

CR205

---

# Sexual boundaries in clinical practice

Guidance for psychiatrists working in adult  
settings

COLLEGE REPORT

# College Report CR205

July 2017

Approved: April 2017

Due for revision: 2020

---

© 2017 The Royal College of Psychiatrists

College Reports constitute College policy. They have been sanctioned by the College via the Policy and Public Affairs Committee (PPAC).

For full details of reports available and how to obtain them, contact the Book Sales Assistant at the Royal College of Psychiatrists, 21 Prescot Street, London E1 8BB (tel. 020 7235 2351; fax 020 7245 1231) or visit the College website at <http://www.rcpsych.ac.uk/publications/collegereports.aspx>

The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).

# Contents

Contributors	2
Context	4
Egregious events	5
The boundaries of professionals	
No offence	6
Colleagues in relationships	6
Common tensions with patients	7
The boundaries of patients	
No means no, but does yes mean yes?	9
Sexual transgressions	10
Restrictive practices	11
Sexual well-being	12
References	14
Useful resources	15

# Contributors

## Lead contributor

**Jonathan Hurlow**, Consultant Forensic Psychiatrist, Birmingham and Solihull Mental Health NHS Foundation Trust

## Other contributors

**Gwen Adshead**, Consultant Forensic Psychiatrist, Ravenswood House, Southern Health NHS Foundation Trust

**Tim Andrews**, Consultant Psychiatrist, Learning Disabilities Service Oxford, Southern Health NHS Foundation Trust

**Ruth Bevan**, Consultant in Gender Dysphoria, Northumberland, Tyne and Wear NHS Foundation Trust

**Susan Bewley**, Professor of Women's Health, Women's Health Academic Centre, King's College London

**Subodh Dave**, Clinical Teaching Fellow and Consultant Psychiatrist, Royal Derby Hospital, Derby, and Associate Dean, Royal College of Psychiatrists

**Mayura Deshpande**, Consultant Psychiatrist, Southern Health NHS Trust

**Sandra Evans**, Consultant Psychiatrist, East London NHS Foundation Trust, and Deputy Dean for Students, Barts & the London School of Medicine & Dentistry, Queen Mary, University of London

**Brian Fitzgerald**, Consultant Psychiatrist, Enfield Integrated Learning Disability Service, and Central and North West London NHS Trust

**Janet Grace**, independent consultant neuropsychiatrist

**Julian C. Hughes**, RICE Professor of Old Age Psychiatry, University of Bristol

**Adrian James**, Consultant Psychiatrist, Devon Partnership NHS Trust

**Marc Jeanneret**, Core Trainee Psychiatrist (CT3), Barnet, Enfield and Haringey Mental Health Trust

**Judith Stellman**, NHS Improving Global Health Fellow in South Africa/  
Core Trainee Psychiatrist

**Mangesh Marudkar**, Consultant Psychiatrist, Old Age Psychiatry  
Faculty, Royal College of Psychiatrists, and Leicestershire Partnership  
NHS Trust

**Helen Murphy**, Eating Disorder Faculty, Royal College of Psychiatrists;  
Consultant Psychiatrist, Lead Eating Disorder Psychiatrist, Nightingale  
Hospital, London

**Sol Mustafa**, Consultant Psychiatrist in Intellectual Disability, Bury/  
Oldham, Pennine Care NHS Foundation Trust

**Sanjay Nelson**, Consultant Psychiatrist, Hackney Learning Disability  
Services, East London NHS Foundation Trust

**Steve Pearce**, Consultant Psychiatrist, Oxford Health NHS Foundation  
Trust

**Nisha Shah**, Consultant Perinatal Psychiatrist, Perinatal Parent Infant  
Mental Health Service, Goodmayes Hospital, North East London  
NHS Foundation Trust

**Pamela J. Taylor**, Chair in Psychiatry, Division of Psychological  
Medicine and Clinical Neurosciences, School of Medicine, Cardiff  
University

**Yulia Zyrianova**, Psychiatrist, Perth, Australia

# Context

The management of sexual boundaries in clinical practice is complex and may be contentious. This document focuses on both the boundaries of professionals and occasions when clinical practice intersects with the sexual boundaries of patients. The context and environment in which we work is fluid and evolving. Research findings and evidence accumulate all the time, and guidance changes as a result. The guidance given here is tempered and deliberately does not point towards absolute rules or solutions.

The General Medical Council (GMC) states that doctors must not use their professional position to pursue a sexual or improper emotional relationship with their patients or with someone close to them, and must not end a professional relationship with a patient solely to pursue a personal relationship with them. We defer to the legal profession, regulatory agencies, or individual employers for laws, absolute rules, policies and procedures (NHS Employers & Council for Healthcare Regulatory Excellence, 2009; GMC, 2013).

