

Sexual safety on mental health wards

SEPTEMBER 2018

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We register health and adult social care providers.

We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.

We use our legal powers to take action where we identify poor care.

We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

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Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

Contents

Foreword	2
Lived experiences	3
Elizabeth’s story	3
John’s story.....	4
Introduction	5
Main findings	8
Our learning and recommendations for action	13
1. People who use mental health inpatient services do not always feel that staff keep them safe from unwanted sexual behaviour	13
2. Clinical leaders of mental health services do not always know what is good practice in promoting the sexual safety of people using the service and of their staff.....	14
3. Many staff do not have the skills to promote sexual safety or to respond appropriately to incidents.....	14
4. The ward environment does not always promote the sexual safety of people using the service	15
5. Staff may under-report incidents and reports may not reflect the true impact on the person who is affected	16
6. Joint-working with other agencies such as the police does not always work well in practice.....	17
Examples of effective initiatives in trusts	19
Our recommendations for action	20
Appendix A	24
Appendix B	26
Appendix C	28
References	29

Foreword

People with mental health conditions have just as much right as everyone else to safe and fulfilling sexual relationships. However, people affected by mental ill health can at times act in disinhibited ways or may lack the mental capacity to make sound decisions about relationships. They may also have experienced abuse in the past, which might have contributed to their mental ill health and which might leave them at risk of exploitation by others. These factors make it more likely that people engage in sexual behaviour that they would not when well or make them vulnerable to sexual abuse.

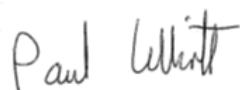
People whose mental ill health is so severe that they require care on a mental health ward are often at the most vulnerable point in their lives. Many will not have consented to being treated in hospital and will have been admitted against their will. Given this, mental health services have a heightened responsibility to protect people using inpatient care from harm.

In our report, *The state of mental health services 2014 to 2017*, we described mental health admission wards as a high-risk environment, citing rising rates of detention, high bed occupancy, frequent incidents of violence between patients and towards staff and increasing use of physical restraint.

Our analysis of incidents reported to the NHS National Reporting and Learning System suggests that sexual incidents are also commonplace on mental health wards. When we discussed our findings with people who have used services, they described the distress they experience when other patients speak to them using sexualised language, or when they observe other patients behave in a sexually disinhibited manner due to their mental ill health. Some told us that they had received unwanted sexual advances from other people or that they had engaged in sexual acts when mentally unwell that they have regretted afterwards. This distress is still very real for people after they leave hospital.

We would not wish for this work to have an impact on safe and fulfilling sexual relationships, as they are a part of a person's human rights. But as the quality regulator, our priority is to ensure that people using health and care services are kept safe, that due consideration is given to their mental capacity and that their privacy and dignity are maintained.

Therefore in this report, as well as sharing our findings, we say what we think should be done to improve sexual safety on mental health wards. These recommendations include: clearer guidance to staff, training so that staff can better support the sexual wellbeing of patients, strengthening of the reporting system, and investment in the physical and therapeutic environment of wards so that they better promote sexual safety. We have developed these recommendations in consultation with people who use services and organisations that represent their views, as well as with providers of mental health services, national system partners and professional bodies.



Dr Paul Lelliott, Deputy Chief Inspector (Lead for Mental Health)

Lived experiences

People have shared their experiences to help us understand the complexity and impact of sexual safety incidents so that we can learn and make improvements.

Elizabeth's^a story

I was working in November 2007 when I disclosed to a psychotherapist how seriously my mental health had declined. I was asked to come back the next day and was sectioned. The way in which everything unfolded so suddenly was very traumatic. I was immediately taken to a mixed-sex acute mental health ward.

Towards the end of my eight-month long stay, while I was under section 3 of the Mental Health Act, an exploitive relationship formed with a male patient in the same ward.

The patient borrowed my phone for a weekend and ran up a huge bill calling sex lines. The patient also started regularly asking for money from me and coming with me to the cash point when I had leave to go out. After confiding in a staff member about my phone bill, I found out after that they must have told him what I had told them, as he knew about it.

The environment was a very difficult one to be in. It was easy to form inappropriate relationships with other patients. It was very busy and staff did not always have time to spend with patients.

The patient's attention soon became relentless and as patients would spend most of their time in the communal areas, I couldn't get away from him. I didn't report this to staff at the time, as after my experience with the financial exploitation, I didn't feel like I could fully trust them. Soon after this, he had sex with me twice. He also got in touch with his brother who had sex with me. I didn't feel like I could explain to anyone what had happened.

It wasn't until much later on when I moved to a new therapeutic community hospital, that I was finally able to share the whole story of what had happened to me six years earlier. At this hospital there was regular therapeutic work with community meetings, facilitated by psychosocial nurses. Being here helped save my life.

Although I still feel angry sometimes, I mostly feel compassion for the patients in that situation and also for the staff. It does concern me that things still need to improve. My fear is that this is happening to someone like me right now, but that you won't hear about it until much later on. Of everything I experienced, the worst harm I suffered by far was the sexual exploitation. That has completely scarred me for life.

^a Not her real name. The story above is a personal account. None of the organisations involved have been asked to respond to these accounts.

John's^b story

My wife developed postpartum psychosis after the birth of our second son. Following the subsequent death of her mother, my wife had a 'breakdown' and was admitted to hospital. At a later date there was a tribunal to review my wife's detention, and I was shocked to hear from a solicitor that she had performed oral sex on a male patient. I was very distressed that my wife, who the tribunal said was "likely to put herself at risk by sexual inhibition", had not been kept safe in hospital.

At the time of the incident, my wife lacked capacity and was on high levels of medication. I later found out that the two nurses on duty that night failed to inform the police, an action I felt was necessary as I believed my wife had been sexually assaulted as she had been coerced into performing a sexual act without her consent. The experience was traumatic to me, and to my wife.

The incident has changed our lives. I worked through a series of investigations, until I reached a point where a further appeal was the next step. I chose not to pursue this as it would mean putting my wife through all that again – her wellbeing is important to me.

When an earlier report on the incident was shared, it was very hard on my wife, and her psychosis returned, meaning she was hospitalised again. One of the nurses on the ward she was admitted to had been present the night of the incident. When my wife saw her she experienced the same trauma and ended up being restrained and secluded. My wife is now so terrified of ever being in hospital again, I fear she would take her own life.

I am determined to highlight the issues to make sure that a similar thing doesn't happen to another family – I want to work to ensure there is change, something that can give my wife and I a little closure. I believe trusts should learn to establish the root cause of an incident, involve all relevant stakeholders including the police and always be open to opportunities to improve.

