

**Sexual rights, mental disorder and intellectual disability. Part 2. Practical implications for policy makers and practitioners.**

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Short title: Sexual rights, policy and practice

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## **LEARNING OBJECTIVES**

- Understand the limited legal basis for the formulation of policies and rules concerning sexual expression, sexual behaviour and related decision-making by people with mental disorder or intellectual disability
- Be able to formulate policies concerning sexual matters as they relate to people with a mental disorder or intellectual disability
- Be able to plan care for patients and service users balancing their rights to sexual fulfilment with the protection of their own welfare and the protection of others

## **DECLARATION OF INTEREST**

None.

## **SUMMARY**

Clear policies as to sexual expression, sexual behaviour and related decision-making assist in ensuring that the rights of people with mental disorders or intellectual disabilities are upheld, and that staff know how to react to situations consistently and lawfully without interfering on the basis of their own moral judgements or personal beliefs. Sensitive and holistic planning of care that complies with domestic law, international human rights law and statutory guidance is necessary to complement such policies. Non-intimate physical contact, masturbation, sexual relationships, contraception, sterilisation and vasectomy, pregnancy, termination of pregnancy, parenthood, marriage and civil partnership, divorce, prostitution, pornography and sex aids and toys are all matters that may properly be part of care planning.

‘The UK appeared the most prohibiting and excluding, its protocols apparently based on risk aversion and lack of emphasis or consideration of patients’ sexual needs’ (Tiwana, McDonald & Völlm, 2016).

In our previous article (Le Gallez, Choong, Rix and Dewson, 20\*\*) we set out the law relating to sexual expression, sexual behaviour and related decision-making on the part of people with mental disorder or intellectual disability. In this second article, we explain why policies are necessary in this area of mental health and community care, we set out their limited legal basis and we consider a range of issues that may need to be addressed in policies and individual care plans.

### **A place for policies**

In *Re SS* [2001] Mr Justice Wall criticised the psychiatric hospital in which a pregnant woman with schizophrenia, SS, was detained and said that ‘each hospital should have a protocol to deal with possible terminations of pregnancy in good time [...] so that wherever practicable [...] a termination can be carried out at the earliest opportunity’. This is only one issue relating to the sexual rights and related behaviour of people with mental disorder or intellectual disability for which a protocol or policy is desirable, if not necessary.

The Royal College of Psychiatrists (1996) had already recommended:

‘Each unit should have a clear written policy which covers acceptable, consenting activity and issues such as harassment and sexual abuse. The policy should ensure that sexuality and sexual issues are considered as part of individual care plans.’

Craft (1987) has identified the advantages of policy guidelines for people with intellectual disability (Box 1). Those who provide treatment or care to people with mental disorder or intellectual disability have commensurate obligations to ensure that the delivery of care does not breach legislation. Service providers are responsible for ensuring that staff have the necessary up-to-date knowledge and skills to identify potential issues or difficulties. They are obliged to provide consistently lawful, ethical and equal care to all patients or service users. Policies and guidance should be available to support identifying, learning, reporting and escalation so as to avoid placing staff in situations which they may feel inadequately informed to address or where they may make ill-informed decisions. Service providers will be liable for unlawful acts committed by their employees unless they are able to demonstrate that reasonable steps have been taken to prevent such acts (s.109 of the Equality Act 2010)

As observed by Bartlett, Mantovani, Cratsley et al (2010), ‘the absence of clear policy increases the probability that staff will be guided by their own moral judgements and personal beliefs, and hence act inconsistently as a group.’

Policies are also important because there is an ‘ongoing tension between helping people to realise their right to develop or maintain relationships, and engage in sexual relationships should they wish to do so, and the need to protect vulnerable people from abuse and exploitation’ (Cheshire and Wirral Partnership NHS Foundation Trust, 2015 (‘the Cheshire policy’)). It is a complicated area of practice. The person who wants to

develop a relationship may seek to form a relationship with someone who is vulnerable but the person seeking to form the relationship may be vulnerable to abuse or exploitation too (Fryson 2015).

### **Policies and the law**

In any institution, or in any service in the community, where people live or come together, there need to be sensible rules to ensure smooth running, the protection of interests and rights, maintenance of standards of common decency, and the avoidance of behaviour that upsets or offends individuals or disturbs the community or the group. However, there is a limited legal basis for making the rules that policies embody. Those who formulate policies need to be aware of this and be informed by relevant legislation, case law and statutory guidance (see Le Gallez at al 20\*\*).

Bartlett et al (2010) are of the view that for the sort of intrusive, and in some cases extraordinarily intrusive, rules in this area, they would expect a clear legal rule-making authority, based in statute and, perhaps, secondary legislation. In contrast to the prison context, they observe that such a structure is conspicuously absent in the context of psychiatric facilities.

For patients detained under the Mental Health Act 1983 (the MHA), the court recognised in *R v Broadmoor Special Hospital Authority* (1998) that ‘the express power of detention must carry with it a power of control and discipline’ including, for example, ‘the power ...to regulate the frequency and manner of visits to (patients)’. However, it is difficult to see that this is a legal basis for ‘rules of governance not directly related to detention, into which category the policies on sexual and emotional expression arguably fall’ (Bartlett et al 2010). Furthermore in this case, relying on *R v Home Secretary, ex p. Leech* [1994], the Court endorsed the rigorous test that for a power for which a policy contended, there had to be ‘a self-evident and pressing need’. Those who formulate policies must ensure that they pass this rigorous test.

