Managing Sexual Behavior on Adult Acute Care Inpatient Psychiatric Units

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Objective: **Protecting and safeguarding persons with impaired decisional capacity are among the critical functions of a psychiatric hospital. The objective of this study was to investigate the elements of these functions as they relate to sexual behavior on an adult acute care inpatient psychiatric unit and to develop a policy to prevent or at least manage such behavior.** ***Methods:*** **The authors undertook an extensive literature review of articles and legal cases. The review was presented at numerous meetings of staff and interdisciplinary teams on the adult teaching unit at Bellevue Hospital in New York City. The findings from the review and the results of staff discussions were used in creating the policy.** ***Results and conclusions:*** **In the acute care setting, it may be both reasonable and prudent to prevent all sexual interactions between patients, especially given the potential risks of such behavior. Concerns include the transmission of sexually transmitted disease, reproductive issues, and the legal implications of nonconsensual activity. Despite these concerns, adult psychiatric inpatients should be granted as many rights as are possible without having an adverse effect on their treatment or recovery. There is currently no standard for a sexual behavior policy for psychiatric inpatients. Thus ward staff are left with minimal guidance and potential confusion in the event that sexual incidents do occur, and there is a greater likelihood of arbitrary responses. The policy developed through this study is an example of how individual institutions can enforce a structured protocol when dealing with an ambiguous and difficult issue. (*Psychiatric Services* 54:346–350, 2003)**

Among inpatient psychiatric units in the United States, there is little consensus on the management of sexual behavior between patients, even in long-term facilities where the length of stay can be years and there is generally a more lenient attitude toward sexual interaction. Contrary to beliefs held in the 1960s (1), patients with mental illness are not asexual. In fact, Cournos and colleagues (2) showed that 44 percent of patients with schizophrenia in facilities ranging from acute to chronic care and from inpatient to outpatient settings were sexually active and engaging in high-risk behavior—for example, multiple partners, unprotected sex, substance use, and sexual exchange.

Sexual behavior on inpatient units is less common than in the outpatient community, ranging from 1.5 to 5 percent of patients on adult units over one to two years (3–6). Nevertheless, it can be a very cumbersome issue when it does occur. Issues of sexually transmitted disease, pregnancy, consent, trauma, and interference in treatment are all concerns. The American Psychiatric Association considers sexual intercourse on inpatient units to be high-risk behavior, specifically in the context of potential transmission of HIV (7). However, many organizations and mental health professionals, backed by legislation such as the Americans With Disabilities Act (8), believe that inpatients on adult psychiatric units, regardless of length of stay, should be allowed as many rights as are possible without having an adverse effect on their recovery or treatment. Some believe that such rights should extend to sexual behavior.

These issues became immediately important at Bellevue Hospital after an incident of alleged consensual sexual intercourse between a female patient with schizophrenia and a male patient with schizoaffective disorder on the adult acute inpatient psychiatric unit. We developed an interest in understanding national trends and recommendations concerning responses to and prevention of sexual behavior. There is currently no agreement on the "correct" way to permit, manage, or prohibit sexual activity on inpatient units, although a few policies are available (3,9–11). We thus attempted to create a policy both to handle sexual incidents on our unit and to serve as a potential model for other institutions.

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Methods

In May 2001 we reviewed the literature by searching MEDLINE, PsycINFO, and MENTAL HEALTH COLLECTION and by cross-referencing from collected articles and examining legal cases. Articles were initially limited to those published in 1990 or more recently, but because of the paucity of relevant data, the search was extended to include articles published since 1975.

In the review, an effort was made to identify common issues and problems related to sexual behavior that arose on psychiatric inpatient units. This information was then presented to an interdisciplinary team of staff members and physicians on the acute care teaching service at Bellevue Hospital. During the course of multiple discussions, nursing staff, attending physicians and residents, activity therapists, and administrative staff highlighted their concerns about and suggestions for appropriately and safely handling incidents such as the one described above. A sample policy was then created to provide a framework for a comprehensive and feasible plan to prevent or at least manage sexual incidents. It should be noted that this policy was designed with our acute care population in mind—primarily young men and women with severe illness, a concomitant substance use disorder, varying degrees of capacity, and an average length of stay of two to three weeks.

