Title: 'Hiding in plain sight': Exploring the complexity of sexual safety within an acute mental health setting

Orchid ID https://orcid.org/0000-0002-7629-2447

Author: Dr Julie McGarry, DHSci, MMedSci, PGDIP (Medical Ethics), PGCHE, RN (adult and mental health) Associate Professor, School of Health Sciences, University of Nottingham, UK.

Email: Julie.mcgarry@nottingham.ac.uk

Tel: +44 1158230516

ABSTRACT

It is increasingly being recognised that individuals who access acute mental health services are at risk of sexual assault. Assaults may be perpetrated by other patients but also by staff working in mental health environments, although this latter group remain largely under researched. Following a reported professional sexual assault and review of an acute in-patient mental health setting in the UK, the overall aim of the present study was to explore the mechanisms and structures that were put into place following the investigation and in so doing examine the wider questions of sexual safety in acute mental health settings. A qualitative approach was utilised and involved interviews with clinical staff (n=8). Thematic analysis was used to analyse the data resulting in four main themes: 'Feeling betrayed': The relational context of the ward environment'; 'Doing what we were meant to be doing': Quality of leadership'; 'Covering yourself': Safeguarding practice; 'The subtleties of abuse': Complexities of safeguarding'. The findings of the study highlights the need for clear organisational structures of support, a clearer understanding of 'sexual safety' and education and training which explicitly addresses recognition and complexity of sexual violence.

KEY WORDS sexual violence, sexual safety, mental health, acute settings

INTRODUCTION AND BACKGROUND

Sexual violence is widely recognised as a significant global issue and is now a priority for healthcare systems in terms of support and service delivery worldwide (World Health Organisation (WHO), 2017). The impact of sexual violence is both immediate and far-reaching and includes both physical and psychological trauma (Campbell et al. 2009). It has been estimated that universally around 1 in 3 (35%) of women have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime (WHO, 2017). In England and Wales for the year ending March 2016 the Office for National Statistics (ONS) reported that of the 421, 185 recorded domestic abuse crimes (this excluded the 609,935 domestic abuse incidents that were not recorded as crimes), approximately 13,000 related to sexual offences. Moreover, women are more than 5 times more likely to have experienced this type of abuse since the age of 16 than men (ONS, 2017). It has also been identified that those who experience mental ill-health experience higher rates of victimisation and within acute care settings women are at particular risk of sexual assault (Ashmore, et al. 2015). However, there is also a clear body of evidence that those working in mental health settings are poorly equipped to recognise and/or respond to sexual violence in this environment (McLindon & Harms, 2011). The experience of sexual violence is wide ranging and has been defined by the World Health Organisation (2002) as *"any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using* coercion, by *any person regardless of their relationship to the victim, in any setting, including but not limited to home and work"* (p149)*.*

The coercive nature of sexual violence is important to recognise and note as it illustrates the complexity of abuse. Coercion may be difficult to articulate and can be hidden or more subtle in presentation than physical coercion, for example encompassing the 'imbalance of power' within relationships that surround coercive control as described elsewhere in the literature (Stark, 2009).

An imbalance of power which for example, when manifested within the context of patient-professional relationships where power is implicitly held by the professional may significantly challenge notions of valid consent. This has particular resonance for the present study and will be explored further within the overall context and background. Coercion is further defined by WHO (2002) in that it [coercion] *"can cover a whole spectrum of degrees of force. Apart from physical force, it may involve psychological intimidation, blackmail or other threats – for instance, the threat of physical harm, of being dismissed from a job or of not obtaining a job that is sought. It may also occur when the person aggressed is unable to give consent – for instance, while drunk, drugged, asleep or mentally incapable of understanding the situation"* (p150).

Sexuality in mental health contexts

Sexuality has been identified by WHO (2004) as a 'central aspect of being human throughout life' (p3). It is broad in scope and encompasses a number of facets such as sexual health and interpersonal/intimate relationships. However, while sexuality is fundamental to wellbeing, Davison & Huntington (2010) highlight that there is general reluctance among mental health care professionals to discuss 'sexuality related issues' (p240) and furthermore, few research studies have explored sexuality within the wider context of relationships but instead have concentrated on 'high risk sexual behaviours' (p240). Randolph et al (2006) have also suggested that there has been little consideration of the possible contextual factors which may influence so called 'high risk' sexual behaviours such as substance misuse or an absence of social support networks. While Bonfils et al (2015) highlight that those 'diagnosed with a severe mental illness may face unique challenges relating to sex' including a 'lower sense of mastery (one's perceptions of being in control of one's own successes or failures)' (p249).