The approach of the courts to smoking in hospital is of relevance to policy formulation, particularly ‘blanket bans’. In the Rampton Hospital case concerning the legality of its smoking ban, (*R(N) v Secretary of State for Health* [2009]), relying on *Kay v Lambeth LBC* [2006], the court held that ‘subject to duties owed to patients or staff, it can set the rules’. However, as *Kay* was a housing case, where tenants could leave if they did not like the rules, its application could, as Bartlett et al (2010) observe, result in ‘a marked disproportion of power in setting institutional rules’.

*R(N)* was cited in *McCann v State Hospitals Board for Scotland* [2017]. The hospital had introduced a blanket ban on smoking. The Supreme Court determined that a comprehensive ban on smoking was within the ambit of art.8 of the ECHR, in that it interferes with a patient’s right to respect for his private life. Although this ban was justified as a proportionate measure due to the risks of secondary smoke under Article 8(2), the ruling marks a shift in favour of personal autonomy and respect for an individual’s rights and freedoms.

There is the related issue of the individual’s right to do to themselves what is physically or morally harmful or dangerous. As established in *Pretty v United Kingdom* (2002), for those individuals with capacity to decide, ‘the ability to conduct one’s life in a

manner of one's own choosing may also include the opportunity to pursue activities perceived to be of a physically or morally harmful or dangerous nature for the individual concerned'. The autonomous right of a capable adult to determine what shall be done to his body is a fundamental civil right, recognised and protected by law.

For those who lack capacity, the MCA provides that any act done, or decision made, on their behalf must be in their best interests. Best interests decisions must include consultation with family, and consideration of previously expressed wishes and behaviour. This may include previous sexual relationships and behaviour.

The Care Quality Commission (2017) has produced guidance on the use of 'blanket bans'. It makes reference to the Mental Health Act Code of Practice at 1.6 (Department of Health, 2015) which states,

'blanket restrictions... should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals. Blanket restrictions should never be for the convenience of the provider. Any such restrictions, should be agreed by hospital managers, be documented with the reasons for such restrictions clearly described and subject to governance procedures that exist in the relevant organisation.'

It follows that for blanket rules created by policies, there has to be a self-evident and pressing need, such as ensuring the safety of patients or preventing harm; and for any interference with rights or freedoms to be lawful, it must be qualified and proportionate.

## **General principles**

### ***Situation or location specific***

Policies should be tailor-made to each specific location or situation. No one policy can address all of the circumstances in which the mentally disordered or intellectually disabled seek to express their sexual desires or make related decisions (Siebers, 2012). A policy for a group home for intellectually disabled people of both sexes will not be the same as the policy for patients housed in single sex wards in a high secure hospital.

### ***Consultation***

The first step is to consult those who will be affected by the policy including, but not necessarily limited to, patients or service users, carers, family members, and staff and partner organisations such as local authority social services departments. Consultation with people who have an intellectual disability should make allowances for their possible difficulties in understanding information and questions and in articulating their responses.

### ***Positive not negative***

Policies should begin with a number of positive statements (Box 2). Which of these are incorporated, and how, will depend on the circumstances. Policies should set out the responsibilities that go with the rights, such as respecting the rights of others to freedom and choice, and respecting the sensitivities of staff.

### ***Staff support and staff responsibilities***

Policies should provide for staff support, addressing the sensitivities and concerns of staff who have a personal value system, culture or religion that makes it difficult or impossible for them to come to terms with particular patient behaviours, for example, same sex relationships. Although staff should avoid their own cultural, moral or religious beliefs conflicting with the rights to sexual expression and the development of sexual relationships of their patients or service users, managers and supervisors must recognise the difficulties that some staff may have and support them non-judgmentally and with respect and sensitivity (see Box 3). As stated in the Cheshire policy ‘there should be no expectation that a staff member should be required to change their own cultural, ethical, moral or religious codes in order to support a service user.’

Balanced against this, however, is the public sector equality duty placed upon all public sector employees by the Equality Act 2010 to ensure that, whilst in the course of their employment, staff adhere to their legal requirements. Individual employees may be held personally liable under the Equality Act for unlawful acts, which they commit in the course of employment, and the employer will be liable for unlawful acts committed by their staff unless they have taken reasonable steps to prevent such acts (s.109, Equality Act 2010).

### ***Capacity***

As capacity is a preliminary and fundamental consideration in many of the difficult cases for which policies will have to make provision, policies need to draw attention to the relevant parts of the MCA. Whether or not the person has a mental disorder that impedes choice as to sexual activity is relevant in relation to the Sexual Offences Act 2003.

There is a need to ensure consistency with, and make appropriate cross reference to, other policies, such as safeguarding, information sharing, confidentiality, equality and diversity. All policies need to comply with the Equality Act 2010 and, in relation to information sharing and confidentiality, the Data Protection Act 1998.