Results

Literature review

Characteristics of high-risk patients. Many psychiatric patients can exhibit sexually inappropriate behavior. Hypersexuality is a feature of a number of psychiatric diagnoses, such as bipolar disorder, organic brain syndromes, mental retardation (6), and borderline personality disorder (2). Persons with schizophrenia may also have an initial increase in sexual activity, although activity often decreases over the course of their illness (2). Akhtar and colleagues (12) found that patients on acute inpatient units who engaged in sex were more likely to be younger, to be single, and to have character pathology. According to Keitner and colleagues (6), patients on a short-term inpatient unit who engaged in "relationships" were more likely to have an eating disorder, bipolar disorder, or a personality disorder. Sixty-nine percent of the patients were single, were aged 15 to 29 years, and engaged primarily in heterosexual encounters; 75 percent of the relationships were reported to be consensual. Among the relationships that were not consensual, the "initiator" was more likely to have a personality disorder or a substance use disorder, and the "recipient" was more likely to have a diagnosis of an eating disorder or schizophrenia. Patients who were seen to be "dependent" were more likely to be linked sexually with someone seen as "angry"; someone "passive" was more likely to be linked with someone "impulsive."

High-risk patients may also be recognized during an interview by identifying specific motivating factors for sexual behavior, such as those described by Modestin (5). He reported that factors such as aggression, deep dependency needs, efforts to compensate for feelings of inferiority, and response to auditory hallucinations are particularly important to recognize. In addition, Akhtar (12) identified loneliness and boredom as possible motivating factors.

Although not mentioned in any of the articles reviewed, a history of sexual assault or inappropriate sexual behavior, especially during previous hospitalizations, would certainly be important to consider as a risk factor.

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Legal cases, precedents, and laws. *Johnson v. United States* (13) found that there should be a "least restrictive" policy on inpatient psychiatric units, with "no more restrictions than good medical practice requires." Although this was not directed specifically at sexual behavior, it has become a widely applied standard. For example, the case of *Farago v. Sacred Heart General Hospital* (14) involved a woman with schizophrenia who was raped and who subsequently sued the Pennsylvania hospital where she had been admitted. She lost her case because she was not deemed to have needed "special observation" on admission, and the judge found that the staff had appropriately followed "least restrictive" guidelines.

However, these guidelines do not imply that hospitals cannot be found negligent or responsible in the event of sexual indiscretions or assault. In *Knoll v. Ohio Department of Mental Health* (ODMH) (15), a woman sued ODMH for an exacerbation of her "mental condition" after being raped by a patient who was known to be "excitable and violent." Although the alleged rapist was indicted, the staff of the hospital were also found to be negligent in providing care.

The Wyatt standards (16), essentially the precursor to the "patient's bill of rights," broadly describe the civil rights to which patients are entitled. These standards have been enacted, in part, by almost all states and Congress, but only four states have included the standard of granting patients "suitable opportunities for . . . interactions with members of the opposite sex" (7). This standard has not been interpreted to mean suitable opportunity for sexual intercourse, and the Supreme Court has never found sexual interaction per se to be a specifically protected right (16). However, the Court has found that individuals have the right to procreate (17), the right to privacy concerning termination of pregnancy (18), and the right to contraception (19).

A psychiatric inpatient's capacity to consent to sexual behavior is an important consideration. For example, engaging in sexual activity with a "mentally defective" person (defined as one not able to consent to sexual

activity) has been found to be a felony in New York State (20). New York State law requires a hospital director to notify the district attorney and local law enforcement if it "appears" that such a crime has been committed (21). Furthermore, in Ohio, hospital personnel who allow sexual contact with "impaired" patients can be indicted on facilitation of a crime (7).

Despite the legal implications described above, state definitions of capacity to consent to sexual interaction are still vague—some states require only an understanding of the nature of the interaction (especially for those with mental retardation), some require an understanding of the nature and consequences, and others require an understanding of the nature, consequences, and moral or social significance (7). The directive on patient sexual activity of the New York State Office of Mental Health makes numerous references to the ability of a patient to consent and instructs that the treatment team leader "shall ensure that an assessment of the patient's ability to consent is completed" (10). However, the policy does not specify how that should be accomplished.

