Development of a Policy on Sexuality for Hospitalized Chronic Psychiatric Patients

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Objective: *This paper describes the need for and development of a policy on patient sexuality implemented at a provincial psychiatric hospital.*

Method: *The need for a policy was assessed by reviewing the literature and interviewing a sample of chronic psychiatric patients. Development of the policy involved surveying 38 Canadian psychiatric hospitals in search of an existing policy to use as a model, as well as soliciting input from a variety of stakeholders and 2 lawyers.*

Results: *Both the literature review and patient interviews indicated that a substantial number of hospitalized chronic psychiatric patients are sexually active. Neither the literature nor the survey of Canadian psychiatric hospitals revealed an existing policy to use as a model. Consequently, a policy was drafted by a task force composed of stakeholders and 2 lawyers. Characteristics of the policy, possibly the first in Canada, are described. The legal basis for the sexual rights of patients is discussed, and the mechanisms for protecting patients from harm are also described.*

Conclusion: *Fundamentally, a policy must balance the patient's right to sexual intimacy in a dignified setting with the hospital administration's duty to take reasonable steps to protect patients from harm.*

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Key Words: *policy on patient sexuality, sexual rights, legal arguments*

Riverview Hospital is British Columbia's (BC) provincial psychiatric hospital. The Continuing Treatment Program (CTP) at Riverview Hospital cares for a large number of patients with chronic psychiatric disorders, primarily schizophrenia, who have not responded to treatment in community hospitals or residences. Most CTP patients remain hospitalized for years. The sexual behaviour of these patients is one of the most difficult aspects of their care (1). In 1989, in response to both patients' concerns regarding their sexual needs and doctors' and nurses' concerns regarding the sexual behaviour of some patients, the Program Director requested the CTP Multidisciplinary Committee to form a task force on patient sexuality in order to formally assess patients' sexual needs. The task force chose to study this issue from 3 perspectives: the professional literature was reviewed; patients attending a sex education class were interviewed informally; and a formal survey of patients' sexual behaviour and needs was undertaken. After establishing the need for a policy, the task force was instructed by the hospital board to develop a policy for possible implementation. This article describes the process of establishing the need for a policy, the process of policy development, and the characteristics of the policy. An evaluation of the policy in practice will be presented in a forthcoming paper.

The Need for a Policy

The Literature

A distillation of the available literature revealed 4 general findings:

- First, many psychiatric patients hospitalized with chronic mental disorders are sexually active. These patients tend, however, to have difficulty establishing intimate relationships, they show a high rate of sexual dysfunction, and they engage in sexual behaviours that sometimes are disturbing to others or dangerous to themselves or others (2–8). Despite these findings, little attention has been given to the sexual needs of hospitalized chronic psychiatric patients—a fact that has been lamented by several authors because sexuality is so very clearly a quality of life issue (8–10).

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- Second, where effort has been made to address the sexual needs of these patients, it most commonly takes the form of a sex education group. Information about anatomy, reproduction, birth control, disease prevention, and social skills is presented to patients verbally and visually by discussion and video (4,8,10–12). For change to occur, however, patients attending such groups must be able to attend, process, and transform information into behaviour. Unfortunately, the cognitive skills required to do so are precisely those that are deficient in many chronic psychiatric patients (1,4,8,13).
- Third, hospital staff have many concerns regarding patient sexuality. These concerns include confusion over how best to respond to patient sexual behaviour, how to prevent the spread of sexually transmitted diseases, what to do about the lack of privacy for patients in hospital settings, whether sexual activity will exacerbate mental illness, and the moral issues that inevitably arise when dealing with the issue of sex (3,10–13). Staff education groups have been highly recommended, since many staff are uncomfortable addressing the issue of patient sexuality (11,14–17).
- Finally, the need for formal hospital policies regarding patient sexuality has been recognized for some time. Nevertheless, such policies are virtually nonexistent (3,12,15,18,19).

Informal Patient Interviews

The CTP periodically offered sex education classes for a small number of patients who were referred by their physicians because of various types of problematic sexual behaviour. An unstructured interview with 21 male patients yielded the following information.