### ***Boundaries***

Staff boundaries should be made clear and reference made to offences under the Sexual Offences Act 2003 which prohibits any sexual activity<sup>1</sup> between a care worker and a person with a mental disorder whilst that relationship of care continues. Such behaviour

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<sup>1</sup> Section 78 of the Act states that ‘penetration, touching or any other activity is sexual if a reasonable person would consider that—

(a) whatever its circumstances or any person’s purpose in relation to it, it is because of its nature sexual, or

(b) because of its nature it may be sexual and because of its circumstances or the purpose of any person in relation to it (or both) it is sexual’.

includes acts, words or behaviour designed or intended to gratify sexual impulses or desires (see Le Gallez et al, 20\*\* for more detail). Staff who ignore this prohibition risk disciplinary action as well as criminal proceedings. The care worker, even in the absence of objection from the patient, would also be liable to prosecution under s.44 of the MCA, which prohibits the ill-treatment of those who lack capacity. This is insofar as a lack of consent for sexual relations could be interpreted as ill-treatment.

### ***Diversity***

Diversity must be recognised and respected; and equality under the law upheld. Policies must not be discriminatory on the basis of age, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender or sexual orientation. It would be discriminatory to have different rules pertaining to homosexual/heterosexual behaviour or married/unmarried patients, or for those of different genders unless qualified, such as allowing spouses of different genders private access to the patient's room whilst, disallowing spouses of the same gender the same level of privacy.

### ***Review***

As with any policy, it should be regularly reviewed.

### **From policy to care planning**

In many instances, a policy will provide guidance of a general nature but not be sufficient to identify and guide all of the actions to be taken in an individual case. So, it is highly important that sexuality and sexual issues are considered as part of individual care plans. In the remainder of this article, we will discuss how sexuality and sexual issues can be accommodated in care plans and give some examples. A clear plan of escalation should be identified to support staff in such circumstances.

### ***The right not to have sexuality and sexual issues in one's care plan***

Although some people with mental disorder or intellectual disability welcome and accept care that addresses their sexuality or sexual needs, for some people this is such an intensely private aspect of their lives that they may not want even to discuss such matters with those providing their care. No one should be forced to have their sexuality or sexual issues addressed in a care plan unless it is relevant, proportionate and necessary.

### ***The right time to address the issues***

Care must be taken to choose the right time to enquire as to a patient's or service user's sexuality and sexual needs. The issues may best be addressed once the person has settled on the ward or in the service, and by the team member who has the best rapport with the patient or service user.

### ***Person-centred care***

What a patient or service user who has the requisite capacity is allowed to do in terms of sexual behaviour or relationships should not ordinarily be discussed or decided by staff in their absence and then, as it were, a prescription, or more likely a proscription, issued. The process should be person-centred with the patient or service user engaged in a dialogue from the beginning and involved in the decision-making and planning throughout. This best ensures that the care is tailored to individual needs and not based on assumptions by staff as to what is best or, worse, reflects the personal beliefs and moral judgements of staff. Also, there is certainly no place for printing a standard care plan for sexual expression and filing it with the other care plans. Account needs to be taken of the life experiences, circumstances, beliefs and values which make the person unique. Although the MCA begins with the principle that a person must be assumed to have capacity unless it is proved that they lack capacity, staff need to ensure that specific capacity assessments are undertaken where appropriate, followed by any necessary best interests decision meetings (see Box 4).

### ***Family and carers***

Although often someone's sexual life will be something they keep private from family, friends or carers, in some circumstances it may be appropriate, subject to consent being given, for others to be involved. Most obviously there will need to be involvement of the spouse or partner when plans are being made that have a bearing on their relationship. Where a young intellectually disabled adult person is contemplating marriage, they may be assisted by discussion with their parents or carers. But, particularly with people who are intellectually disabled, staff need to guard against parents or carers, albeit well-meaning, who may be protectively minded or cautious. Some parents or carers may not want their offspring to receive private sex education or contraception as happened in *Gillick v Wisbech and West Norfolk Health Authority* [1986]. The concerns of family members and carers should be addressed but the overriding consideration will be the best interests of the patient or service user.

### ***Record keeping***

Records relating to the sexuality, sexual needs or sexual behaviour of a patient or service user must be made confidentially, with sensitivity and non-judgmentally. Lurid, sensational or inappropriately explicit form or content should be avoided unless essential. No more should be recorded than what is necessary.

### ***Collaborative care planning***

Where a patient or service user is in, or contemplating, a relationship with another patient or service user, it may be necessary not only for issues to be addressed in both care plans but also for two different or overlapping teams to meet and discuss the cases jointly. However the confidentiality of both parties must be maintained and information only shared either with informed consent or in the best interests of one or both parties if one or both parties lack the capacity to consent.

### ***Reporting to the police and safeguarding authorities***

Within the context of protecting and empowering individuals, safeguarding considerations apply to both the individual and to others who may be at risk of harm or exploitation. A thorough safeguarding identification and reporting system must be in place along with policies relating to when safeguarding referrals to the local authority are appropriate to enable a multiagency safeguarding enquiry to be implemented under the Care Act 2014. Such safeguarding enquiries promote outcomes that both protect and support independent choices whilst protecting individuals from harm.

### **Specific issues in policy making and care planning**

The following issues may call for the formulation of policies and need to be addressed in individualised care plans.

#### ***Non-intimate physical contact***

As the title of the paper by Bartlett et al (2010) indicates – ‘You may kiss the bride, but you may not open your mouth when you do so’ - policy writers may be tempted to seek to draw a line and separate acceptable non-intimate affectionate physical contact from non-acceptable sexual behaviour. It is a moot point whether kissing with the mouth closed is sexual behaviour. That it is a moot point illustrates both the need for careful definition and the difficulties which may arise when such strict definitions are applied.