Documented policies and approaches. In 1981, Keitner and Grof (22) surveyed 70 psychiatric facilities in Canada (43 general, 21 provincial, three geriatric, and three private units) and did not find any with an official policy. Ten years later, a task force in British Columbia polled 38 Canadian hospitals to find existing policies and again found none (11). However, in 1997 Buckley and Hyde (4) found that of 57 state facilities in the United States, 83 percent had a policy. (The details of those policies were not requested as part of the study.) In 1999 another study found that 25 percent of acute care facilities in Ohio had a documented policy (1). Notably, only 4 percent of those acute care units cited sexual behavior as a problem, compared with 26 percent in the 1997 survey of long-term facilities (4).

Rochester State Psychiatric Center is a good example of the impetus to create a policy for sexual behavior. In response to a suit filed against the hospital after a patient was sodomized, a grand jury made recommendations for the hospital to "[complete] its development of a policy for all state hospitals in sexual contact and how staff should deal with such conduct. The policy should clearly state the criteria to determine competency [capacity] to consent to a sexual act, who makes that determination, and how it is made" (23). This recommendation was carried out.

The center developed a six-page document (21) outlining a policy to be implemented if staff found patients engaging in sexual intercourse. First, the patients should be asked to stop all activity and not to change their clothes, bathe, or wash, so as not to disturb physical evidence.

Many variables must be considered in developing a policy to address sexual behavior. Most important, a clear definition of the behavior is needed.

Second, a physical examination, including checks for tears, bleeding, and trauma, was to be conducted immediately on all parties involved. Third, a collection of blood samples as well as nasal, throat, and possibly vaginal or rectal swabs were to be collected. Finally, the entire chain of command for the hospital was to be notified immediately.

It should again be emphasized that long- and short-term units often have differing views on sexual interaction among their patients, and thus policies will likely address such interaction with varying levels of tolerance. For example, the University of California, San Francisco, locked crisis intervention unit has a no-sex policy (3). The unit attempts to prevent sexual contact by including rules about sexual activity in a handbook that is given to patients at admission. Although prevention may not be feasible on a chronic unit such as the Rochester State Psychiatric Center, unit rules are of utmost importance for safety in an acute unit, where patients are less stable and less familiar.

Elements of a model policy. Numerous variables must be considered in developing a policy to address sexual behavior (22), many of which we have attempted to include in our model policy. Most important, a clear definition of the behavior is needed. Other variables that must be considered include legal and moral concerns (affected by age and marital status), issues of capacity to consent (influenced by cognitive impairment and other variations in mental status), and general health concerns (such as sexually transmitted disease and pregnancy).

It is also important to consider staff variables. In a study of 131 mental health professionals aged 25 to 79 years, more people approved of consensual, heterosexual interactions in a private place than any other scenario; more approved of the female's being the initiator; and consent did not appear to play a significant role in the respondent's interpretation of an interaction as positive or negative (24). Other variables include, but are not limited to, the education of the team, the proficiency of their assessment skills, and the chief psychiatrist's leadership style.

Model policy

A copy of the policy presented as a protocol—that is, in outline format—is available from the authors.

Defining zero tolerance. On short-stay wards where acutely ill voluntary or involuntary patients are hospitalized for a matter of weeks at most, this policy will standardize the prevention of sexual interactions and appropriate reactions to incidents and assaults on the unit. In recognition of the difficulty in defining "sexual interaction," no physical interactions of any

kind will be tolerated by this policy, including handholding and hugging.

As patients are assessed for dangerousness to self or others upon admission, they should also be evaluated for propensity to engage in sexual behavior during hospitalization. This evaluation may include a questionnaire of risk factors such as diagnostic history, age of 15 to 30 years, heterosexuality, a history of sexual assault, a history of inappropriate sexual behavior during previous hospitalizations, and a history of violence. A basic sexual history should be obtained, including HIV status and history of other sexually transmitted diseases. Patients identified as high-risk patients should be managed as described above.