Although a number of patients complained of erectile dysfunction, most of the men acknowledged that they had engaged in some form of sexual activity within the hospital. Many were distressed by the lack of privacy within the hospital, which necessitated the use of uncomfortable places such as bushes and stairwells for sexual encounters.

Several patients expressed the belief that the ''appropriate'' social skills and sexual behaviours taught in the sex education class were unnecessary in the hospital because the absence of a private and dignified setting for sexual intimacy made it impossible to put those behaviours into practice. In contrast, offering to exchange coffee or cigarettes for sexual favours often led to sexual encounters on the grounds, commonly behind bushes, or in stairwells. In essence, because the hospital did not actively support appropriate and responsible sexual behaviour by providing a private and dignified setting within which it could occur, the skills taught in the sex education classes were not applied.

Some patients were confused by the double messages they believed they received from staff. For example, one man's perception was that staff did not approve of sex between patients. The absence of a private place for sexual intimacy served for him as proof of this perception. Yet at the same time, all patients were encouraged to practise safe sex. For him the double message was, ''don't have sex but use a condom.''

Finally, our interviews with these men raised the possibility that the problematic sexual behaviour that necessitated their referral to the sex education classes might have been caused, at least in part, by the lack of opportunity afforded them to practise appropriate sexual behaviour during their years of hospitalization. We have discussed this possibility in more detail elsewhere (1).

Survey of Patients' Sexual Behaviour and Needs

The task force drafted a brief structured questionnaire (10 questions) designed to obtain information about CTP patients' sexual behaviours and needs. The head nurse of each ward explained the questionnaire to the primary nurses and told them that their participation was voluntary. Primary nurses were asked to interview their patients using the questionnaire as a guide, to explain the purpose of the questionnaire to their patients, and to explain that patient participation was voluntary and anonymous.

After interviewing their patients, the nurses were asked to indicate if their patient's sexual behaviour was posing a problem to the patient or others. They were also asked to indicate whether or not their patient's responses to the questionnaire were accurate or delusional, based upon each primary nurse's knowledge of the patient.

At the time of the survey there were 296 patients in the CTP. The number of questionnaires returned by nurses was 161. A patient was considered to have *participated* if he or she answered at least 1 of the 10 questions. The number of participants was 139 (47% of the total number); the number of participants whose responses were judged by nurses to be accurate was 118 (86% of participants). Of the *accurate participants*, 96 (81%) were males, 22 (19%) were females, 74 (63%) were on unlocked wards, and 44 (37%) were on locked wards. Their average age was 42 years. The average admission length was 8 years. Most of the patients answered only a few of the 10 questions, which limited the analysis.

Sexual activity was defined as an act of heterosexual contact, homosexual contact, or masturbation occurring within the last year. The number of accurate participants who stated that they were sexually active was 57 (48%), while 61 (52%) stated they were not sexually active. Of the sexually active patients, 43 (75%) said they engaged in masturbation, 30 (53%) had heterosexual contact, and 8 (14%) had homosexual contact. The frequency of sexual activity reported by the 57 sexually active patients ranged from daily to once in the last year.

The 57 active patients said their sexual activities occurred in the following locations: dorm, 49%; grounds, 23%;

bathroom, 19%; and elsewhere in hospital buildings such as stairwells, 16%. When asked if these locations were ''okay'' for sexual activity, 31 (54%) of the 57 sexually active patients said ''yes,'' 16 (28%) said ''no,'' while 10 (18%) did not answer.

The 61 patients who denied being sexually active were asked why. The reasons they gave included having no interest, having no partner, having no place for sexual activity, and being unable to obtain an erection.

When the entire sample of 118 accurate participants were asked if they would like a more private place for sexual activity, 49 (42%) said ''yes,'' 43 (36%) said ''no,'' and 26 (22%) did not answer. Since some of the nonactive patients said that they would like more privacy, it is possible that a lack of privacy was responsible for their inactivity. The 118 patients were asked for suggestions for increasing privacy. Many did not answer this question. The most common suggestion from those who answered was to make private rooms available to patients.