^b Not his real name. The story above is a personal account. None of the organisations involved have been asked to respond to these accounts.

Introduction

This report aims to raise awareness of issues around sexual safety in mental health wards. This is one aspect of the wider safety agenda being moved forward by the sector. In our report, *The state of care in mental health services 2014 to 2017*, we identified safety as the area in which services were most likely to perform poorly, with 4% of NHS core services and 5% of independent mental health core services rated as inadequate for safety, and only 59% and 61% respectively rated as good.¹ We had a particular concern about the safety of inpatient services. On too many wards, we found that the combination of a high number of detained patients who pose a risk to themselves and sometimes to others, old and unsuitable buildings, staff shortages and a lack of staff training, made it more likely that patients and staff are at risk of suffering harm. As this report shows, we have now also identified the harm experienced by some patients as a result of sexual safety incidents.

People have a right to feel and be safe while accessing treatment in mental health wards. As the quality regulator, our priority is to ensure that people using healthcare services are kept safe and that their privacy and dignity are maintained. This means ensuring that patients are protected from sexual safety incidents, and supporting patients who may behave inappropriately due to their condition.

It is important to note that all of the incidents that we analysed were reported by trust staff through a reporting system that trust managers had full access to. We therefore expect that managers of these services knew of these incidents and would have responded to them appropriately. We only have partial information about what these actions were, because it is not a requirement of the system that the person records this when they submit an incident report. CQC has followed up the most concerning reports, including alleged rapes and alleged incidents carried out by staff, and were assured that appropriate action had been taken by the trusts concerned. The purpose of the report is not to investigate individual incidents, but to provide an overview of these incidents nationally, identify key themes and enable the sector to come together to prevent incidents, share good practice around upholding sexual safety and responding to incidents.

Having listened to the experiences of people who have used services, we have been broad and inclusive in categorising sexual safety incidents (see illustrative examples in [appendix A](#)). In order to be as clear as possible, we have included a glossary in this report. We have also attempted to ensure that this report is respectful and free from gender and sexuality-based assumptions, while acknowledging that this is an area where mental health services could strengthen their approach.

Finally, we are aware that the content of this report may at times be difficult to read due to the nature of the subject area. We have done our best to be respectful and use appropriate language. The terminology in this area is constantly developing and evolving – as you read on, please bear in mind that it is not intended to cause upset or disrespect. Instead, the report is based on the analysis of real experiences, and on co-production with those who have an understanding of the impact of sexual incidents in mental health wards.

Why did we carry out this work?

Last year, inspectors in one of our regional teams issued a requirement notice because an NHS mental health trust did not comply with the national guidance on eliminating mixed-sex accommodation on some of its mental health wards.² The trust was slow to act. As part of their further assessment of the impact of this breach, the inspectors looked at the reports on patient safety incidents that staff working at the trust had submitted through the National Reporting and Learning System (NRLS), a system to enable learning from patient safety incidents in the NHS. Reviewing and analysing these incidents provides a greater understanding of national priorities for safety improvement, and helps to identify emerging risks and issues that might not be recognised locally and could merit national action.

They found a number of reports that described sexual incidents that had taken place on these wards. CQC took the further action necessary to ensure that this particular trust protected patients under its care.

These events made us decide to examine how often other mental health trusts in England report sexual incidents. We wanted to see whether there were any themes and areas where improvements could take place.

How did we examine the issue further?

We started by analysing reports of incidents that took place on wards in the three-month period from April to June 2017. The 54 mental health trusts in England had submitted 58,464 such reports through the NRLS. We used a 'text-mining' approach to identify which of these reports may be about sexual incidents. We were looking for incidents that involved sexual assault or harassment of patients or of staff, and sexualised behaviour. We also included incidents of nakedness, even when this was in a non-sexual context, and sexual words used as insults. We did this because people had told us about the distress that such acts can cause. We included reports that appeared to describe consensual sexual activity because it was rarely possible to determine from the description whether those involved had the mental capacity to agree to engage in sexual activity.

We then carried out a more in-depth analysis of those reports that described sexual incidents involving patients, staff, visitors and others.

Engagement, consultation and co-production

We held four engagement events to present and discuss the findings from our analysis. We used these events to help us better understand the effect of such incidents on patients and staff, the factors that influence sexual safety on mental health wards, and what might be done, locally and nationally, to improve the situation.

These events were attended by:

- 106 healthcare professionals, who represented 49 NHS trusts and independent sector providers

- 14 people who work for an arms-length body (a term covering a wide range of public bodies, including non-ministerial departments, non-departmental public bodies, executive agencies and public corporations)
- 16 people who have used mental health services or who work for organisations that directly support people who have used mental health services. Some of these people have experienced sexual abuse on a mental health ward.

In addition, a small number of people asked to speak to us individually to share their experiences or those of people they care for.

Review of previous work in this area

Others have explored and written about sexual incidents involving people using mental health inpatient services. This literature has covered definitions, prevalence and the effect on patients.

In 2004, the mental health charity Mind published the findings of its Ward Watch campaign. It showed that 18% of people had experienced sexual harassment, and 5% had experienced sexual assault while they had been an inpatient.³

In 2006, the National Patient Safety Agency (NPSA) published an analysis of patient safety incidents, including sexual safety incidents, occurring on mental health wards between November 2003 and September 2005. The NPSA repeated the analysis in 2007. Both identified significant numbers of sexual safety incidents. For example, between October 2006 and September 2007, there were 887 sexual safety incidents including 44 incidents which described an allegation of rape or sexual assault.

The work of the NPSA prompted a number of initiatives to promote positive practice in sexual safety for people using mental health inpatient services and to develop risk reduction strategies. These included national guidance on eliminating mixed-sex accommodation published by the Chief Nursing Officer in November 2010.²

During our engagement we found that a number of services in England are making positive use of work that has been carried out in Australia to improve sexual safety and support patients. The Ministry of Health in New South Wales published its *Sexual Safety of Mental Health Consumers Guidelines* for inpatient settings in 2013.^{4,5} This provides practical advice and strategies to help mental health services to meet their responsibilities to promote the sexual safety of people who use services. It outlines what information people who use services should be given about their rights and obligations in sexual safety. It also calls for stronger relationships between mental health services and other services that support victims of sexual assaults.