It is common to see references in medical records to ‘inappropriate sexual behaviour’. However, sometimes enquiry reveals that the inappropriateness is a subjective interpretation based on many individual factors, and it is behaviour which in all circumstances other than, for example, a psychiatric ward or a day centre, would be regarded as appropriate; and there may not be unanimity amongst the staff as to its inappropriateness. As Rosen observed in 1972, ‘institutions are generally not good at helping people distinguish between acceptable and unacceptable sexual expression’ and it is the experience of two of us (HD, KR) that this remains so. Flirting is often cited as ‘inappropriate sexualised behaviour’ even in instances where such behaviour does not cause offence or concern. It should be clear why such behaviour is inappropriate and has been added to a patient’s risk profile. ‘Flirting’ by a convicted sex offender with a history of grooming may well be a risk behaviour and appropriately flagged. ‘Flirting’ between individuals without such a risk profile will need to be evaluated within the context of normal human behaviour. ‘Sexting’ using mobile phones or computers may require additional consideration in terms of risk assessment and monitoring.

If distinctions are to be made between inappropriate/unacceptable and appropriate/acceptable behaviour or if, for example, kissing or hugging is permitted in some areas but not others, clear definitions and reasoning must be provided.

#### ***Masturbation***

Masturbation is a normal sexual activity for many people. Policies must include respect for patients’ and service users’ right to masturbate in private without interference, censure or condemnation by those who care for them. Policies may also need to make it clear that masturbation in the presence of others, unless it is with their consent and in private, is unacceptable. Where an individual wishes to purchase masturbatory aids, such as vibrators, passive or overt criticism or invasive questioning should be qualified.

## *Sexual relationships*

In a study of psychiatric units in West London in 2004, Warner, Pitts & Crawford concluded, 'The amount of sexual activity disclosed by the survey was remarkably high'. Of 27 staff members who completed questionnaires, 26 believed sexual activity to be occurring in the psychiatric unit; 13 thought it happened often.

The starting point should be a consideration of how patients or service users can be enabled to exercise their right to maintain or form sexual relationships in the particular service or institution to which the policy applies.

Issues may also arise involving people who are not in receipt of services. Box 5, a case which came to the Court of Protection, illustrates how the care planning of sex education enabled a married man with an intellectual disability, who lacked capacity to consent to sexual relationships, to resume a conjugal relationship.

In residential facilities, such as a care home, a shared house, a group home, a hostel or where other supported living arrangements exist, it should be recognised that residents may wish to engage in sexual activities with another person in the privacy of their own room. In other settings, this may be more challenging for staff (see Box 6). They should be able to lock their bedroom doors, unless this is prohibited as part of their general risk profile. Staff should not, other than in exceptional and defined circumstances, enter their rooms without their consent unless this is as part of an existing observational level, in which case appropriate discretion and courtesy should be observed. Staff should assist, where appropriate, in making the resident's room a comfortable one in which friends can be received in private. Box 7 illustrates an issue that can arise where a married person is resident in a care home.

The corollary of this is that under common law, it is an offence to outrage public decency by engaging in a sexual act in public. The public element is satisfied if at least two persons are present, or may reasonably be believed to observe such behaviour. But, even if one person is present, who may be offended by what they witness, this may legitimately be something which a policy should discourage even though it is not unlawful. Similarly, voyeurism and exhibitionism are criminal offences under the Sexual Offences Act 2003.

It is not simply a case of distinguishing between acceptable and non-acceptable venues for sexual behaviour. A community day centre, in most if not all circumstances, will not be an acceptable venue for sexual behaviour. The ward of an inpatient unit might be if sufficient privacy exists such that no one observes, or is likely to interrupt, it. Indeed, in some facilities accommodating patients on a medium or long-stay basis, there may be good grounds for making provision for conjugal visits to satisfy their right to a family life (ECHR art.8(1)).

Very careful consideration needs to be given to a policy that actively discourages or bans sexual activity between patients or service users. This may infringe their art.8 right. As the case of *Re MM, Local Authority X v MM and KM* [2007] makes clear, 'any public body which proposes to interfere with the sexual life of someone who [...] has capacity faces a heavy burden'. 'Particularly serious reasons' must exist and in the case

of those who are in an ongoing relationship, and the more so if it is long-standing, then ‘especially pressing reasons must surely be shown to exist.’

In *R(RH) v Ashworth Hospital Authority* [2001], where the claimant challenged the refusal of the hospital to provide condoms for patients who were sexually active, the court accepted the hospital staff’s view that a prohibition on sexual activity between patients was justified in order to manage the risks of sexual offending and sexual abuse. However, Bartlett et al (2010) have referred to the evidence given by the hospital staff in support of this policy as ‘statistical nonsense’ and ‘not particularly convincing’. They have pointed to the inconsistency between the court’s acceptance that virtually no sexual activity occurred in Ashworth Hospital, and the contrary evidence of the applicant and the contrary acknowledgment in the hospital’s own policy, and they conclude that it is a moot point whether the nature of the patient population warrants a blanket no sex policy. They go on to observe that the case does not stand as a precedent that a blanket ‘no sex’ policy can be justified outside high security hospitals where patients are less ill and less dangerous (see Box 8).