We restricted guidance in this document to psychiatrists who work in adult settings. The Faculty of Child and Adolescent Psychiatry of the Royal College of Psychiatrists advised that the needs of children were distinct and better addressed separately. Subject to oversight by the College's Professional Practice and Ethics Committee (PPEC), the document was authored by more than 20 psychiatrists and informed by years of combined professional experience. We take a patient-centred approach and espouse a cultural aspiration of promoting good mental health and contentedness among our patients. We are mindful of varied personal, family and cultural considerations, as well as legal and resource restraints.

# Egregious events

Figures from the Medical Defence Union (2015) show that allegations of sexual misconduct against doctors remain low and most accused doctors are cleared of misconduct in this area. Between 2003 and 2013, 167 doctors were accused. Nevertheless, the significant harm that can be caused by the few who perpetrate sexual misconduct was evident in the shocking set of circumstances in which two psychiatrists sexually abused patients over many years with relative impunity, leading to the Kerr/Haslam Inquiry (HM Government, 2005) and the first publication of this document.

Key issues that emerged in that inquiry were that many complaints were made but not believed, and that the doctor's status of 'being a doctor' in itself seemed a protective factor for the abusers – much as has, sadly, turned out to be the case for politicians, religious authorities and media stars in recent years. These many scandals show that no one should be considered above suspicion, regardless of their role or status, and the threshold for believing the vulnerable and following due investigative processes has been lowered dramatically in recent decades. In order to prevent the recurrence of rare but egregious events, it is essential that we continue to nurture the culture of listening to the concerns and complaints of patients, residents in institutions, and colleagues, friends and families. We must take them seriously and have channels open for 'whistle blowing'.

## Case vignette 1

**Situation** A 19-year-old woman serving a prison sentence has a history of substance misuse and sex work to support her habit. She was seen by the mental health team because she was depressed and prone to self-harm. She reported to the psychiatrist that one of the prison officers caressed her and asked for sexual relations in exchange for cosmetics and cigarettes. She wanted to get away from the particular prison wing where this officer works and did not know how else to do it. The psychiatrist was the first person she told.

**Guidance** While it is important not to assume the veracity of this allegation, if it took place it is clearly an egregious event. The psychiatrist must initiate procedures that will investigate this allegation to safeguard this woman and potential future victims from sexual harm. This process should be fair to the officer as well as the woman, taking care to not assume guilt or innocence. The psychiatrist should make use of the governance structures of the prison, mental health trust and local authority. The clinical team should provide additional support for any impact that the process and alleged event may have on the prisoner's psychiatric condition and risks.

# The boundaries of professionals

## No offence

It is important to be aware that sexualised commentary, jokes or banter which may be acceptable to some people could be distressing to others. Even clinical inquiries can risk offence if pursued from a heterosexual stance in a manner that does not account for the particular experiences of women, people who are lesbian, gay, bisexual or transgender, and survivors of sexual abuse. It is equally important that responses to loose talk or other behaviours which are seen as hurtful or otherwise unacceptable are proportionate. It is likely to be sufficient in many cases simply to point out to the 'offending' individual(s) that the behaviour is problematic. Further measures are only likely to be necessary for those who will not accept that and/or will not desist.

Doctors should never use work or National Health Service (NHS) servers to access pornography or any other sexual services that can be accessed online, as this is unprofessional and will risk their registration. Most large organisations are able to block access to sensitive sites. Pornography causes offense to many even when it is legal, especially when one considers concerns about the objectification of women and the vulnerabilities of those who may have no meaningful options to work in any other trade. Doctors should be mindful at all times to not cause offence, but they must be especially diligent about not causing offence at work, for example, by leaving mobile phones or other personal devices lying around, which may contain material that others may see and then become offended by.

## Colleagues in relationships

Between staff, as between staff and patients, there are often power imbalances which require particular sensitivity. These include relationships between senior and junior staff and between genders. Most commonly, this is construed as placing the junior in a vulnerable position, leading him or her to suffer unacceptable sexualised advances because of fear of standing up to a boss or line manager, or fear that a career pathway could be damaged by rejection of such behaviour.

It is not inconceivable, however, that problems may arise in the other direction. If an inquiry is triggered, it is vital that investigators enter the process with a truly open mind.

It is inevitable in large organisations like the NHS that there will be the making and breaking of wanted relationships – but these too can create difficulties for those working with the couple, particularly if the relationship is, or has to be, covert. Favouritism may be perceived, whether or not it actually happens. Workmates could be caught up in hostilities between a once-close couple who are now angrily estranged.