Main findings

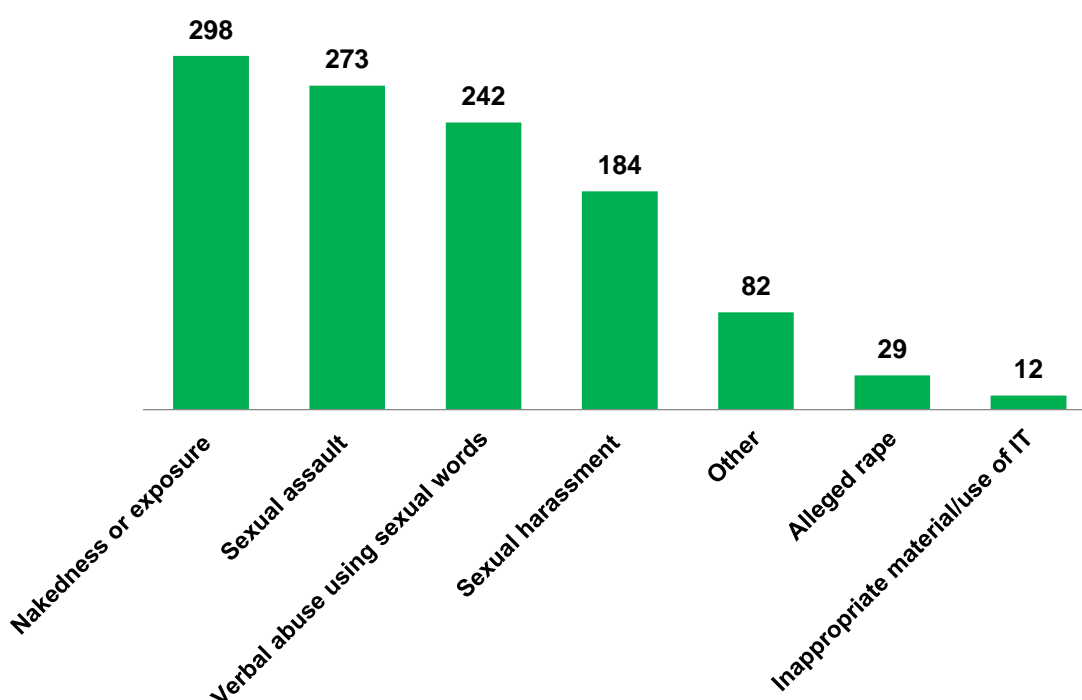
Our analysis of nearly 60,000 reports that took place on NHS trust mental health wards from April to June 2017 found 1,120 sexual incidents involving patients, staff, visitors and others described in 919 reports. This was 1.6% of all the reports.

Types of incident

From the description provided, more than a third of the incidents could be categorised as sexual assault or sexual harassment of patients or staff.^c We found 29 reports where allegations of rape were made. Other common types of incidents included nakedness (including in contexts where this was clearly non-sexual) and exposure, and sexual words used as insults (figure 1).

CQC has followed up each of the alleged rapes with the trusts to ensure they have addressed the incidents appropriately.

Figure 1: Types of incident



Source: Mental health trusts reports to the National Reporting and Learning System (NRLS) from April to June 2017

Note: 'Other' includes sexual activity where it was not possible to determine from the reports whether the people concerned had the mental capacity to make the decision to participate in sexual activity.

^c Defined in the Equality Act 2010 section 26, and the Sexual Offences Act 2003.

People involved in sexual incidents

The alleged incidents were mostly carried out by patients (95% of all reports). However, in 51 (5%) of the reports, it was alleged that a member of staff was the person who carried out the incident. In all but one of the incidents where a member of staff was the alleged person, the incident had been reported by a patient. CQC has followed up the reports where the alleged person who carried out the incident was a member of staff, and the description of the incident suggested that further action was necessary but the report did not state whether action had been taken.

About two-thirds (594) of the people affected were categorised as patients and one third (301) were staff, with a small number (24) who were others, such as visitors to the ward.

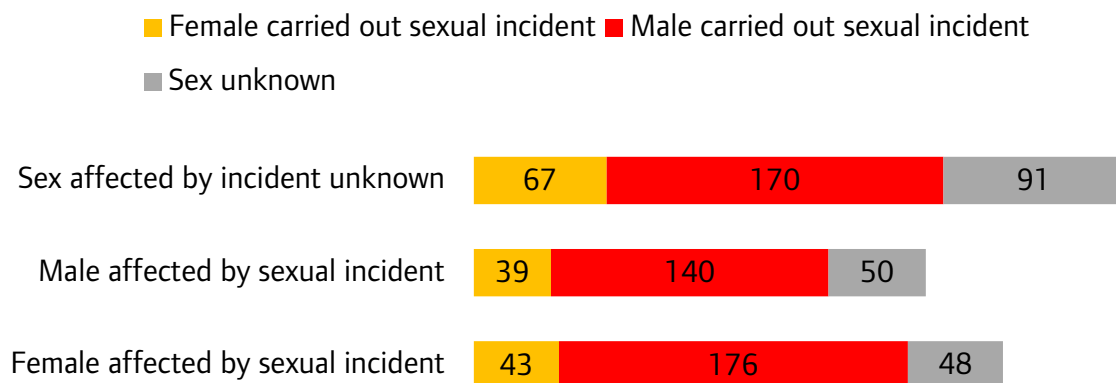
Where we could determine the sex of the person who carried out the sexual incident, they were male in 495 reports and female in 153 reports.^d

In 328 of the reports, the sex of the person affected was not recorded. In the reports where sex was reported, females were more likely to be the person affected: 267 reports versus 229 reports where a male was the person affected (figure 2). In the remainder of the reports both males and females were affected. In more than a quarter of the reports, more than one person was affected by the sexual behaviour.

For the females who were affected, 66% of the people who carried out sexual incidents were male, 16% female and in 18% the sex was not known.

For the males who were affected, 61% of people who carried out sexual incidents were male, 17% female and in 21% the sex was unknown.