Consideration also has to be given to the potentially counter-productive effects of a ban on sexual relationships between patients. ‘A simply prohibitive policy [...] risks driving the relationship into secrecy so that those involved are effectively precluded from talking about the relationship and its effects on them’ (Bartlett et al 2010). This places outside risk management issues such as venereal infection and, if the relationship is heterosexual, pregnancy. Bartlett et al (2010) also point out how a blanket ban can work against the eventual well-being of patients who are married or in long-term relationships for whom ‘(u)pon release, it is of course highly desirable that the individuals have a secure social system in the community; typically through family relationships.’ Indeed it is arguable that for such patients, facilitation of a sexual relationship may be in the patient’s, and their partner’s, interests as the relationship will be under closer scrutiny than following discharge and, if it is required, immediate support or intervention can be provided.

### ***Contraception (including emergency contraception)***

Patients and service users may wish to use contraception to avoid pregnancy or to reduce the risk of contracting a sexually transmitted disease (STD). Information and advice should be available including that provided by specialist services such as family planning services. It may be advisable to initiate such discussions where staff are aware that an individual is sexually active. Policies should recognise such wishes and set out how information and advice can be sought.

For those people who lack capacity to consent to contraception but possess the capacity to consent to sexual relations it may be appropriate to hold a best interests decision meeting to consider the provision of contraception. This may include sexual education and provision of condoms, or the provision of long-acting depot contraception.

Where exceptionally access to contraception, such as condoms, is forbidden, policies need to justify such a prohibition. If the purpose of the policy is to discourage sexual activity, the policy itself may place the individual at risk of STD or pregnancy. Such an outcome is contrary to the individual’s own health and safety and that of the wider public at large.

Policies should include consideration of emergency contraception because its effectiveness is related to how soon it is taken. Staff, service users and patients need to be aware of its availability and effectiveness. Staff should be prepared to assist service users in seeking such treatment.

### ***Sterilisation and vasectomy***

Patients and service users may seek sterilisation or vasectomy. Staff should be in a position to advise, support and inform them. Particularly in the case of people with intellectual disability, family members or carers may suggest sterilisation or vasectomy. Policies need to make it clear that sterilisation and vasectomy cannot be performed on people with capacity to consent without their permission or on people who lack capacity unless a court decides that it is in their best interests. Policies must identify the steps to be taken in order to obtain a decision of the Court of Protection.

### ***Pregnancy, termination of pregnancy and parenthood***

People with mental disorder or intellectual disability have the same rights to become parents as other citizens. When a patient with a mental disorder or a service user with an intellectual disability becomes pregnant, it may be of little or no concern to those responsible for their care beyond sharing their delight or supporting them in their distress. But policies must provide for the provision of appropriate support, education and assistance for those who are unprepared for parenthood and for those who will only make a success of parenthood with appropriate care. It may be necessary to take into account not only how the mother will cope with the child but any limitations the father may have and the help the father may also need. Early referral to the relevant services is of paramount importance.

A woman who is uncertain about continuing with her pregnancy may require prompt assistance in weighing up the advantages and disadvantages of continuing with the pregnancy and a timely referral to a pregnancy advisory service or other appropriate impartial professional advisor so as to be able to make an informed decision about the continuation of the pregnancy. If he is involved, the baby's father may have similar needs. In recognition of the fact that for some staff, termination of pregnancy is for religious or cultural reasons contentious, policies need to ensure that the feelings, values and attitudes of staff do not compromise care.

Any best interests decision in relation to termination of pregnancy must place the patient at the centre of the decision. The best interests of the patient override all other considerations (Abortion Act 1967). Where a patient with significant mental disability is delighted with a pregnancy, a termination may not be in her best interests due to the distress this may cause. This does not preclude subsequent best interests decisions in relation to the child in matters relating to child protection issues.

### ***Marriage***

The right to marry is a fundamental human right enshrined in art.12 of the ECHR and this should be affirmed in policies. There may be little or no issue in the case of an outpatient who has the capacity to consent to marriage. It is a far more complicated

matter if the person who wishes to marry is a detained patient in a high security hospital and the more so, if their intended spouse is similarly detained. It may be rare for a patient in a high security hospital to express a wish to marry but this right is protected by law (Marriage Act 1983). It is better to have an appropriate policy than have to decide how to proceed after the issue has arisen. The MCA prohibits best interests decision makers from agreeing to a marriage where the person lacks the capacity to consent for themselves.

### ***Divorce and separation***

Policies should make it clear that patients and service users are subject to the same laws relating to divorce as other citizens. Provision needs to be made for access to appropriate advisory and support services, both within the service and from external agencies such as Relate, and legal advice. The MCA prohibits best interests decision makers agreeing to a divorce where the person lacks the capacity to consent for themselves.

### ***Sexual diversity***

As it is unlawful to discriminate against any person on the grounds of their actual or presumed sexual orientation when providing facilities or services, policies should draw attention to this. It may also be appropriate to spell out the need to ensure that civil partners or same sex partners are treated in the same way as married or mixed sex unmarried couples. In Box 9, we set out staff responsibilities in this regard from the Cheshire policy.

Box 10 illustrates an issue relating to sexual diversity.

### ***Access to prostitution***

Policies should address the circumstance in which staff become aware of a patient or service user using, or seeking to use, the services of a prostitute. Prostitution is not in itself illegal<sup>2</sup>. However, if staff are aware that patients or service users are using the services of prostitutes in their premises, this may give rise to a charge of keeping, or managing or acting to assist in the management of, a brothel. Assisting a patient or service user in obtaining the services of a prostitute could be illegal under s.53A of the Sexual Offences Act 2003.