The 118 patients were asked if they had any concerns about their sex life (or lack thereof) in the hospital. Forty-six (39%) said that they had no concerns, and 25 (21%) did not answer the question. The remaining 47 (40%) listed a variety of concerns, including: (a) lack of privacy; (b) having no partner; (c) insufficient time with partner; (d) disease or birth control; (e) medications impairing sexual performance; and (f) fears of the opposite sex or fears of homosexual approaches.

The accurate participants were asked if they were bothered by the sexual behaviours of other patients. Eighteen (15%) said ''yes,'' 75 (64%) said ''no,'' and 25 (21%) did not answer. Most commonly, patients were bothered by inappropriate sexual propositions and the witnessing of sexual acts in public.

The nurses returned questionnaires for 161 patients, 24 (15%) of whom were considered to have problematic sexual behaviours. The reasons given by nurses for classifying the patients' behaviours as problematic included: (a) exhibitionism; (b) making inappropriate propositions; (c) having sex in public; (d) being sexually assaultive; (e) permitting sexual abuse of self; (f) talking inappropriately; and (g) not practising safe sex.

In retrospect, several problems with the questionnaire itself were identified. There were too many questions, and some questions were too sophisticated for many patients. This likely accounts for why few patients answered all questions. Despite this problem, our findings are reasonably consistent with those reported elsewhere (2–8).

Conclusions and Recommendation

Based upon information obtained from the literature, informal interviews with 21 patients in the sex education classes, and formal interviews of 118 CTP patients, several conclusions were drawn.

Many CTP patients (almost 50% of our ''accurate'' sample) were sexually active. Masturbation was the most common form of sexual activity, but a substantial number of patients had heterosexual or homosexual contacts.

Many CTP patients felt that the hospital did not understand or address their sexual needs and concerns. Patients had no choice but to use uncomfortable and undignified locations for sexual activity such as public dorms, toilets, stairwells, and bushes because no private facilities were available within the hospital. The task force concluded that the hospital did not adequately address the sexual needs of the CTP patients, many of whom had spent a substantial portion of their lives there. This situation reduced the patients' quality of life, may have promoted aberrant sexual behaviour (1), and may have increased patients' risk of contracting sexually transmitted diseases because sex occurring behind bushes or in stairwells is unlikely to include condom use.

The task force also concluded that the sex education classes that were offered periodically in the CTP were insufficient for promoting healthy sexual behaviour. Many chronic psychiatric patients have cognitive deficits that limit their ability to benefit from sex education classes in the absence of an opportunity to practise the responsible sexual behaviours and attitudes learned in those classes.

The literature and informal conversations with head nurses suggested that hospital staff were uncertain about how to respond to patients' sexual needs and behaviours. Moreover, staff attitudes toward patient sexuality varied considerably. Most staff were in favour of providing increased education. The idea of providing private rooms for sexual intimacy, however, was a very contentious issue.

A single recommendation was made. In consideration of the fact that patients' sexual needs constitute an issue important to their quality of life, psychosocial rehabilitation, and physical health (that is, prevention of sexually transmitted diseases), the task force recommended the creation of a formal hospital policy on patient sexuality.

Development of the Policy

In 1991 the task force was directed by the hospital administration to develop a formal policy on patient sexuality for possible implementation. Two general approaches to policy development were undertaken.

First, an effort was made to ensure that the task force received representation from as many relevant stakeholders as possible. Consequently, in addition to representation from clinical departments such as Medicine, Nursing, Pastoral Care, Psychology, and Social Work, the task force received representation from related hospital committees such as the

Ethics Committee, Mental Health Education Services, and the Patient Environmental Needs Committee. Additionally, representation was solicited from patients through the hospital's Patient Empowerment Society and from family members through the Riverview Hospital Family Group. Representation from a special interest group external to the hospital, the BC Schizophrenia Society, was obtained. Finally, legal representation was obtained from 2 sources, the Mental Health Law Program at the hospital and the BC Ministry of Health's Special Health Law Consultant.

Although representation from so many groups slowed the process of policy development, it seemed likely that each stakeholder group would have unique concerns that would be best identified at the outset.