From this perspective understanding sexuality and addressing this topic within mental healthcare encounters is therefore arguably fundamental to wellbeing. Mental healthcare services may also

bridge a significant gap in sexual health care for example, they may be the principle contact point for those who may lack access to primary health care or sexual health education (Davison & Huntington, 2010). However, despite this identified need for support it is also clear that issues relating to sexuality and sexual health remain poorly addressed within mental health provision generally (Hughes et al. 2017). If mental health workers feel ill equipped, embarrassed or lack guidance in working with sexual health issues this may present a significant deficit in understanding and care.

'Hiding in plain sight'

It has been identified by Ashmore et al (2015) that individuals who experience mental ill-health are subject to higher rates of all types of victimisation while *"psychiatric in-patient settings are now beginning to be recognised as high risk sites for the sexual assault of patients, particularly women"* (p139). In their review of a number of salient studies, Ashmore et al (2015) note that anywhere between 5% and 45% of mental health patients are reported to have been subject to sexual violence during an in-patient admission episode. While the authors state that many of these assaults were perpetrated by other patients, in one study cited by the authors, 6% of the sexual assaults were reported to be perpetrated by staff (Grubaugh et al 2007).

A number of recent high profile institutional sexual abuse cases for example, The Jimmy Saville Investigation (Kirkup, 2014) in the UK have raised many questions regarding how such abuse could be perpetrated unnoticed and unchallenged and crucially, how the abuser could carry out the abuse while 'hiding largely in plain sight' (Boyle, 2017). Boyle's analysis of the Saville case – told through the lens of journalism – highlights more fundamental questions surrounding societal norms and attitudes towards gender and power. Consideration of the issues raised by Boyle (2017) may also be helpful in understanding some of the key barriers that prevent patients in mental health settings from speaking out about sexual abuse. These include issues such as hierarchical power relationships between staff and patients and cultures of silence (Ashmore, et al. 2015).

The issue of professional sexual abuse in mental health settings has received very little consideration within the safeguarding literature or education and/or training of professionals (Melville-Wiseman, 2016) and remains largely absent within the wider literature surrounding this subject area. Melville-Wiseman (2016) also highlights however that in the UK, professional sexual abuse accounts for a sizable number of fitness to practice hearings among health and social care regulatory bodies. Even though both in the UK and internationally the sexual abuse of adults and children can be traced back through many decades, as seen in a number of recent high profile media reports, contemporary abuse by those who are responsible for their care remains a *'difficult subject to think about and a difficult subject to speak about'* (Melville-Wiseman, 2011 p27). Moreover, there is little current academic literature to draw upon to broaden this debate or add to the existing evidence base in this field.

Finally, it is also of importance to note that a significant number of women who utilise mental health services are themselves survivors of sexual violence (McLindon & Harms, 2011). In these circumstances women's' prior experiences may deter them from disclosing abuse or disclosure and subsequent questioning may in effect represent 're-traumatization' (Sweeney at al. 2016). Furthermore, McLindon & Harms (2011) however highlight that in a similar vein to sexuality and sexual health that mental health workers feel ill equipped to respond to disclosure of sexual violence.

Context for the present study

The subtle nature of coercive control as highlighted earlier is arguably key to foregrounding the context of the present study. This is then set within the broader literature surrounding the lack of professional confidence or engagement with issues of sexuality or sexual violence among those who

work in mental health services. The impetus for carrying out this study was based on a serious incident that occurred within one large mental health organisation in the UK.

As a result of the findings of the internal investigation, detailed quality safety improvement plans were put into place. The recommendations arising from the investigation included a number of documentary and procedural actions to be implemented. The support measures included for example, the inception of processes to promote clear channels of communication across intra professional boundaries and mechanisms through which both staff and patients would be able to voice their concerns with regard to care quality and/or organisational matters in a safe and transparent environment. The need for visible leadership at all levels was also identified as a key action and systems were again initiated to respond to this identified need.