Figure 2: People involved in sexual safety incidents by sex

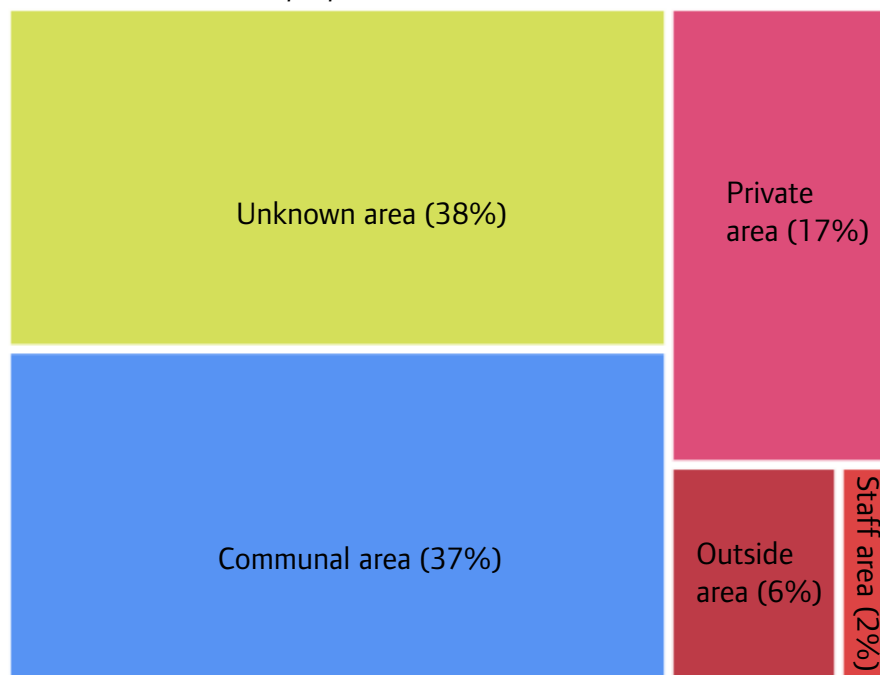


^d The division between male and female described in this section should be treated with caution as some aspects of the data mining may have made reports involving males more likely to be identified and included.

Where the sexual incidents happened

Most of the alleged incidents took place in communal areas (416 incidents), with a smaller proportion of incidents taking place in patients' rooms or other private areas such as toilets and bathrooms (194 incidents), in outside areas of the ward such as gardens and courtyards (70 incidents), or in areas where staff may be present (23 incidents). A small number of alleged incidents happened when patients were on escorted or unescorted leave. In the remainder of the reports, we could not determine where the incident took place. Figure 3 below is a visual representation of incident locations and how often incidents occurred in each.

Figure 3: Incident locations, as proportions of the total



For the great majority of the reports we could not determine with any certainty whether the ward admitted both men and women (mixed-sex) or was single-sex. Around half of the incidents took place in acute adult wards or psychiatric intensive care units, with almost a quarter reported from forensic units and smaller proportions reported from learning disability units, older people's mental health units, and child and adolescent units.

Response by the provider to the incident

For 332 of the 919 descriptions, the person making the report did not state what action had been taken following the incident. Where they did, provider responses often involved several actions, for instance advising patients on appropriate behaviour and increasing observation, or restraint followed by seclusion and administering medication.

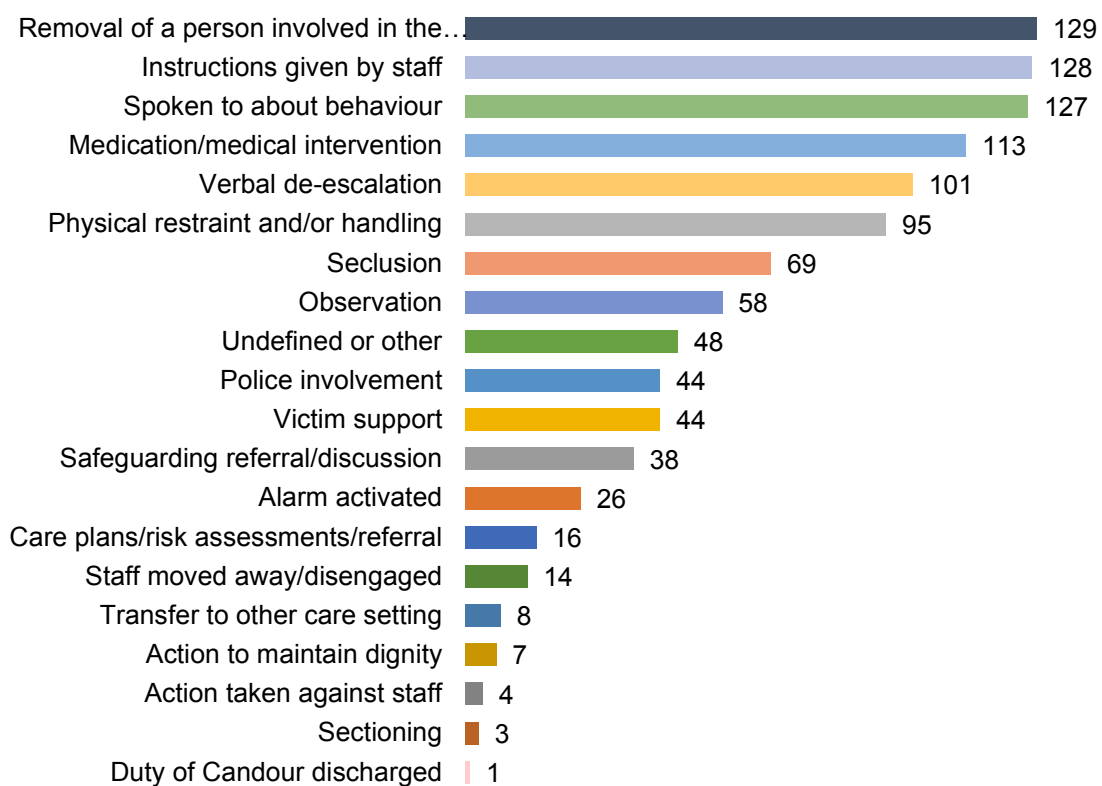
No single type of provider response dominated. Removing people who were involved from the scene, staff talking with the people involved about their behaviour, medication and medical

interventions, verbal de-escalation and handling/physical restraint all featured in near equal numbers.

For 44 of the incidents, the report stated that the police had been involved and that 38 resulted in a referral to safeguarding.

Forty-eight responses were categorised as ‘undefined/other’, which mostly captured reporting along the lines of “staff intervened...” without any more detail (figure 4). As outlined in the limitations of the data section below, it is likely there were other responses including referrals to safeguarding or involvement of the police that were not recorded in the system, as there is no requirement to do so.

Figure 4: Provider responses to incidents (these often involved several actions)



The limitations of this analysis

Although this analysis provides important information and will stimulate debate on how sexual safety can be improved, it is important to also recognise its limitations:

- The main analyses drew on the text description of the incidents by the staff member who completed the report. The length of the description varied greatly, with a mean length of 141 words and a range from seven to 780 words.