It is important that there are policies and procedures in place to help all staff manage such situations. The policy document should be brief, with all details set out in supporting procedural guidance. This should include steps to ensure that professionals are not in a relationship with their line managers.

A positive account of relationships between staff should be emphasised at this juncture. There are many positive stories one could tell or quote, but some are neatly summarised by Kathy Otoxby (2015) in *BMJ Careers*.

## Common tensions with patients

Policies and procedures which are set up in the wake of major, unusual and egregious boundary violations may risk neglecting more commonplace, but still potentially damaging, transgressions. The professional–patient relationship inevitably involves some power imbalance. The professional has the ultimate responsibility for managing that safely. Some colleagues and patients are particularly vulnerable, for example, when therapist–patient relationships are long-term and intense (Royal College of Psychiatrists, 2013). Social media (e.g. Facebook) increase the potential for contact to occur outside working hours.

Perhaps the simplest and most direct guidance on personal identification of a potential sexual boundary problem is ‘as soon as you think there is an aspect of your relationship with a patient, or another member of staff, which you want to keep private, it is essential that you find a way of telling someone who could help’ (source unknown; see also Psychiatrists’ Support Service, 2016). While it might be ideal for any such matter to be discussed at an early stage within the clinical team, this may be far too daunting for many, at least in the first instance. All employing agencies would be well advised to have a clearly identified individual to whom staff could report in complete confidence, before any boundary has actually been crossed.

By the same token, the employer should have a widely advertised named person to whom staff who think they may be observing sexual boundary problems in others could turn, at least initially, in confidence.

In both such situations, any limits to confidentiality should be clearly documented and agreed when this person is consulted. Any staff concerned about possible unfairness or inappropriate raising of concerns should seek advice from their trade union (e.g. the British Medical Association for doctors) or medical defence organisation.

#### Case vignette 2

**Situation** A 25-year-old woman with borderline personality disorder, who had been sexually abused over a number of years by her stepfather, was admitted to a medium secure unit. In the context of a deterioration in her mental health, she had set fire to her room in a hostel after escalating disputes over curfews and drug use with the hostel manager, a man with whom she had initially seemed to form a strong attachment. Once in the secure unit, she was emotionally labile and threatened to harm herself several times a day. Over the first 3 months of admission, staff noticed an emerging pattern – that her actual self-harm always took place when a particular male nurse was on duty. He invariably cleaned and dressed her wounds and then had a long one-to-one supportive counselling session with her.

**Guidance** The male nurse and his colleagues should have access to a reflective space to discuss the emerging pattern and the associated potential harms to her health, risks and team work. His line manager should supportively address ways to adapt this pattern with him individually. A widely accessible named individual with expertise in supporting colleagues to manage professional boundaries should be made available by the employer to enable the male nurse or other colleagues to seek advice on the emerging pattern and any concerns. This named person should coordinate their interventions within the appropriate trust governance structure.

# The boundaries of patients

## No means no, but does yes mean yes?

Respect for the autonomy of patients and the benefits of sexual activity in their lives appears to be well defended in law. Regrettably, at present this appears to result in a greater potential for unintended harmful consequences of sexual activity for some patients. The Mental Capacity Act does not allow another person to make a best interests decision about sexual contact for a person who lacks capacity. The Mental Capacity Act test for capacity to consent to sexual contact is rudimentary, requiring only knowledge of the mechanics of the act, that sexual contact between a man and a woman may result in pregnancy, and that there is a risk of sexually transmitted infections. In practice, this may mean that some people with a psychiatric condition are above the threshold to consent to sexual contact, in situations where the treating team have significant concerns about vulnerability or exploitation. This may highlight the benefit of safeguarding procedures and consideration of alternative legislative frameworks such as the Mental Health Act 1983.

### Case vignette 3

**Situation** A 17-year-old woman with an autism spectrum condition living in supported accommodation was befriended by a woman who took her on a day trip. This woman asked her to have sex with a male stranger and herself. She also met lots of people online who asked her to engage in sexual relationships, both online and meeting up. The clinical team working with her doubted that she could weigh up the benefits and harms of sexual relationships, choice of friends, choice of home and use of the internet.

**Guidance** The clinical team will need to weigh up how to make use of trust and local authority governance structures when considering how to safeguard this woman from potential sexual harm. Attention should be paid to the different approaches afforded by the mental capacity and mental health laws. Careful balancing between safety and autonomy will require particular attention.

People who normally have mental capacity but have temporary impairment because of conditions such as psychosis require different support. Here, it may be appropriate to override usual rights in the interests of safety for the short term, until capacity is restored.