AIMS

In light of the changes that were initiated following the incident and investigation the overall aim of the present study was to explore the following:

- The investigative process and outcomes for staff including support

- Staff perceptions of the nature and extent of improvement plans set in place following the investigation

- The perceived effectiveness of safeguarding practice in line with the current procedures and management / supervisory systems that have been put in place

PARTICIPANTS AND SETTING

This study setting was one acute mental health adult in-patient ward in the UK. At the time of the study the ward area accommodated both male and female patients (mixed care ward). In total 8 healthcare staff members agreed to take part in the study. Convenience sampling was used to

identify participants to the study. Information sheets outlining the rationale for the study alongside researcher contact details for those who wished to discuss the study further were distributed to all members of the clinical team and management team via group email. The email was authored by JM but forwarded by a member of the Trust to ensure privaxcy of In addition, JM attended ward staff meetings in order to present an overview of the study and to answer any questions or queries regarding participation. Additional follow-up email reminders were also sent to all staff. In total 8 members of staff agreed to take part in the study. Due to the sensitivity of the subject area and the requirement to retain anonymity the participants have been identified by participant number only. The study was undertaken approximately 18 months post-investigation.

DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

Mental healthcare (n=7) and allied health (n=1). All but one of the participants was female. The number of years in the field of practice ranged from 4 – 30 years.

ETHICAL APPROVAL

The requisite university ethical committee and organisation governance approvals were sought and granted (Reference 42-1706) prior to the study taking place.

METHODS

Study design

The aim of the study was to explore and provide an in-depth account of the experiences of study participants. Qualitative approaches to research enquiry have been described as interpretive and naturalistic (Denzin & Lincoln 2000) and are underpinned by an emphasis on the meanings that individuals attribute to their social world. Therefore a qualitative approach was chosen for the present study.

Data collection

Using a pre-piloted interview guide, semi-structured interviews were conducted with all study participants at a time and place that was convenient to them. The interview guide was designed with the study aims in mind and contained a series of prompts including participant's rationale for taking part in the study, events surrounding the investigation, thoughts and feelings about support and leadership and subsequent developments and actions following the investigation. Prior to the study taking place the interview guide was piloted with two colleagues, neither of whom were part of the study. Following feedback, minor reordering of prompts was undertaken. Interviews were either face-to-face or over the phone and with the participants permission the interviews were audio-recorded and subsequently transcribed. Each interview typically lasted for 45 – 60 minutes.

Data analysis

In the present study thematic analysis was used to analyse the data which was informed by the Analytic Hierarchy Model (Ritchie & Lewis 2003). The Analytic Hierarchy Model is described as having essentially three stages; data management, descriptive accounts and developing explanatory accounts. Although the framework is described as a hierarchy there is also explicit recognition of the iterative nature of the analysis:

> The analytic process, however, is not linear, and for this reason the analytic hierarchy is shown with ladders linking the platforms, enabling movement both up and down the structure. As categories are refined, dimensions clarified, and explanations are developed there is a constant need to revisit the original or synthesised data to search for new clues, to check assumptions or to identify underlying factors. In this respect, the platforms not only provide building blocks, enabling the researcher to move ahead to the next stage of analysis, they also

make it possible to look 'down' on what is emerging, and to reflect on how much sense this is

making in terms of representing the original material (p.212)

Four themes were identified from the data as outlined below and form the basis of the

findings section. Each theme is presented with quotes from the transcripts and is

representative of the data as a whole:

- 'Feeling betrayed': The relational context of the ward environment
- 'Doing what we were meant to be doing': Quality of leadership
- 'Covering yourself': Safeguarding practice
- 'The subtleties of abuse': Complexities of safeguarding

FINDINGS

'Feeling betrayed': The relational context of the ward environment

Setting the relational context of the ward was central to the presentation of the findings of the

study. The relationships that are forged among clinical staff are an important part of everyday

working within acute care environments. The relationships that clinical staff held with each other in

the present context formed a major part of the interviews for participants in sharing their accounts

and as such form a key theme in the findings.

In the present study a cohesive and supportive clinical team was both highly valued and also a

necessary factor in effective day-to-day practice. As noted by Participant 3 who described a recent

unrelated incident:

You know, and that just showed what the team was like; everybody was there for each other [after a recent serious incident on the ward]. I had probably 30 messages at home to see if I was OK from my colleagues and stuff like that. So I feel like everyone was really supportive (Participant 3).