Policies should make clear that staff who are aware that a patient or service user is obtaining, or proposing to obtain, the services of a prostitute have a responsibility to counsel the patient or service user concerning the legal, social, moral and health aspects of prostitution without being judgmental and, where appropriate, having regard to any relevant aspects of the patient's or service user's history, such as a history of violence, sex offending, victimisation or victimhood (see Box 11).

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<sup>2</sup> However, in Northern Ireland it is illegal to pay for sex (Human Trafficking and Exploitation Act (Northern Ireland) 2015).

It may be appropriate for policies to make it clear that staff cannot and will not condone the purchase of the sexual services of a prostitute by a patient or service user.

### ***Pornography, sex aids and sex toys***

Policies should define pornography and specify the materials covered by the policy, e.g. magazines, posters, films, DVDs, videos and books. A distinction should be made between pornography which it is not illegal for people over the age of 18 years to access or possess, and pornography which it is illegal to access or possess, as defined by Part 5 of the Criminal Justice and Immigration Act 2008 such as that depicting children or extreme violence. In relation to films, a distinction might be made between films classified 18 by the British Board of Film Classification, and unclassified films and R18 films.

Distinctions should be made between what is not permitted under any circumstances, what is freely permitted and what is permitted in certain circumstances (i.e. restricted).

Where access or possession is permitted, it should be made clear that patients or service users must recognise that some people find such materials offensive and they have a responsibility only to use such materials in private and to store them in a private place. It needs to be clear, for example, that whilst it may be acceptable for a hospital patient to have a sexually explicit poster on the inside of a wardrobe door, it is not acceptable to have such a poster on the outside of the wardrobe door (see Box 12).

Sharing of pornography or trading it with other patients or service users should be discouraged or even prohibited as other patients may have different risk profiles to the individual.

Similar consideration should be given in policies to sex aids or sex toys.

The issue of staff purchasing pornography for or on behalf of patients or service users, or otherwise obtaining or providing pornography for them, should be addressed. Staff should be advised that they should not make derogatory remarks about, or make fun of, patients or service users who use pornography or sex aids. Pornographic materials should not be used for sex education.

Consideration needs to be given to restriction of access to particular 'free to view' television channels, which may broadcast sexually explicit material. A distinction may be made between access via a communal television and access via a television in a patient or service user's private room.

Employers should ensure that staff are informed by policy or guidance as to what to do in the event of a patient or service user being found in possession of illegal pornographic material.

Access to social media, and forms of online sexual behaviour or online relationships should also be subject to risk assessment and adherence to local policies. This may include the sending or receiving of sexualised images, including 'selfies'. Article 8 may be engaged in circumstances where a patient is prohibited from forming or maintaining relationships in this manner.

## Conclusion

It is in the interests of patients, service users, their families and their carers and staff to have policies that uphold the rights of patients and service users to pursue a 'satisfying, safe and pleasurable sexual life' and to make decisions as to related matters such as sexual relationships, marriage, civil partnership, divorce, contraception, sterilisation and termination of pregnancy with no more interference or curtailment than is relevant, proportionate and necessary having regard to domestic and human rights legislation. Such policies are the starting point for ensuring that sexuality and sexual issues are considered as part of individualised care plans.

## References

- Bartlett, P., Mantovani, N., Cratsley, K. et al. (2010) 'You may kiss the bride, but you may not open your mouth when you do so': policies concerning sex, marriage and relationships in English forensic psychiatric facilities. *Liverpool Law Review*, **31**: 155-76.
- Care Quality Commission (2016) *Brief guide: the use of blanket restrictions in mental health wards*.
- Cheshire County Council and Cheshire and Wirral Partnership NHS Foundation Trust (2015) *Social, personal & sexual relationships good practice guidance*. CP44 Issue number 1.
- Department of Health (2015) *Mental Health Act: Code of Practice*. TSO.
- Fyson R (2015) 'Promoting Sexualities and Protecting from Abuse' in E. Chapman, S. Ledger & L. Townson (eds). *Sexuality and Relationships in the Lives of People with Intellectual Disabilities: Standing in My Shoes*. Jessica Kingsley Publishers.
- Rosen M (1972) Psychosexual adjustment of the mentally handicapped, in Bass MS and Geloff M (eds) *Sexual Rights and Responsibilities of the Mentally Retarded* Proceedings of the Conference of the American Association on Mental deficiency, Region IX (revised edition) (quoted in Craft 1975).
- Royal College of Psychiatrists (1996) *Sexual abuse and harassment in psychiatric settings*.
- Siebers T (2012) 'A Sexual Culture for Disabled People' in R. Mccruer and A. Mollows (eds), *Sex and Disability*. Duke University Press.
- Warner J, Pitts N, Crawford MJ (2004) Sexual activity among patients in psychiatric hospital wards. *Journal of the Royal Society of Medicine* **97(10)**: 477-479.
- Tiwana R, McDonald S, Völlm B. (2016) Policies on sexual expression in forensic psychiatric settings in different European countries. *International Journal of Mental Health Systems* **10(5)**: 1-11.

## **Law Reports**

Gillick v Wisbech and West Norfolk Health Authority [1986] AC112.