Second, in order to take advantage of work on policy development that may have been done at other hospitals, the task force decided to survey psychiatric hospitals in Canada with over 100 beds to acquire policies already in existence for use as models. Thirty-eight were identified from the 1991 *Canadian Hospital Directory* (20). A brief survey was sent to the CEOs of these hospitals, and 25 were returned. All CEOs or their designates expressed concern about the issue of patient sexuality, and several indicated that the matter was under study at their hospitals. None, however, had a formal policy on patient sexuality for us to use as a model. As indicated previously, no model was available in the literature, either.

The Riverview Hospital Policy

In the absence of a model, the Riverview Hospital Policy on Patient Sexuality was created from input from the multifaceted task force. It is composed of 7 parts.

Part A outlines the rights of patients and the duties of hospital administrative and clinical staff, according to the opinion of the 2 task force lawyers. The spirit of each right and duty is embodied in the *Canadian Charter of Rights and Freedoms*, provincial legislation, the common law, and the mission and philosophy statements of the hospital.

First, chronically hospitalized patients have a right to sexual intimacy in a private and dignified setting. The primary justification for our contention that patients have a right to sexual intimacy while in hospital is found in sections 7 and 15 of the *Charter*. Section 7 states, ''Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.'' Section 15(1) states, ''Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, nationality or ethnic origin, colour, religion, sex, age, or mental or physical disability'' (21). Although technically only government institutions must comply with the *Charter*, it is arguable that any provincial psychiatric hospital, as opposed to a community hospital, does qualify as a government institution. Additionally, under the common law, everyone has the right to autonomy and self-determination except as limited by law. While the *BC Mental Health Act* (22) does place certain constraints upon the rights of involuntary patients, the right to sexual intimacy is not constrained by the Act. Since this right has not been taken away by law, involuntarily detained patients are allowed to exercise it. The right to a private and dignified setting is justified by the fact that failure to provide such a setting amounts to denial of access to the right to sexual intimacy.

Second, staff have a duty to accept and address patients' sexuality, regardless of sexual orientation or marital status, in an empathic, nonjudgemental, and humane manner. This duty arises from the sections of the *Charter* and *Mental Health Act* previously mentioned. Staff's fulfillment of the duty is essential if the fundamental rights of the patients are to be achieved.

Third, the hospital has a duty to take reasonable care to protect patients from possible harm arising from sexual encounters and to provide education and rehabilitation relevant to patient sexuality. The hospital administration's duty to protect arises from several sources. In a general sense, the *parens patriae* power of the state carries with it a duty to protect. In a more specific sense, section 3 of the *Occupiers Liability Act* (23) requires the administration to ensure that everyone on the premises will be reasonably safe from harm. Moreover, the common law imposes on health care professionals and hospitals a duty to act reasonably and prudently while providing care to patients. The duty to provide education and rehabilitation pertaining to patient sexuality is required as one part of a reasonable effort to protect patients from harm. Also, section 8 of the *BC Mental Health Act* (22) requires that patients receive professional service, care, and treatment appropriate to their condition.

The complexities of these rights and duties gave rise to the creation of a guiding principle. The Task Force on Patient Sexuality has attempted in all areas to balance patient rights and hospital duties in a reasonable manner.

Part B of the policy outlines the environmental, educational, and therapeutic supports that are to be available to patients. In essence, this part of the policy specifies the infrastructure necessary within the hospital in order for policy implementation to be viable. In summary, it calls for the following to be made available to patients: (a) privacy curtains around beds, removable in certain circumstances; (b) private suites for purposes of sexual intimacy; (c) condoms, usually placed in machines in washrooms; (d) a sex education course available on a regular basis; and (e) counselling for issues pertaining to sexual abuse, sexual dysfunction,

sexually transmitted diseases, and family planning. In addition, the policy calls for seminars for the education of staff with regard to the policy itself and patient sexuality in general.

Part C outlines the orientation, assessment, and treatment protocol with respect to sexual issues to be followed when a patient is admitted to a hospital program. In summary, it states that the patient shall be informed about the policy; a sexual history shall be taken; a physician shall inquire about the patient's desire for birth control, testing for sexually transmitted diseases and counselling regarding any sexual issues; and the patient shall be encouraged to attend the sex education course as soon as possible.