In the present study, central to working within and being part of a cohesive and supportive team was the notion of trust. For example, a number of study participants spoke of the importance of trust and that you could or 'had' to 'trust' that someone 'had got your back' in difficult or volatile situations. For those in the study it was particularly difficult to comprehend that they had trusted someone who had ultimately betrayed that trust:

Some people still can't come to terms with what happened, some people feel betrayed and they've got no, they've had no real outlet for that, which is a shame (Participant 4).

…few members of staff that had a strong opinion about the person that the whole incident was around, the staff member, and felt that they were trusting friends and they feel very cheated and I think there's still those residual feelings there in a couple of members of staff definitely (Participant 1).

Moreover, as Participant 8 describes, it was not only the betrayal of trust that was hard to accept. In mental health environments, as with other professions where every day work is inherently interwoven with interpersonal relationships, those in the study felt that should have been able to 'spot the signs that something wasn't right'. That not 'seeing this coming' somehow reflected negatively on their professional judgement and personal integrity:

You have to know the person you're working alongside has got your back. And you have to be able to trust them. I'm getting better at it now. So you have to trust them to go out and do their job to the best of their ability, and to the highest standards for patients that you possibly can. And if there's any, it's just soul destroying to think that you couldn't have that with somebody. I don't know, and you couldn't see it coming either, I think that's the worst thing. That's the worst about not seeing it

coming. If there was any indication, I genuinely believe that nobody on that ward had a clue what was going on. (Participant 8)

The relational context of the ward however also extended beyond the staff. A number of study participants highlighted that the incident and subsequent court case had featured in local media. This was felt to be potentially detrimental in terms of the nature of relationships between staff and patients who may have been admitted to the ward previously or those who may receive care in the future. As Participant 8 further describes:

It was hard for us as a team to believe that one of our number could do something like that. But it must have been really hard for [patients], I mean how can you possibly trust any members of staff. There's a very shaky trust often anyway, so then if you learn something like that happens, I would just imagine it dissolves. [Imagines patient saying] 'If you can't even keep me safe in hospital what good are you basically', which would be completely justified (Participant 8).

'Doing what we were meant to be doing': Quality of leadership

While relationships are a central part of day to day working, not everything occurs at a relationship level and ward environments also have structures of management in place. Broadly speaking, management and leadership have a number of key functions and in theory these include ensuring that policy and mandate are translated into practice and that standards are maintained so that staff feel supported and patient care is provided to the highest standards. The quality of leadership and management, an issue of scrutiny during the investigation, was also identified by those in the present study in terms of 'lacking' both prior to and during the investigation. For example, as Participants 4 and 5 note with regard to following safeguarding processes:

I think we were probably a bit lackadaisical before, like we trusted everybody as such, we see someone you trust them, it wasn't - I think the trust has gone downhill a bit with other members of staff (Participant 4).

[During the investigation] I think there were some issues around who was doing observations and stuff in the evening… and just making sure that the people who were meant to be doing it were doing it (Participant 5).

During the investigation those in the study also spoke of how they felt that leadership was largely absent and as such they were left feeling unsupported:

Felt unsupported, lack of management, just lack of being led on the ward really (Participant 1).

We didn't get any [support]. We didn't get any. We didn't get any at the time. We got offered some afterwards, because when we found out the truth we got offered some support (Participant 4).

Given that those in the study described the investigation as 'brutal' and clearly articulated the sense of 'betrayal' and 'loss of trust' that surrounded them at this time, it is clear that the impact was both significant and detrimental. Those in the study have described how they felt for example, that they were 'guilty by association':

But immediately it just felt like we were all in massive trouble. We all felt very blamed. We all felt that we were […] that we were, you know, that we've also possibly engineered, orchestrated situations for the predator to have his opportunity. We just felt really blamed (Participant 2).

I felt like guilty of something when I wasn't. So I felt like it perhaps wasn't handled as well as it could have been in a more sensitive way if you like, during the interview. I mean I think anyway it's an anxiety provoking situation (Participant 5).