- The NRLS reporting system does not require the person making the report to state what action was taken in response to the incident and reports made shortly after the incident are not always updated later. Therefore, just because the reporter has not recorded an action, we cannot conclude that this did not happen.
- We found that 97% of these reports were classified by reporting organisations as ‘no harm’ or ‘low harm’ incidents. It could be that some of these incidents did cause little physical harm or emotional distress. For others, it could be a reflection of how providers are asked to classify levels of harm when reporting incidents to the NRLS. While the harm classification includes physical and psychological harm, degrees of harm relate to the additional treatment requirements of the patient – as a result of the patient safety incident – rather than to the impact on the person. For example, the NRLS defines moderate harm as “a patient safety incident that caused a moderate increase in treatment and which caused significant but not permanent harm”. A moderate increase in treatment is described as “an unplanned admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another area”. A person who has been subject to sexual assault or harassment may not require additional treatment – or the need for this might not be immediately obvious.
- The NRLS is a system for reporting incidents that affect patients. Providers should not use it for incidents where the person affected is a staff member. Despite this a staff member was the alleged person affected, in nearly one third of the reports. This might be because, in many cases, the staff assault is described in order to explain the subsequent impact on the patient, such as restrictions being placed on them. Whether this is the case or not, it does, suggest that there is a need for a system to report incidents where staff are the subject of events that might cause them physical and emotional harm.

Our learning and recommendations for action

This section summarises what we have learned and concluded from analysing the incidents reported through the NRLS, exploring previous work in this area and gathering the views of those involved in the engagement work. It was clear from our engagement with providers that there is a growing awareness of and commitment to making improvements. A few trusts have already started on this. However, trusts were struggling as there is no national guidance or training to support practice. There was broad consensus among those we consulted on the major themes and the type of action that should be taken to improve sexual safety.

1. People who use mental health inpatient services do not always feel that staff keep them safe from unwanted sexual behaviour

People who have experienced inpatient care, and their families, told us that they find it difficult to talk about sexual safety incidents. They may be afraid to report an incident because the person who carried it out may still be on the same ward. If they do speak up, staff may be slow in reporting the incident and may not inform the patient of what action has been taken to protect them from further harm. They believe that, whenever possible, the patient should be involved in helping to complete the incident report and agreeing the actions to be taken.

People who use mental health services and their families want sexual safety incidents to be taken seriously. They would also like to be involved in planning improvements to practice going forward. This reinforces the importance of creating a culture that is intolerant of any unwanted sexual behaviour and open in encouraging staff and patients to report and discuss sexual wellbeing and sexual safety incidents.

How can this be addressed?

Staff must listen to, and take seriously, any report of a sexual safety incident made by a patient. Even if it is concluded that the alleged incident did not take place, staff must work to understand why the person made the allegation and acknowledge the distress associated with it.

Staff must behave in ways that ensure that patients feel supported and able to speak freely. This means that staff who know the patient must find the time to engage patients in regular one-to-one conversations. This should be carried out by a staff member of the same gender as the patient when requested or indicated. It is also important that patients have unhindered access to advocates and to external helplines if, for any reason, they feel unable to speak out on the ward due to fears that this may delay their discharge, or not wanting to damage relationships with staff by making an allegation against the person who carried out the incident who may then be responsible for their care at a later date. They may also need access to appropriate victim support.

For staff to make sure that appropriate boundaries are maintained, they must communicate clearly to patients what behaviours are not acceptable and how the ward responds to sexual safety incidents.

2. Clinical leaders of mental health services do not always know what is good practice in promoting the sexual safety of people using the service and of their staff

Clinical leaders may be uncertain about the behaviours that are acceptable on mental health wards and those that are not. Also, they may not always be aware of the impact that unwanted sexual behaviour has on patients and staff, and the impact that potential false allegations have on staff and people who use services. Clinical leaders' opinions and approach to these difficult issues vary and may be affected by their personal values. This, and the absence of clear guidance or set of expectations, makes it challenging for staff to manage sexual incidents on mental health wards.

Clinical leaders may have a particular problem in deciding how staff should respond to what appears to be consensual sexual activity between patients. Those involved in the consultation told us how difficult it can be to balance their duty to protect people whose capacity to make decisions might be temporarily impaired, with their wish to respect patients' right to a private life. This is likely to be a particular challenge on longer-stay wards.

How can this be addressed?

There is a need for clear guidance for good practice in this area. This must be co-produced by mental health professionals working in partnership with people who use services and organisations that represent people who use services. It is important that this guidance addresses the issues, including promoting sexual wellbeing.

3. Many staff do not have the skills to promote sexual safety or to respond appropriately to incidents

Although mental health staff wish to keep patients safe, in the absence of clear guidance from leaders they often feel ill-equipped to manage sexual safety incidents. This includes occasions when staff are themselves subject to sexual assault, abuse or harassment or have allegations made against them (including false allegations, by people who use mental health services).

Staff told us that they sometimes feel 'paralysed' and unable to act when a sexual incident occurs. Some staff do not know how to respond to these, or to disclosures from people who use mental health services, and may not always address them promptly and appropriately. This includes the question of determining whether patients have the mental capacity to decide to engage in sexual activity.

How can this be addressed?

There is a pressing need for better staff development on these important issues. This development should be co-produced and must equip staff to:

- Develop the skills and confidence to have conversations with patients and with colleagues about the sexual health and sexual safety of patients, using appropriate language to support patients to feel comfortable talking about their experiences.
- Make a full assessment of patients that includes historical details about their sexual safety (both in terms of vulnerability and potential to display sexual behaviour that puts others at risk). This will enable them to sensitively identify potential risks and plan the person's care.
- Understand the principles of trauma-informed care and embed these into every day practice.
- Respond to the needs of people who identify as lesbian, gay, bisexual, or non-binary or who are transgender.
- Ensure that staff are supported when faced with allegations of a sexual nature.
- Consider the difficult issues of mental capacity and consent with the involvements of the full multidisciplinary team working on the ward.
- Identify a person who has particular expertise in this area who can lead this work on behalf of the provider. The lead would help to develop this work locally and could act as a valuable source of advice to staff throughout the organisation.

4. The ward environment does not always promote the sexual safety of people using the service

Most people admitted to hospital cannot choose their ward, or whether it is a same-sex or mixed-sex ward. For the great majority of NRLS reports, we could not tell whether the incident happened on a same-sex or a mixed-sex ward. However, we do know that in two-thirds of cases where the report indicated that a female was the person affected, a man was alleged to be the person who carried out the incident. We know from our inspection programme that, on mixed-sex wards, it is often difficult to ensure that gender separation is maintained effectively and to ensure that patients cannot access bedroom areas intended for those of the opposite sex. The data also shows that a significant number of the incidents occur in communal areas.