Part D deals exclusively with masturbation. Because our survey indicated that masturbation was the most prevalent form of sexual activity, because it is a relatively safe form of sexual activity, and because it commonly occurred in inappropriate places, this variant of sexual expression was considered to warrant special attention. In summary, the policy states that each patient is to be informed by a physician or nurse that masturbation is healthy and acceptable within the confines of their privacy curtain; each bed area is to contain tissues and a waste basket; and patients are to be allowed to possess erotic pictures or literature, provided that the material is legal and available to the general public, is stored in the patient's locker, and for any specific patient, is not deemed to be countertherapeutic.

Part E deals with patient access to private suites located in a cottage on the hospital grounds for the purpose of sexual intimacy. The cottage at Riverview Hospital is reasonably home-like. The main floor contains a kitchen where patients may have coffee, snacks, and cigarettes, a living room for conversation, and an office for the Cottage Supervisor. The suites and a bathroom are upstairs. Normally, the cottage is open 3 days a week for 4 hours a day. Consistent with the duty to protect, each suite contains condoms and an alarm button connected to the staff office downstairs. The Cottage Supervisor is always downstairs while patients are in the cottage. The Cottage Supervisor also receives information from the wards in regard to which patients are eligible to use the suite and accepts reservations from patients who are eligible.

Consistent with the intention of balancing patients' rights with the hospital's duties, the policy requires that certain conditions be met that constitute a reasonable effort to protect patients from harm before they are allowed access to a private suite. In summary, the policy states: (a) a patient must complete the sex education course before accessing the suite; (b) assuming the course is completed, a request to use the suite shall be granted unless there is a known medical or psychiatric contraindication (the former is a condition that would make sexual activity dangerous to the patient or partner such as HIV infection, while the latter is a mental condition that renders the patient incapable of consenting or behaving responsibly); (c) a patient shall be presumed capable of consenting and behaving responsibly unless explicit indicators of possible incapability are present; (d) if indicators are present, a capability test shall be applied; (e) when a patient is found incapable, the patient's treatment plan must be reviewed and changes made that may help make the patient capable in the future; (f) patients found incapable may apply again in one month, and after 3 successive denials, may appeal to an independent psychiatrist; and (g) patients granted access may have access suspended or revoked, should indicators of possible incapability arise.

The aspect of the policy relating to the presumption of capability to consent and behave responsibly, item (c) above, follows from recently enacted adult guardianship legislation (24–26) in British Columbia, which requires the presumption of capability unless a clear indicator of possible incapability is present. To facilitate implementing our policy, a checklist of indicators of possible incapability, based upon suggestions in the literature (27,28), was drafted.

With regard to item (d), the application of a capability test for those patients whose capability is questionable, the task force again faced uncharted territory. As no model for a test of capability to consent to sexual behaviour or behave responsibly was available, the task force created its own test. It has 3 parts. The first is a mental status exam where the examiner looks for a disorder of attention, memory, language, thought form, thought content, perception, mood, or control that is severe enough to render the patient incapable of the specific ability to consent to sexual intimacy or behave responsibly. The qualifier ''severe enough'' is important because almost none of our patients has a clear mental status. The question is, does the patient's mental status impact specifically on these 2 areas of capability? Since this requires a clinical judgement, more than one member of a patient's treatment team participates in this judgement. The second part requires the patient to demonstrate a factual understanding of the meaning of certain relevant terms (for example, ''safe sex''). The third part requires the patient to demonstrate a more pragmatic understanding of relevant issues and the risks of engaging in sexual behaviour (for example, ''How do you use a condom correctly?''; ''What will happen to you if you get AIDS?''). All information required to answer these questions is presented in the sex education class.

Part F addresses the reality that the policy is untested and may, therefore, contain features or omissions that prove not to be in a patient's best interest. Consequently, until the policy is fully evaluated, a ''notwithstanding option'' is available, whereby the multidisciplinary team may override any aspect of the policy, provided that the reason is in a patient's best interest and the circumstances are fully documented.