The structures and boundaries of leadership on the ward following the arrival of a new ward manager were also described by those in the present study. Participants for example, felt that the parameters of their role and the overall structure of work practices were more clearly defined:

[Since the incident] the boundaries are in place […] with regards to conduct (Participant 1).

(and afterwards) a lot more structure. Again with the door open and the manager's door is always open and I really like that (Participant 7).

In addition, to a more transparent yet clearly defined leadership structure, a number of those in the study also spoke of the inception of regular clinical supervision alongside managerial supervision. However, there were mixed feelings among those in the study regarding the usefulness and regularity of sessions. Although, as Participant 7 below highlights, the degree of flexibility is largely dependent on the client group at a given time and may suggest a responsive approach to the supervision process:

..So [there's] managerial supervision […] looking at things like audits […] And then the clinical side […] probably looking at things like safeguarding […] talk about difficult case reviews, or, you know, certain behaviours on the ward (Participant 1).

Yes, well, it's usually once a month, but I've not had one for six weeks, but yeah, we do have clinical supervision (Participant 4).

Yeah great [supervision]. I just go and talk to someone when I need supervision. We are supposed to have it every month but I don't always to be honest with you. I have it, and then sometimes I'll have it more than once a month. It depends what the ward's like because it does tend to be quite circular in its, as in difficult times. We seem to get a lot of difficult patients all come together, and then we'll have quite an easy, so we might have a really difficult few months, and then we'll have an easier time if that makes sense (Participant 7)*.*

'Covering yourself': Safeguarding practice

Those in the study described the changes that they had witnessed since the investigation. These changes included the tightening of safeguarding processes especially those surrounding observation and patient contact:

So [with new staff] we try and tell them, yeah, cover yourself, don't go in there on your own, […] now we have cameras as well on the ward […] So that's another thing, we've got CCTV cameras (Participant 4).

And then there's the observation boards so that staff are going round doing the obs [observations] regularly. There seems to be a lot more paperwork. That's obviously a big change. There was always paperwork before but that's more so now (Participant 5).

However, similarly to Participant 4 above, who notes the necessity of 'covering yourself', it may be argued that safeguarding was viewed as a measure of protection for staff as much as for patients. This also perhaps raises a question with regard to perceptions among staff, as noted by Participant 4, with regard to the setting and maintenance of professional-patient boundaries:

*So safeguarding each other as well for the fear of allegations, so that's probably changed, the staff are more aware I think and you just…(*Participant 6)

[now] we're more distant. Well, not distant, it's more like, not pushing them [patients] away, but keeping a distance, like don't come too close, we can't, you know (Participant 4).

In a more formal sense safeguarding dominated many of the accounts of practice in the present study. It is unsurprisingly therefore that all participants spoke of the 'hyper sensitivity' surrounding safeguarding that now pervaded their everyday work:

I think the legacy that's been left due to this major incident has made people hypersensitive to safeguarding needs (Participant 1).

[at] every handover [someone will say] I've talked to safeguarding regarding this patient because I'm concerned about what's happening, so yeah, we [didn't have] as many safeguarding issues before (Participant 4).

I think people are a bit more acute when it comes to safeguarding. Because of what's happened, people are more likely to raise it as a safeguarding concern. Even if you get a letter back saying we've looked into it and nothing, you know, because people are more on edge about it and people are more, they'd sooner do that then something happen (Participant 6).

And safeguarding is obviously one of those things. So I would say now we're acutely aware of the fact that if we don't know if there are any safeguarding issues, then that will be counted as a red [flagged]. As in maybe before it would have been oh yeah, we don't know anything so that's OK, there probably isn't anything. Whereas now it's more we don't know anything but let's find out just in case there is something (Participant 8).

'The subtleties of abuse': Complexities of safeguarding

The background to the present study centred on an investigation into a serious sexual incident involving a female patient and a member of clinical staff on an acute mental health ward. In this final theme the dual factors which make up the complexity of safeguarding alongside the subtlety of abuse – and the interwoven threads of these factors in totality – are considered. For example, the female patient, the victim of the abuse, in the present study was identified at the outset by several participants in terms of her diagnosis. Her diagnosis and previous history which may have deemed her to be an unreliable informant:

The lady in question had the diagnosis of personality disorder, also a history of allegations of a sexual nature, so there was, it did cause quite an atmosphere and a divide on the ward (Participant 6).