Those we consulted with agreed that dormitory accommodation, or other arrangements where bedrooms are shared (by patients of the same sex), are unacceptable and do not offer privacy or dignity.

Significant investment would be needed to change all inpatient provision to single-sex wards and remove all shared rooms. It might also reduce flexibility of overall bed provision, meaning that more people would be admitted to wards a long way from their home areas which can also lead to increased clinical risk. Also, those we consulted with told us that it is harder to recruit staff to work on single-sex wards.

The diversity on a mental health ward reflects the diversity of the country. It is important that the ward environment meets the needs of everyone – and does not make predetermined

gender-based assumptions. This may be particularly important for those people who identify as LGBT+.

How can this be addressed?

Healthcare professionals and representatives of arms-length bodies that we consulted with agreed that CQC should not simply recommend that all mental health wards become single-sex. As well as the cost and potential impact on out-of-area placements, this would not affect the significant proportion of incidents that involve people of the same gender or a staff member as the person who was affected by the unwanted behaviour.

However, we believe that where a patient has a history of sexual abuse or exploitation a clear care plan must be put in place and, where it is in the person's interests and/or they express a preference, they should be cared for in a single-sex ward.

For wards that admit both men and women, the arrangements to keep the sleeping and bathroom areas apart must work in practice and communal areas should be closely supervised. Those we consulted with told us of examples where door security was not working properly and patients could move freely between different areas of the ward. CQC has encountered similar situations on inspections of mixed-sex wards.

The 'ward environment' is far more than its physical structure or layout. It also encompasses:

- how staff manage the physical environment – awareness of 'blind spots' and staff being always present in communal areas
- ensuring that staff are proactively engaging with positive therapeutic engagement skills
- providing patients with the means to summon help, for example by giving them personal alarms
- making sure that patients are occupied and have access to therapeutic and leisure activities – including at weekends
- developing an appropriate culture on the ward, for example, providing accessible information about sexual wellbeing and sexual safety helps to inform patients that this is something that is taken seriously
- considering the potential for sexual harassment to happen virtually through use of mobile phones or computer terminals as well as in person.

5. Staff may under-report incidents and reports may not reflect the true impact on the person who is affected

From our engagement work, we heard that staff and patients find it difficult to speak up when they observe, or are the person affected by, unwanted sexual behaviour. We were told that staff may become 'desensitised' to the issue because sexual incidents happen regularly, particularly on acute wards. This may discourage staff from reporting incidents. This lack of encouragement may be made worse when staff struggle to find the time to report incidents when wards are

very busy. This means that the actual number of such incidents may be higher than suggested by our findings.

In our analysis, there was great variation between trusts in the number of sexual incidents identified that had been reported through the NRLS over the three-month period. This might be due partly to when the incidents were uploaded onto the reporting system and differences in the number and type of wards managed by the trust. It may also reflect different practices and thresholds for reporting.

While the data can be used to identify broad themes and trends, the variability in reporting means that the true nature and extent of the problem, both locally and nationally, is masked. Nor can we determine whether a trust that reports many incidents is less safe or simply has a lower threshold for reporting.

We have described above how the classification of harm used by the NRLS may mean that the way some sexual incidents are classified by the reporter may not fully reflect their true psychological and emotional impact of sexual incidents.

How can this be addressed?

Clinical leaders in provider services must support best practice to prevent, report and proactively respond to sexual safety incidents, and work with staff to create a culture that promotes sexual wellbeing. It is essential that staff recognise the physical and psychological harm caused to people who use services, and to their families and friends, from sexual abuse and harassment experienced during inpatient stays. It is important for mental health services to recognise the likelihood that people who are using their services may have experienced sexual incidents of an abusive nature in the past, and ensure that staff are trained to follow the principles of trauma-informed care.

To develop this culture, staff themselves must feel safe from unwanted sexual behaviour, confident that their safety is also protected and know that if they report a sexual safety incident, it will be acted on.

Trusts must have governance processes in place to monitor the quality of reporting, and ensure that actions are taking place to improve the sexual safety of patients. For instance, most trusts will already report on patient safety and safeguarding to their boards, and it is important that sexual safety is built into this.

6. Joint-working with other agencies such as the police does not always work well in practice

The decision to charge a person detained in inpatient mental health services with a criminal offence is a sensitive matter. It requires close cooperation between police investigators, healthcare professionals and Crown prosecutors. There are examples across the country of successful partnerships between mental health providers and police services where officers are posted as liaison officers or investigators to handle reports of people who use services

offending in the hospital (see case study on Cornwall Partnership NHS Foundation Trust, page 21).

However, there are particular challenges in working with the police to make sure that people who use services are taken seriously when a crime has been committed and get access to the support they need.

Representatives of people who use services told us that patients who have experienced a sexual safety incident sometimes do not feel they are believed or, if they are detained, that they do not have the same rights as other people.

It is generally accepted that many victims of sexual crime can find their contact with police difficult. We were told that this was even more difficult if the victim has a mental health problem. Likewise, it can be challenging for individuals who have had negative encounters with the police previously, perhaps in connection with their mental health problem, or who have a history of trauma.

Only a small minority of NRLS reports stated that staff had made a safeguarding referral in response to the sexual safety incident. Although this may understate the true picture, the senior trust professionals that attended the engagement event agreed that providers might not always make appropriate use of safeguarding procedures.

How can this be addressed?

Providers must work closely with other agencies such as the police and local safeguarding teams on the response to sexual safety incidents. If needed, clearer guidance on joint-working between providers and the police should be developed based on good practice.

Safeguarding teams are an integral part of this work and help to determine the criteria for which reported incidents should be more fully investigated.

Advocacy services, sexual assault referral centres and local rape crisis services can be crucial to help support people who are affected by sexual incidents.

Examples of effective initiatives in trusts

Midlands Partnership NHS Foundation Trust (The Redwoods Centre)

Staff at The Redwoods Centre identified that, while they were reporting incidents and working with safeguarding and the police, they could do more to support patients.

They moved to having more single-sex acute wards, with one for men, one for women and one mixed-sex. To complement this change, they embedded procedures and guidelines for staff on how to carry out risk assessments which looked at historical risks. When a risk was identified, staff responded by using enhanced observations in a personalised care plan.

Additionally, staff carry out enhanced observations of patients admitted to the remaining mixed-sex wards to further assess risk. Any patient that feels vulnerable is offered access to a personal alarm.