People with acquired but life-changing problems, such as severe head injury or dementia, pose a further range of dilemmas. Here, at least, lifelong patterns and wishes may be clearly established, and long-standing partners may be able to contribute to care planning. Safeguarding may still be required.

Some patients may lack the mental capacity to understand that certain pornography sites are illegal or involve serious harm to those being videoed, but still have capability to access the sites. There are many reports of vulnerable adults being groomed by people via the internet. This can be particularly problematic if the grooming is subtle or done from outside the UK. An example was a report of an adult UK resident with autism and intellectual disabilities being encouraged to take off clothes and expose himself in front of a web cam.

## Sexual transgressions

Rarer situations such as working with patients whose sexual offences were contributed to by their psychiatric condition exemplify how obstructing sexual activity may be necessary in order to protect others from harm. However, these situations are rare, and the criminal justice system is equipped to address the risks of most people whose sexual behaviour transgresses laws in a way that harms others. Nevertheless, a wide range of conditions contribute to everyday challenges for some patients, and there is a potential need for professionals to consider intervening in their sex lives in order to protect others from harm.

Patients accessing pornography and other services on the internet raises challenges, depending on circumstances and context, if offence is caused to others, if the act is in itself illegal, or if arrangements are being made online to do something illegal. Different considerations apply if one is acting freely in one's own home, or in a care setting where the organisation has some responsibilities, or if the patient is detained under the Mental Health Act and responsibilities are specifically managed by the responsible organisation and clinicians.

#### Case vignette 4

**Situation** Steve, a 56-year-old married man, presented to the regional neuropsychiatry team following a complicated resection of a frontal meningioma. He came to the clinic with his wife, Sheila, who was clearly distressed. Over the 6 months following discharge from neurosurgery he had become increasingly demanding and wanted to have sexual intercourse up to four times a day. His wife was particularly distressed as prior to the surgery the couple had not had sex for several years owing to her health problems. Steve became verbally aggressive when thwarted and had propositioned family friends and health professionals. Sheila explained that, as Steve appeared 'basically normal' apart from his sexualised behaviour and a degree of perseveration, friends and family did not understand that his behaviour was part of his illness. She was scared to take Steve out the house in case he did or said something that upset other people or put him in danger. In the clinic, Steve made sexualised comments to the female consultant and the FY2 doctor training in psychiatry.

**Guidance** The team will need to sensitively assess Steve's potential for sexual harm. Use of structured professional judgement risk assessment tools (e.g. risk of sexual violence protocol) may assist in making complex clinical judgements. This practice is often more common in forensic services, so it may be useful to contact forensic colleagues for advice on the management of these risk behaviours. Interventions, which may include the use of mental health law, will be required in order to minimise potential harm to others in the least restrictive way. Support for his wife is clearly an additional important consideration.

## Restrictive practices

Responsible clinicians and managers in any unit where people are detained against their wishes, or restricted in their liberties owing to a lack of mental capacity, must be mindful of sex, sexuality and what happens in these units.

Most patients in specialist secure mental health units are of an age of peak interest in sexual activity and reproduction, but some patients are there at least in part because of difficulties in intimate relationships which have become dangerous. Patients have rights in the matter of romantic/marital partnerships. Article 12 of the European Convention on Human Rights (ECHR) expresses the right to marry and found a family. Article 8(2), however, permits limited interference in the relationship 'for the prevention of disorder or crime, for the protection of health or morals or [...] rights and freedoms of others'. Some literature is published about these tensions to assist professionals in navigating these potentially competing rights (Taylor & Swan, 1999; Hales *et al*, 2006; Commission on Sex in Prison, 2013, 2014*a,b*, 2016; Stevens, 2016).

### Case vignette 5

**Situation** A 30-year-old man attacked and killed his partner during a drug-fuelled deterioration in mental state. As his health improved, he started to take a protective interest in a much younger man, more recently admitted. At first, hospital staff were impressed by his apparently caring attitude, which was a side of him that they hadn't previously seen. They then noticed that the younger man was following the older one in everything – beginning to cut his hair in the same way, and getting a number of intimate tattoos, which he said he had asked the older man to do. When asked about the relationship, the younger man told staff that he was falling in love with the older man.

**Guidance** While it is not clear that love is requited by the older man, this is a serious possibility, and there is a need to be mindful of the right to family life. However, this will need to be balanced against the risks both men may present to each other and their treatment needs. There may need to be arrangements made for disclosure of risks. It is unlikely that the therapeutic environment could be maintained if both men remained on the same ward, owing to the intense emotions that intimate relationships provoke. Sexually intimate behaviour within a hospital will also need to be prevented when other patients live nearby and nurses have to carry out regular therapeutic observations.