And because also of the nature of the diagnosis of the victim, and her history, and her presentation previously with a lot of manipulative behaviour and splitting of staff and just being quite challenging, that added to the struggle that people had to accept what had happened (Participant 8).

In addition to the questions that ward staff were presented with in relation to the patients 'reliability' and 'truthfulness', as Participants 6 and 8 clearly highlight, the complexity of sexual violence – the issues of coercive control and of boundary transgression – are not always easily identified. Traditional safeguarding training and preparation, while raising awareness of abuse in terms of signs of abuse, statutory and legal requirements and, for want of a better word, more straightforward cases, arguably does not help professionals to consider or to become skilled or alert to noticing more 'subtle' forms of abuse or exploitation:

[after] and then there was suggestions that safeguarding wasn't followed correctly, but it's nobody, nobody knew that there was any safeguarding issues to be answered, so why would you even implement safeguarding? She did appear to have quite a good bond with him and it was noted. That was noted that, you know, but not to a point where anybody suspected anything, to my knowledge anyway (Participant 6).

[…] suggested that we didn't do anything in terms of patient safety or safeguarding, and we did […] and he was very good at what he did. But I think what we've done, we've been really good on trying to provide a little bit more training for safeguarding and patient safety, and in terms of safeguarding […] what we aren't good at is the subtleties of exploitation and abuse, you know, those sort of interactions and behaviour. You can see the big stuff when it presents to you, but not the real, the antisocial kind of manipulation and predator […] and just that acknowledgement that we do, unfortunately these really unpleasant people who want, who come into this job to do nasty things, we have to acknowledge these people do exist. It's almost like the Jimmy Saville stuff isn't it? (Participant 2).

DISCUSSION

The aim of the present study was to explore the perceptions of staff in one mental health trust acute admission ward in the UK in light of an investigation as outlined earlier, and the subsequent inception of safeguarding recommendations. The findings of the study would suggest that the core recommendations had been implemented alongside a strong sense of leadership and management. The staff also appeared – perhaps unsurprisingly - to be sensitive to safeguarding procedures overall. The focus of this discussion section therefore is to consider how the findings from the study – and lessons learnt – can inform practice more broadly within mental health settings beyond the immediate clinical area that formed the focus for the original study.

It was clear from the interviews with staff in the present study that the quality and/or structural measures, which had been introduced or revised directly after the investigation, for example, regular clinical as well as managerial supervision, were largely embedded within the ward routine. The significance of safeguarding clinical supervision has been further supported in the literature as beneficial in examining complex care situations and is 'pivotal' but only where the focus moves beyond managerial to clinical and contextual (Melville-Wiseman, 2016) . In the present study it was also clear that staff were acutely aware of the importance of adherence to documentation and observation protocols and these measures formed a central topic for discussion during the interviews.

The adherence to policy and protocols is clearly important and should not be undermined at all. However, it has also been highlighted elsewhere in the literature that structural changes within organisational systems for example, the inception of single sex wards may not on their own automatically lead to safer patient environments (Bowers et al. 2014). This is an important observation and clearly highlights that safeguarding encompasses a number of facets beyond measures which are quantifiable or structural in nature and in so doing that the wider determinants of safeguarding also need to be recognised.

The multi-faceted scope of 'safeguarding' that surrounded the present study, and which was articulated in the final theme, are key considerations in the context of contemporary mental health practice. As highlighted earlier many of those who access mental health services will have experienced sexual violence previously and may find disclosing abuse extremely difficult and traumatic (Sweeney et al. 2016). A number of commentators have also identified that there needs to be a clear understanding among staff working in mental health environments regarding the ways in which those who access mental health services may not always be able to articulate or report sexual abuse in ways that are overtly 'plausible'(Ashmore et al. 2015). Ashmore et al (2015) also go on to add that even when plausible, these accounts are often met with 'disbelief'. The authors identify a number of reasons for the failure of staff to believe patient accounts and these include not wanting to acknowledge that abuse could happen in their care and/or a lack of knowledge about 'the nature and extent of sexual violence' (p141). A lack of understanding of the complexity of disclosure and presentation such as this can engender a culture that '*lead(s) to pathologisation and inadvertent victim blaming* (Melville-Wiseman, 2016, p2193). Moreover, as noted in the introduction many of those who have experience sexual violence have also experienced violence and/or abuse in the past. Disclosing recent experiences requires a skilled approach in order to minimise further trauma or re-traumatisation (Sweeney et al. 2016). As previously highlighted however, these skills including 'sexual literacy' (Melville-Wiseman, 2016) are often absent from safeguarding training and/or professional educational preparation but are key to ensuring empathic and timely support.