Kay v Lambeth LBC [2006] UKHL 10

McCann v State Hospitals Board for Scotland [2017] UKSC 31, [2017] MHLO 22

Pretty v United Kingdom (2002) 35 EHRR 1

R v Broadmoor Special Hospital Authority (1998 WL 1044171)

R v Home Secretary, ex p. Leech [1994] QB 198, CA

R(N) v Secretary of State for Health [2009] EWCA Civ 795

R(RH) v Ashworth Hospital Authority [2001] EWHC Admin 872

Re MM, Local Authority X v MM and KM [2007] EWHC 2003

Re SS [2001] 1 FLR 445

## **Statutes**

The Abortion Act 1967

The Mental Health Act 1983

The Marriage Act 1983

The Children Act 1989

The Data Protection Act 1995

The Sexual Offences Act 2003

The Mental Capacity Act 2005

The Criminal Justice and Immigration Act 2008

The Equality Act 2010

The Care Act 2014

Box 1. Advantages of policy guidelines relating to the sexual expression of people with an intellectual disability (from Craft A (ed) *Mental Handicap and Sexuality*. Tunbridge Wells: Costello, 1987).

<b>To Clients</b>	<b>To Staff</b>
<p>Explicit acknowledgment of his/her right to be a sexual being/to grow up/to have ordinary life experiences</p> <p>Safeguard against the idiosyncratic beliefs, attitudes and responses of individual staff members</p> <p>A more enabling/empowering environment/atmosphere</p> <p>Relationships are valued rather than belittled</p> <p>Privacy is respected</p> <p>Appropriate socio-sexual education as a matter of course rather than crisis prompted</p> <p>Availability of a counselling service for specific needs</p> <p>Dignity and respect enhanced</p>	<p>Boundaries of acceptable behaviour become clear/defined</p> <p>Managers have to give realistic and constructive consideration to the issues and to place the statements on record</p> <p>Legal position clarified</p> <p>Responsibility for teaching/counselling clearly allocated</p> <p>Problematic areas can be openly discussed with an enabling structure</p> <p>Counselling service for staff</p> <p>Management decisions are facilitated and become less anxiety-provoking</p> <p>Gives a baseline in discussions with patients.</p> <p>Training needs are acknowledged and catered for</p> <p>Involvement in the process strengthens commitment to the policy and is in itself a valuable experience</p>

Box 2. Some positive statements for incorporation in a policy relating to sexual expression.

- Everyone has the right to be treated as an autonomous individual and to be treated with respect and dignity at all times
- Each person has a right to express their sexual feelings and develop consensual relationships of their own choosing without condemnation or censure, but subject to consideration of the rights and feelings of other patients and staff and within the limits of the law
- Each person has a right to be informed and educated, and to receive information, about sexual matters that is meaningful and appropriate for their needs and sufficient for them to make informed choices about sexual expression, relationships and behaviour

- Patients and service users have the same rights as any citizen to receive advice and support, including sexual and relationship counselling, marriage guidance, family planning, advice as to abortion, advice as to sterilisation, advice with regard to sexual difficulties and sexual health and wellbeing services
- Each person has a right not to be exploited or abused

### Box 3. Staff attitudes

M is a patient in a rehabilitation ward. She is in a same sex marriage with P. There are no concerns about her capacity in relation to her marriage, and physical contact with her wife. She is permitted to demonstrate the same level of physical affection with her wife as other patients are permitted within the open lounge area. In the communal area they hold hands, they hug and show each other affection, they call each other pet names and generally behave in a loving affectionate way. In ward reviews, M prefers to have her wife sit alongside her, holding her hand and generally supporting her. Two members of staff find this situation difficult. Staff member A holds no religious views but is generally homophobic. Staff member B believes that same sex marriage conflicts with her religious beliefs. Both members of staff have undertaken their required equality training.

Staff member A refuses to make eye contact with patient M, refuses to acknowledge M's wife as next of kin, and tells them that their behaviour is a bad influence on the younger patients.

Staff member B is kind and considerate to M, and explains that her religious views make it very difficult for her to accept the marriage. She explains that she is unable to allow M's wife in to the case review and requests that while she is on shift, M's wife remains outside.

It is explained to both staff members that the Equality Act 2010 outlaws discriminatory behaviour towards M due to her sexual orientation. Although staff member B has a protected characteristic herself, namely religion or belief, the manifestation or expression of that religion or belief is not an absolute right, and in this circumstance, the right is restricted by the Equality Act.

Both staff members request transfer from the ward. Staff member A's request is refused and she is referred for disciplinary action as a result of her unlawful behaviour. Staff member B's request is allowed on the basis that she herself has a protected characteristic, namely religion and belief. However, she is informed that in the event that her request is unable to be fulfilled on a particular shift, she will also face disciplinary action if she directly or indirectly discriminates against patient M.

### Box 4. Capacity and best interests

Patient X has a mild intellectual disability. He was admitted to hospital initially with depression. He has progressed well, and is currently having trial overnight home leave. He has a long term girlfriend, Y. They live together in a supported living facility. He has previously been assessed as lacking capacity in relation to finances and decisions about where to live. Nursing staff are concerned about X re-establishing a sexual relationship with Y during home leave.

The consultant and the nursing team conduct a capacity assessment in relation to his expectations of resuming sexual relations with Y during leave. They are all satisfied that he is able to understand his own feelings, and wishes, and those of his girlfriend, and his responsibilities towards himself and towards her.