The matron, clinical psychologist and nurse consultant provide sexual safety awareness sessions to staff on a monthly basis and they have developed gender and trauma-informed care plans for individual patients.

The work has been embedded by all of the teams, and has greatly improved the culture throughout the wards in the Mental Health unit of The Redwoods Centre.

Cornwall Partnership NHS Foundation Trust

Staff at Cornwall Partnership NHS Foundation Trust were informed that approximately 40% of the police activity in Cornwall related to people with mental ill health. This highlighted the importance of close joint working between health services and the police to meet the needs of vulnerable people. It led to the joint-funding of a neighbourhood beat manager to work with the patients and staff on the trust's wards.

The beat manager has worked with staff at the trust to develop protocols, together with easy-to-follow flow charts and training for both police officers and inpatient staff to support areas for joint working. This means that there are clear, shared expectations about reporting and investigating offences committed in inpatient settings.

This work relates to wider safety for inpatients but it has also led to improved joined-up working around all offences, including sexual safety. Patients report that they feel safer on the wards. Also, the better understanding of the interface between mental health teams and the police ensures that the police make a proportionate response to incidents based on the actual level of risk.

Following a number of sexual incidents, staff devised a sexual safety assessment tool, launched in February 2018. The tool supports staff to assess people using inpatient services, including recognising cases of historic abuse. Sexual safety is now an integral part of the trust's ongoing quality improvement programme.

Our recommendations for action

Our data analysis and engagement with providers, public representatives and voluntary and charity sector stakeholders has found that sexual safety is still a major issue in mental health services. We have been working closely with national bodies and other stakeholders to agree what needs to be done to improve the sexual safety of people who use services. Action needs to happen at every level of the system:

1. There is a need for national guidance on sexual safety on mental health wards that can be adapted to specific inpatient settings. This should be co-produced by healthcare professionals working with people who have experienced inpatient care and should address for staff and people who use services:
 - what is acceptable behaviour and what kind of behaviour would be considered sexual harassment or abuse.
 - how staff should respond to sexual incidents – including those that are triggered by disinhibition or some other feature of a person’s mental state.
 - a recognition of the potential physical and psychological harm caused by those affected by unwanted sexual behaviour.
 - what support people who experience unwanted sexual incidents can expect in terms of staff response.
2. Clinical leaders in provider services should support best practice to prevent and respond proactively to sexual safety incidents. This includes:
 - creating a culture on mental health wards that promotes sexual wellbeing, actively encourages disclosure, and supports those affected by unwanted sexual behaviour.
 - ensuring that staff assess risk and where it is in the person’s interests and/or they express a preference, they should be cared for in a single-sex ward.

This work would be facilitated by trusts nominating a board member to hold responsibility for this area.
3. Providers should work actively to uphold the sexual wellbeing of people who use services, by promoting access to information and support for patients, their families and carers. These should take into account the culture and diversity of people who use services.
4. Staff working on mental health wards should have access to learning and development opportunities, including trauma-informed care principles, so they can better assess patient risk (both of those carrying out and experiencing incidents), and promote strategies to support sexual safety and to respond appropriately to sexual safety incidents.

5. Providers must ensure that the physical environment of mental health wards promotes the sexual safety of patients in terms of layout and use, and identify high-risk areas and locations.
6. Providers should work collaboratively with stakeholders, including patients, the police and safeguarding teams, to ensure that sexual safety incidents are taken seriously and addressed appropriately. This should draw on the principles that underpin existing examples of successful collaboration, including police liaison models.
7. The process for reporting and learning from sexual incidents on mental health wards should be strengthened so that:
 - incident reports better reflect the impact on people who use services.
 - it enables proper reporting of incidents where staff are involved.
8. The process of monitoring, assurance and regulation of this issue and of the factors that influence sexual safety and wellbeing should be strengthened.

Glossary

We are aware that the content of this report may at times be difficult to read due to the nature of the subject area. We have done our best to be respectful and use appropriate language. We have developed this glossary in the hope of being as clear as possible on what we mean by the terms used throughout this report.

- **LGBT+:** encompasses people who identify as lesbian, gay, bisexual, transsexual and all spectrums of sexuality and gender (including intersex and non-binary).
- **Patient safety:** the avoidance of unintended or unexpected harm to people during the provision of health care.
- **People who have carried out sexual incidents:** a person who has carried out sexualised behaviour or activity that has involved another individual directly or indirectly (for example, by witnessing a behaviour). The use of this term does not necessarily imply intent, because incidents can result from sexualised behaviours associated with a person's illness.
- **People who have been affected by sexual incidents:** a person who has been directly involved in or witnessed sexualised behaviour or activity that was carried out by another individual. The use of "affected" includes the potential to be affected both physically and psychologically at the time of the incident and in the future.
- **People who have been involved in sexual incidents:** refers to both people who have carried out sexual incidents and those who have been affected by sexual incidents.
- **Sexual assault:** intentional touching of another person of a sexual nature where the other person does not consent to the touching and the individual does not reasonably believe that they consent.
- **Sexual consent:** where an individual has the freedom and capacity to agree to sexual activity with other persons. It is important to note that individuals with mental health conditions may appear to consent to activity, but may lack capacity due to their mental health condition. Some of the incidents in this report may be consensual sexual activity between two patients but have been included as it was not possible to determine whether the people concerned had the mental capacity to make the decision to participate in sexual activity.
- **Sexual harassment:** any unwelcome or unwanted sexual behaviour that makes the individual feel offended, humiliated or intimidated. This includes unwelcome sexual advances, unwelcome requests for sexual favours and other unwelcome/inappropriate conduct (including staring, leering, and suggestive comments/jokes).
- **Sexual incidents:** the analysis in this report includes any behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable or afraid. This includes assault and harassment as described above. It also extends to being spoken to using sexualised language or observing other people behaving in a sexually disinhibited

manner, including nakedness and exposure or self-stimulation which may have occurred in a private bedroom or bathroom.

- **Sexual safety:** in this report, this is defined as feeling safe from any unwanted behaviour of a sexual nature, as defined in sexual incidents (above).
- **Sexual wellbeing:** in this report, this is defined as feeling and being sexually safe in acute mental health inpatient environments, including being free from unwanted sexual activity, sexual harassment and sexual assault.

Appendix A

We identified illustrative examples that helped us to categorise most of the descriptions in the incident reports. This was helpful in directing our thinking about the nature of the problem and how it might be addressed:

- **Sexual activity between patients that is likely to be consensual**

Patient A and patient B were sat in the communal garden, patient B went to patient A and kissed. Staff member C went and explained that this was inappropriate behaviour. Both patient A and patient B replied that they were consenting adults but they would not do it again.