As highlighted in earlier themes within this study, mental health practice is largely based on the formation of professional boundaries, therapeutic relationships, of human contact and reciprocal trust – especially among staff. The notion of trust and the boundaries of relationships are central to understanding sexual violence in mental health contexts. It is also acknowledged that professional – client boundaries within healthcare contexts are important yet complex (McGarry, 2009). Melville-Wiseman (2016) describes how those who have experienced boundary violations previously, for

example sexual abuse, should be able to trust the professionals charged with their care to know how and where boundaries lie ' without replicating the abuse' (p2193). Furthermore, in the same paper Melville-Wiseman (2016) also explicitly addresses the dynamics of power between professionals and service users within the context of 'consent' – highlighting the power imbalance inherent in any such relationship and as such the negation of any suggestion of 'consensual' sexual contact.

Taken as a whole therefore the present study has illuminated the complexity of safeguarding within the particular context of one case study, but which have wider implications for safeguarding practice beyond the immediate focus of the study. As noted previously, in the UK with a few notable exceptions there is a paucity of clear organisation guidance with regard to what has been termed 'sexual safety' elsewhere (New South Wales (NSW) Government, 2013) and this represents a significant gap in both understanding and practice. Within the NSW guidance 'sexual safety' has been defined as the *'recognition, maintenance and mutual respect of the physical (including sexual), psychological, emotional and spiritual boundaries between people'* (p6). In the absence of comprehensive structures in the UK, this approach to 'sexual safety' may provide a helpful starting point for further exploration of this pivotal issue with the potential to inform developments within other contexts.

STRENGTHS AND LIMITATIONS

It is acknowledged that this is a small-scale study undertaken in one mental health Trust in the UK. As such, there are clearly some limitations regarding the extent to which the findings are transferable beyond the immediate locality. However, the findings add a valuable contribution to the limited available evidence in this field and offer recommendations for further enquiry and practice development.

CONCLUSION

It is clear from the underpinning literature alongside the findings of the study presented here and the subsequent discussion that professional sexual abuse is a significant issue and that approaches to 'sexual safety' safeguarding within mental health care are largely uncharted territory requiring further development and articulation. However, available evidence suggests that a multi-faceted approach encompasses clear structures and processes, alongside education and training, has the potential to address the issues raised within this study and gaps identified in the wider literature. Specifically there is the need for further investigation of the perceptions of clinical staff towards 'sexual safety', including an exploration of current knowledge, skills and attitudes towards sexuality and sexual health.

RELEVANCE FOR CLINICAL PRACTICE

For those working in mental health education and training beyond the traditional delivery of safeguarding training/education is indicated and should include sexual literacy education and training in sexual safety and sexual safeguarding. This needs to be supported by a clear infrastructure for example, regular clinical as well as managerial supervision undertaken by skilled supervisors. It is also suggested that there is little to guide those working in mental health with regard to sexual health issues and there needs to be consideration of how services such as specialist services can work alongside mental health and eradicate 'silo' working approaches that often predominate health care. Centrally, there is a clear need for the voices of service users to be heard in terms of the facets of care and systems that promote an environment of safety.

REFERENCES

Ashmore, T., Spangaro, J. and McNamara, L. (2015), 'I was raped by Santa Claus': Responding to disclosures of sexual assault in mental health inpatient facilities. Internal Journal of Mental Health Nursing, 24: 139–148. doi:10.1111/inm.12114

Bonfils, K. A., Firmin, R. L., Salyers, M. P., & Wright, E. R. (2015). Sexuality and intimacy among people living with serious mental illnesses: Factors contributing to sexual activity. Psychiatric Rehabilitation Journal, 38(3), 249–255. http://doi.org/10.1037/prj0000117

Bowers, L., Ross, J., Cutting, P. and Stewart, D. (2014), Sexual behaviours on acute inpatient psychiatric units. Journal of Psychiatric Mental Health Nursing, 21: 271–279. doi:10.1111/jpm.12080