## Sexual well-being

One concern which may be considered less often is that healthy and pleasurable sexual activity is often constrained or prevented by illness and/or disability. For some, the problem is resolved by successful treatment of the disorder. For others, the main task will be to adjust medication. This is often achieved by varying the psychotropic medication, but it may mean a decision to add sildenafil to the mix and consideration of the fears of doing so.

For some people with chronic illness or permanent disability, the question arises of paying a sex worker to provide them with sexual pleasure. These questions are posed to many professionals in the caregiving industries, so psychiatrists will be able to reflect with multi-disciplinary colleagues and managers, depending on the context. There are similar, if perhaps lesser, concerns about helping people who cannot access pornography for themselves. There are concerns that many sex workers are themselves vulnerable and exploited, for example, because they have an illegal drug dependency, are victims of abuse, are trapped in a cycle of abuse, or have been trafficked from abroad, with little control over their circumstances, and effectively forced into the trade.

Psychiatrists, as is the case for all professionals and employees, cannot support or encourage any illegal activity. However, our awareness of the potential harms to sex workers means that psychiatrists should be additionally wary of any endorsement of acts between their patients and sex workers, or supply of pornography, even if the specific acts or material are legally acquired.

#### Case vignette 6

**Situation** A man with a tested IQ of 55 and a long history of living in an institution moved to a community home. Neighbours started to complain because he repeatedly exposed himself at the nearby bus stop. It was a stop often used by school children. Staff at the home asked him to stop doing it, but this had no effect. He was then moved to a closed institution. He said that he was 'glad to be out of [the community home]', because he 'hated it' and the staff were 'mean'. After moving to the institution he became a model patient and, if he did masturbate, he did it in his own room, discreetly. The only request from him of a sexual nature was to have access to regular, legal, adult pornography, routinely available in newsagents.

**Guidance** Bearing in mind guidance that professionals should never access pornography at work on the grounds of not causing offence, efforts should be made to enable the man to choose and acquire the pornography for himself. If support is required, it should be discreet and minimal.

# References

- Commission on Sex in Prison (2013) *Consensual Sex among Men in Prison*. Howard League for Penal Reform.
- Commission on Sex in Prison (2014a) *Women in Prison: Consensual and Coercive Sex*. Howard League for Penal Reform.
- Commission on Sex in Prison (2014b) *Coercive Sex in Prison*. Howard League for Penal Reform.
- Commission on Sex in Prison (2016) *Healthy Sexual Development of Children in Prison*. Howard League for Penal Reform.
- General Medical Council (2013) *Maintaining a Professional Boundary between You and Your Patient*. GMC.
- Hales H, Romilly C, Davison S, et al (2006) Sexual attitudes, experience and relationships amongst patients in a high security hospital. *Criminal Behaviour and Mental Health*, **16**: 254–63.
- HM Government (2005) *The Kerr/Haslam Inquiry*. TSO (The Stationery Office).
- Medical Defence Union (2015) Sexual assault allegations against doctors increase. MDU (<https://www.themdu.com/press-centre/press-releases/sexual-assault-allegations-against-doctors-increase>).
- NHS Employers, Council for Healthcare Regulatory Excellence (2009) *Clear Sexual Boundaries between Healthcare Professionals and Patients: Information for Patients and Carers*. CHRE.
- Oxtoby K (2015) Love on the wards: relationships between doctors. *BMJ Careers*, 14 Dec.
- Psychiatrists' Support Service (2016) *PSS Information Guide: Professional Boundaries*. RCPsych.
- Royal College of Psychiatrists (2013) *Vulnerable Patients, Safe Doctors: Good Practice in our Clinical Relationships* (2nd edn) (CR180). RCPsych.
- Stevens A (2016) *Sex in Prison: Experiences of Former Prisoners*. Howard League for Penal Reform 2015.
- Taylor PJ, Swan T (eds) (1999) *Couples in Care and Custody*. Butterworth Heinemann.

# Useful resources

The following national helplines or sources of information are for people who have been abused, and for relatives or others wishing to provide support.

- National Society for the Prevention of Cruelty to Children  
<http://www.nspcc.org.uk/preventing-abuse>
- The Survivors Trust  
<http://www.thesurvivorstrust.org/national-helplines/>
- Mind (mental health charity)  
<http://www.mind.org.uk/information-support/guides-to-support-and-services/abuse/>
- The *My Body Back* project  
<http://www.mybodybackproject.com/> This is a website designed as a safe space for survivors of sexual violence to share their stories.
- SANE (mental health charity)  
<http://www.sane.org.uk/home>