- **Sexual contact by a person on another person that is unwanted by the individual who is affected**

Male patient touched female patient on the breasts. This was unwanted and without consent. Female patient asked the patient not to do this again, as this was the second occasion of him touching her.

- **Sexual activity where one party did not have capacity to consent**

Patient A approached patient B in the corridor and was inappropriate and kissing her. Mental capacity assessment was completed. Both patients did not have capacity. Safeguarding referral was completed. Level of observations increased to safeguard both patients.

- **Sexual assaults by patients on staff^e**

Patient targeted staff and grabbed/pinched at female staff member's breasts.

- **Allegations of sexual incidents that are likely to be unfounded**

[Patient] has accused male members of staff of having sex with during her sleep and raping her when awake. [Patient] has also been exposing parts of her body when male staff have been present. [Patient] is extremely psychotic at present.

- **Sexual behaviour triggered by a patient's mental state**

Patient A was observed to be highly agitated in her presentation. She was intrusive and sexually disinhibited, grabbing staff members by the breasts and private parts.

^e The NRLS is not intended to capture incidents where anyone other than a patient was affected, so this part of the analysis will only reflect occasions where incidents affecting staff were uploaded to the NRLS in error or were reported as background to something affecting a patient (for example a report of physical restraint after a sexual assault on staff).

- **Allegations by patients that they have been sexually assaulted by a staff member or of sexual activity between staff and a patient**

Patient A stated that nurse B touched her on her vagina while giving her an injection. She stated after that she elbowed him. She also stated that nurse C was in the clinic room at the time.

- **Sexual words used as insults**

Patient A shouted at patient B that he was a fat paedophile.

Appendix B

NHS trusts and other providers that have participated in co-production events

2gether NHS Foundation Trust
Betsi Cadwaladr University Health Board
Birmingham Community Healthcare NHS Trust
Black Country Partnership NHS Foundation Trust
Bradford District Care NHS Foundation Trust
Camden and Islington NHS Foundation Trust
Central and North West London NHS Foundation Trust
Central London Community Healthcare NHS Trust
Cheshire and Wirral Partnership NHS Foundation Trust
Cornwall Partnership NHS Foundation Trust
Cumbria Partnership NHS Foundation Trust
Derbyshire Healthcare NHS Foundation Trust
Devon Partnership NHS Trust
Dorset Healthcare University NHS Foundation Trust
East London NHS Foundation Trust
East of England Ambulance Service NHS Trust
Essex Partnership University NHS Foundation Trust
Greater Manchester Mental Health NHS Foundation Trust
Hertfordshire Partnership NHS Foundation Trust
Humber Teaching NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Leicestershire Partnership NHS Trust
Lincolnshire Partnership NHS Foundation Trust
Medway NHS Foundation Trust
Mersey Care NHS Foundation Trust
Midlands Partnership NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
Northampton Healthcare NHS Foundation Trust
North Staffordshire Combined Healthcare NHS Trust
Nottinghamshire Healthcare NHS Foundation Trust
Oxford Health NHS Foundation Trust
Pennine Care NHS Foundation Trust
Priory Healthcare
Rotherham, Doncaster and South Humber NHS Foundation Trust
Royal Surrey County Hospital NHS Foundation Trust
Sheffield Health and Social Care NHS Foundation Trust
Somerset Partnership NHS Foundation Trust
South East Coast Ambulance Service NHS Foundation Trust
Southern Health NHS Foundation Trust
South London and Maudsley NHS Foundation Trust
South West London and St Georges Mental Health NHS Trust
South West Yorkshire Partnership NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation Trust
Surrey and Sussex Healthcare NHS Trust

Sussex Partnership NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
Torbay and South Devon NHS Foundation Trust
West London Mental Health NHS Trust
Worcestershire Health and Care NHS Trust

Organisations representing people who use services who have participated in co-production events

Against Violence and Abuse Project
Agenda
Become
Choice Support
Healthwatch Coventry
Healthwatch Hackney
Healthwatch Waltham Forest
Imkaan
LGBT Foundation
ManKind
Mind
National Dignity Council
Remploy
Rethink
Service user and Carer Committee at West London Mental Health Trust
Young Minds

Other arms-length bodies that have been consulted

Department of Health and Social Care
Equality and Human Rights Commission
Health Education England
NHS England
NHS Improvement
NHS Providers
Royal College of Nursing
Royal College of Psychiatrists
University of Cambridge: Cambridge Centre for Health Leadership and Enterprise

Appendix C

Our approach to analysing the National Reporting and Learning System (NRLS) data

The methodology used for the analysis contained in this report is summarised as follows:

- Analysts extracted 58,464 NRLS reports submitted by 54 mental health trusts with an incident date between 1 April and 30 June 2017.
- We included those relating to wards and excluded those relating to community services where possible. This was done initially using the categorical fields and checked again at the review stage.
- We compiled a list of key words and phrases relating to sexual parts of the human body, nakedness or exposure, clothing, behaviour that is sexual in nature including verbal abuse, sexual harassment, sexual assault, rape, and the use of pornography – in order to identify which reports may be relevant. We then added in words that we found in relevant incident reports that we had not previously identified. The key words were broad and inclusive for example “sex” and “oral”.
- We searched through these 58,464 for any reports containing these key words and identified 18,786 reports containing one or more of those key word hits.
- A team of analysts, inspectors and managers reviewed the 18,786 key word hit reports. At this point we were not working to a set definition, but were looking for incidents or allegations of sexual harassment or assault, or incidents likely to have caused distress to patients or to staff for example, from other patients speaking to them using sexualised language, using sexual words as insults or observing other patients behave in a sexually disinhibited manner due to their mental illness. This resulted in a list of 919 reports.
- In order to check the utility of our search terms, 1,039 randomly selected reports from April 2017 that did not contain any key words or phrases were reviewed. From these reports we found three that described sexual safety incidents. This means that we did not capture and analyse all relevant reports from the total number (58,464) we looked at, but we could conclude that relatively few were missed within the 39,678 reports that did not contain any of our selected key words or phrases.
- A team of analysts then carried out the in-depth study described in this report on these 919 reports. To categorise the sexual safety incidents in the reports, we made reference to the legal definitions of rape, sexual assault and sexual harassment contained in the Equality Act 2010 and the Sexual Offences Act 2003.

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- ⁴ Ministry of Health, New South Wales, [Sexual Safety of Mental Health Consumers Guidelines](#), 2013
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