Boyle, K. (2017) Hiding in Plain Sight. Journalism Studies, DOI: 10.1080/1461670X.2017.1282832

Campbell, E., Dworkin, E., Cabral G. (2009) An Ecological Model of the Impact of Sexual Assault On Women's Mental Health Trauma, Violence, & Abuse, 10: 3, 225 - 246

Davison, J. and Huntington, A. (2010), "Out of sight": Sexuality and women with enduring mental illness. International Journal of Mental Health Nursing, 19: 240–249. doi:10.1111/j.1447-0349.2010.00676.x

Grubaugh, A. L., Frueh, B. C., Zinzow, H. M., Cusack, K. J., & Wells, C. (2007). Patients' perceptions of care and safety within psychiatric settings. Psychological Services, 4(3), 193-201. http://dx.doi.org/10.1037/1541-1559.4.3.193

Hughes, E., Edmondson, A. J., Onyekwe, I., Quinn, C. and Nolan, F. (2017), Identifying and addressing sexual health in serious mental illness: Views of mental health staff working in two National Health Service organizations in England. International Journal of Mental Health Nursing. doi:10.1111/inm.12402

Kirkup B & Marshall P (2014) Jimmy Savile Investigation: Broadmoor Hospital Report to the West London Mental Health NHS Trust and the Department of Health https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323458/Broadmoor_report.pdf (accessed January 2018)

McGarry, J., 2009. Defining roles, relationships, boundaries and participation between older people and nurses within the home: an ethnographic study Health and Social Care in the Community. 17(1), 83-91

McLindon, E. and Harms, L. (2011), Listening to mental health workers' experiences: Factors influencing their work with women who disclose sexual assault. International Journal of Mental Health Nursing, 20: 2–11. doi:10.1111/j.1447-0349.2010.00697.x

Melville-Wiseman, J. (2016) The Sexual Abuse of Vulnerable People by Registered Social Workers in England: An Analysis of the Health and Care Professions Council Fitness to Practice Cases, The British Journal of Social Work, 46:8, 2190–2207,

Melville-Wiseman, J. (2011) Professional sexual abuse in mental health services: capturing practitioner views of a contemporary corruption of care. Social Work and Social Sciences Review, 15 (3) 26-43. ISSN 0953-5225.

Ministry of Health New South Wales (2013) Sexual Safety of Mental Health Consumers Guidelines

http://www1.health.nsw.gov.au/PDS/pages/doc.aspx?dn=GL2013_012 (accessed January 2018)

Office for National Statistics (2017)

https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonvi

olentcrimeandsexualoffences/yearendingmarch2015/chapter1overviewofviolentcrimeandsexualoffe

nces#main-points   (accessed January 2018)

Quinn, C. and Happell, B. (2016), Supporting the Sexual Intimacy Needs of Patients in a Longer Stay

Inpatient Forensic Setting. Perspectives in Psychiatric Care, 52: 239–247. doi:10.1111/ppc.12123

Randolph, M. E., Pinkerton, S. D., Somlai, A. M., Kelly, J. A., McAuliffe, T. L., Gibson, R. H., & Hackl, K.

(2007). Severely Mentally Ill Women's HIV Risk: The Influence of Social Support, Substance Use, and

Contextual Risk Factors. Community Mental Health Journal, 43(1), 33–47.

http://doi.org/10.1007/s10597-006-9069-0

Ritchie, J. and Lewis, J. (2003) Qualitative Research Practice: A Guide for Social Science Students and

Researchers. London: Sage

Stark. E. (2009) Coercive Control: How men entrap women in personal life. US: Oxford University

Press

Sweeney, A., Clement, S., Filson, B., Kennedy, A. (2016) "Trauma-informed mental healthcare in

the UK: what is it and how can we further its development?" Mental Health Review Journal,

Vol. 21 Issue: 3, pp.174-192, https://doi.org/10.1108/MHRJ-01-2015-0006

World Health Organisation (2017) Violence Against Women: Intimate partner and sexual violence against women http://www.who.int/mediacentre/factsheets/fs239/en/ (accessed January 2018)

World Health Organisation World report on violence and health (2002)

http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap6.pdf

(accessed January 2018)