Each patient should be assessed for his or her capacity to make decisions about sexual behavior. This assessment should include a mental status examination, including the patient's level of orientation, and an assessment of the patient's level of understanding of the rules on the unit, including the repercussions of and alternatives to sexual behavior. Patients should receive a verbal explanation and a written copy of the hospital's policy. Each patient's chart should contain documentation showing that this information was provided and indicating whether the patient appeared to understand the policy. This documentation may be incorporated into existing unit orientation forms.

Patients should be asked to abstain from any physical contact with peers or staff. Patients may also be informed of alternatives to sexual intercourse, including masturbation. Depending on patients' beliefs and personal dynamic issues, they may be informed that masturbation serves as a safe outlet for channeling normal sexual drives, provided it is done privately and at an appropriate time and place.

All patients should have the opportunity to participate in sex education, including open discussions about sexuality and sexual preferences, personal body awareness, pregnancy and contraception, prevention of sexually transmitted diseases, and any other issues specific to a given individual.

If a high-risk patient understands the hospital policy but does not agree to follow it, he or she should be placed on 15-minute checks (or an equivalent monitoring standard); special attention should be paid to the patient's interactions with peers and any potential for sexual behavior. Such potential—for example, making plans with another patient to meet privately—should be reported on morning rounds and one-on-one observation initiated if necessary. If the patient is not capable of understanding the hospital policy, he or she should be placed on five- to ten-minute checks for sexual behavior with continued redirection and, if necessary, one-on-one observation.

It is important to provide a consistent framework for all interactions on acute care units, in terms of both therapeutic structure for patients and minimal confusion for staff.

A seven-step procedure can be put in place for the evaluation of a sexual incident. First, all incidents should be immediately reported to the treating physician. Second, the patients involved should be immediately evaluated for their capacity to consent to sex and to participate in a management or treatment protocol. If such capacity is not established, an alternate decision maker should be sought. Third, HIV status must be assessed and HIV testing and antiretroviral prophylaxis offered. Fourth, physical and gynecologic exams and rape kits should be offered to assess for signs of sexual activity, potential assault, and sexually transmitted disease. Fifth, a pregnancy test should be offered at the earliest reliable time. Sixth, if possible, all medications that are potentially harmful to a fetus should be stopped until a reliable pregnancy test can be obtained. Finally, all patients involved should be placed on a one-on-one watch until the incident is properly investigated and the patients show the ability to understand the unit's policy.

All allegations of sexual assault must be immediately reported to the treating physician and, if necessary, the police. The patient must be kept safe and segregated from the alleged perpetrator of the assault. A rape kit and physical and gynecologic examinations should be offered, and a pregnancy test should be given at the earliest reliable time. Emergency contraception should be considered, and HIV testing should be conducted if the patient's HIV status is unknown; a month's course of antiretroviral therapy should be considered if appropriate. The patient should also be offered trauma counseling. Staff meetings should be held regularly—daily if necessary—to discuss the event and to assess how the event should be managed.

Staff members should receive training in the following areas to ensure that patients' rights are not violated and that the safety of all patients is protected: admission and screening procedures; sensitivity to patients' sexual needs; instruction on sex education, contraception counseling, and discussion of safe outlets for sexual impulses; prevention of sexual assault and quick and appropriate reactions to these incidents; restriction of physical contact and prevention of sexual interactions; and regular meetings to discuss and debrief after incidents.

This policy does not address moral issues concerning sexual behavior among inpatients, because it is our assertion that all sexual interaction on a short-term, controlled unit should be prohibited to ensure as safe an environment as possible. We are not proposing that this model be instituted in its current state but rather are attempting to provide guidelines to be used by individual institutions and

tailored to their specific population and needs.

Conclusions

Sexual behavior on psychiatric units has long been an important issue but apparently has rarely been specifically addressed in terms of protocol and policy. It is important to provide as consistent a framework as possible for all interactions on acute care units, in terms of both therapeutic structure for the patients and minimal confusion for staff members. The policy described here is intended to increase awareness about policy formation and the avoidance of incidents that can become medically and legally catastrophic. The policy should be considered a work in progress. In response to the presentation of this policy to the psychiatric staff at Bellevue Hospital, efforts are under way to implement it on appropriate units. Further investigation and follow-up of the efficacy of this implementation would certainly be helpful in continuing to address this important issue. ♦

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