%)	4 (5.3%)
Masturbation	37 (49.3%)	30 (40%)	---	---
Access to pornography	18 (24%)	32 (42.7%)	14 (18.7%)	8 (10.7%)
With married or long-term partner	24 (32%)	45 (60%)	---	1 (1.3%)
With new partner from outside the facility	11 (14.7%)	41 (54.7%)	13 (17.3%)	5 (6.7%)
Between patients	8 (10.7%)	49 (65.3%)	12 (16%)	4 (5.3%)
Paying for sex	1 (1.3%)	6 (8%)	25 (33.3%)	38 (50.7%)

Table 3
Clinical considerations

	Very Important	Somewhat Important	Not Important
Diagnosis	30 (40%)	32 (42.7%)	12 (16%)
Clinical Stability	49 (65.3)	25 (33.3%)	7 (9.3%)
Offending History	50 (66.7%)	22 (29.3%)	1 (1.3%)
History of Victimization	62 (82.7%)	9 (12%)	2 (2.7%)
Vulnerability of Patients	70 (93.3%)	5 (6.7%)	---
Sexual Orientation	13 (17.3%)	8 (10.7%)	54 (72%)
Risk of Spreading Sexually Transmitted Infections	71 (94.7%)	2 (2.7%)	1 (1.3%)
Level of Hospital or Community Access	33 (44%)	31 (41.3%)	10 (13.3%)
Capacity to Consent	72 (96%)	2 (2.7%)	2 (2.7%)

Table 4
Professional responsibilities

	Always	In Certain Circumstances	Never
Relationship counseling should be provided	42 (56%)	32 (42.7%)	---
Sex education should be provided	55 (73.3%)	18 (24%)	---
Sexual activities should be documented	14 (18.7%)	52 (69.3%)	3 (4%)
Capacity to consent should be assessed	51 (68%)	21 (28%)	1 (1.3%)

Table 5
Additional professional responsibilities

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
Staff should help patients identify ways to meet sexual needs	10 (13.3%)	32 (42.7%)	20 (26.7%)	5 (6.7%)	5 (6.7%)
Opportunities for sexual activity should be afforded equally to heterosexual and homosexual patients	46 (61.3%)	18 (24%)	4 (5.3%)	---	7 (9.3%)
Clinicians should inform patients about sexual side effects of medication and be prepared to make treatment adjustments	28 (37.3%)	35 (46.7%)	4 (5.3%)	1 (1.3%)	6 (8%)
There should be a policy about sexual activity for forensic patients	22 (29.3%)	28 (37.3%)	15 (20%)	5 (6.7%)	4 (5.3%)
If there is a policy it should be readily available to patients	39 (52%)	29 (38.7%)	5 (6.7%)	1 (1.3%)	---