Part G requires that a formal evaluation of the policy occur a year after the policy is fully implemented. The evaluation will examine patient and staff knowledge of the policy and sexual issues, the use of the sex education course and private suite, problems encountered in implementing the policy, and patient and staff satisfaction with the policy.

The Question of Legal Liability

A policy on patient sexuality that permits the use of a private suite for sexual purposes naturally raises questions regarding legal liability. If a treatment team permits 2 patients to have access to a private room for purposes of sexual intimacy, could the hospital or staff be liable if any harm were to arise from the encounter? This is a complex question. The potential for legal liability always exists, but the opinion of the lawyers on the task force was that risk is increased in the absence of a policy and decreased in its presence. Administration and staff know, or ought to know, that some patients are sexually active. Consequently, the failure to develop a policy on patient sexuality could be seen as a neglect of moral responsibility and a negligent omission in law. Developing a policy that is both respectful of patients' needs and mindful of possible risks is a responsible action.

A formal policy protects individual staff members. Without a formal policy, clinical staff must rely on their own judgement when dealing with issues related to patient sexuality, yet this is an area where clinical judgements frequently diverge. A formal policy takes most of the guesswork and personal opinion out of the decision-making process.

Readers may wonder if a policy will promote sexual activity among patients and thereby increase their risk of contracting HIV or becoming pregnant. It is important to remember that the literature and our survey indicate that many patients are already sexually active and are, therefore, already at risk. A formal policy should reduce risk through education and by permitting capable patients to practise what they learn in a setting that is relatively safe, humane, and dignified. The alternative is to leave patients on their own, which is neither respectful nor responsible.

Policy Evaluation

The Riverview Policy on Patient Sexuality received approval at all levels of hospital management. A decision was made to implement it in the CTP on a pilot basis. The complex nature of the issue guarantees that changes to the policy will be required over time. Plans have already been laid, for example, to expand the educational aspect of the policy to include counselling for substance abuse because of its association with HIV infection. We intend to report on the outcome of the formal evaluation, as well as subsequent modifications to the policy, at a later date. Readers who may wish to use the current Riverview Policy as a model for policy development in their own hospitals should remember that such a policy does not have to be perfect to be ethically and legally defensible. It must reflect a recognition of the fact that some patients have sexual needs and that these needs are normal, and it must reflect a reasonable effort to balance patients' needs with the hospital's duty to protect patients from harm.

Clinical Implications

- Patients have a right to sexual intimacy; hospital administrators have a duty to protect patients.
- A policy on patient sexuality should balance these rights and duties.
- A policy should reduce the risk of contracting sexually transmitted diseases.

Limitations

- Patients who participated may not be representative of all hospitalized chronic psychiatric patients.
- The legal arguments presented herein have not been tested in court.
- This policy may be too conservative; patients may find it difficult to access the private suite.

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Résumé

Objectif : *Description de la nécessité et de l'élaboration d'une politique sur la sexualité des patients dans un hôpital psychiatrique provincial.*

Méthode : *Évaluation de la nécessité d'une politique par un examen de la littérature et par des entrevues auprès d'un échantillon de malades mentaux chroniques. L'élaboration de la politique exige une enquête dans 38 hôpitaux psychiatriques canadiens pour trouver une politique existante, qui servira de modèle, et la consultation de divers intervenants et de 2 avocats.*

Résultats : *L'examen de la littérature et les entrevues avec les patients révèlent qu'un grand nombre de malades mentaux chroniques hospitalisés ont des activités sexuelles. Ni la littérature ni l'enquête sur les hôpitaux psychiatriques canadiens n'a révélé l'existence d'une politique pouvant servir de modèle. Un groupe de travail, composé d'intervenants et de 2 avocats, rédige donc une politique. Les caractéristiques de la politique, peut-être la première au Canada, font l'objet d'une description. Le fondement juridique des droits sexuels des patients est le thème d'une discussion, et les mécanismes de protection des patients font également l'objet d'une description.*

Conclusion : *Une politique doit fondamentalement faire l'équilibre entre le droit du patient à l'intimité sexuelle, dans la dignité, et le devoir de l'administration hospitalière d'adopter des mesures raisonnables pour protéger les patients.*