Staff at the supported living home also discuss the issues with Y. They determine that she does not understand all the issues in relation to resuming a sexual relationship. However, she clearly states that she loves X, and that she is happy with the physical intimacy they have previously enjoyed. The details of their physical relationship are explored through pictures. A best interests decision is made that the relationship X and Y enjoy is important to Y, and that she derives a great deal of happiness from the relationship. The decision is made that it is not in her best interests to interfere with the physical side of the relationship. A similar process is conducted in relation to contraception, and it is determined by all that it is in her best interests to receive a depot contraceptive to avoid an unwanted pregnancy. A care plan is devised to include close monitoring of the wishes and feelings of both X and Y in relation to sexual contact, and their views on pregnancy.

Some months later, X and Y decide they would like a child. It is determined that there is no legal authority to interfere with this right, and the depot contraception is stopped. The care plan reflects the need for immediate referral to relevant services in the event a pregnancy is established.

Box 5. Intellectual disability and sexual relations in marriage (the case of *CH v A Metropolitan Council* [2017] EWCOP 12).

CH was 38 years old. He has Down syndrome and an associated intellectual disability. He had been married for four years to WH. She does not have a mental disorder or intellectual disability. Since they married, they had been living together in CH's parent's home. CH and WH enjoyed normal conjugal relations. The nature of their relationship became apparent when they sought fertility treatment.

This prompted an assessment by a psychologist who concluded that CH lacked the capacity to consent to sexual relationships. Following this assessment, the couple were informed of this conclusion and WH was advised that she must abstain from sexual intercourse with CH as that would, given CH's lack of capacity to consent, amount to a criminal offence under the Sexual Offences Act 2003. WH was advised that if she did not comply, safeguarding measures would be taken and as a result, she or CH would have to be removed from the home. WH moved into a separate bedroom. CH could not understand why this had happened. WH reduced physical expressions of affection so as not to 'lead him on'.

A plan was made for CH to undergo a course of sex education and this was delivered by a therapist. The course was completed in the expected time scale. The therapist reported that CH had made sufficient progress except that CH could not understand the health risks associated with sexually transmitted disease. However, this was not considered to be 'relevant information' within the meaning of the MCA because the couple were in a monogamous and exclusive relationship. Nevertheless, for other reasons, further sex education was advised. Following the completion of this additional course, re-assessment established that CH now had the capacity to consent to sexual relations. CH and WH then resumed their conjugal relationship.

Box 6. Where is private? (from A Craft (ed) (1987) *Mental Handicap and Sexuality*: Costello.)

“Sexual expression is essentially a private matter, but where is private? Staff have a major part to play here, because privacy has to be somewhat artificially created and then respected. So, for example, in a shared room or dormitory a person’s bed may be deemed a private area; or where a couple have taken the trouble to find a quiet room away from others, that privacy should be respected. All this can only work satisfactorily within the framework of policy guidelines so that boundaries are clear, clients have access to information, guidance and counselling, and staff have specific training. The mainspring for policy guidelines and humane, enriching and enabling environments is the accordance of value and respect to individuals with mental handicaps.”

Box 7. Dementia and sexual relations in a care home

L is a 78 year old married man with dementia who resides in a care home. His placement has been arranged through the old age psychiatry services. His care coordinator, a nurse, is contacted urgently by the care home manager. A member of staff has discovered his wife in bed with him during one of her almost daily visits. Some of the care home staff want him transferred to a psychiatric hospital. His children have been informed. They say that their parents ‘shouldn’t be doing it at their age’ and they want their mother’s visits restricted to the communal area of the home. It is established that the couple had been having sexual relations every two to three weeks before L’s admission to the care home, sometimes initiated by him and sometimes initiated by his wife. Although L lacks capacity to consent to sexual relations, it is agreed that there is no lawful basis for preventing him from initiating sexual relations with his wife and it is agreed that when she visits, staff will afford them privacy. In considering how this differs from CH above (Box 4), it is important to note that each case was considered on the specific facts, and with regard to the views of those assessing capacity and risk.

Box 8. Extra-marital sexual relations in a low secure unit.

V is a man with schizo-affective disorder. He has no history of sexual abuse, sexual dysfunction or abnormal sexual behaviour. He is the subject of a hospital order with restrictions that was made following his conviction for offences of arson committed when he was psychotic. W is a woman with an emotionally unstable personality disorder who was sexually abused in childhood. She is the subject of a hospital order that was made following her conviction for a number of assaults on children. They first met in a medium secure unit and, although contact was limited, were known to have formed a romantic attachment there. V was transferred to a low secure unit 9 months ago and in the meantime V and W have kept in contact by letter and telephone. W has now been transferred to the same low secure unit. Staff learn from another patient that V and W are having sexual intercourse in a storeroom in the rehabilitation suite during the evening social hour.

The first response of the staff is to ensure that the storeroom door is locked during the social hour. Both patients are reviewed by their care teams. W’s case is referred to the

local safeguarding authority. Some staff want V and W transferred back to medium security. Some staff want them restricted to their wards. The care teams responsible for V and W arrange for the senior occupational therapist, who knows both of them, to discuss with them their relationship and any plans for the future. V and W indicate that they want to get married. W explains that V is the first man who has treated her kindly and with respect. When the occupational therapist reports back to a joint meeting of the two care teams, there is agreement that there are no grounds for seeking to interfere with the relationship between V and W. Both are judged to have capacity to consent to sexual relations. It is decided that contraception and sexual health should be addressed in their care plans. V and W are relieved that staff have found out about their relationship. They ask if they can be allowed into each other's room so that they can be together in private.

Staff explain that male visitors are not allowed in the rooms of female patients and vice versa. However, as V and W plan to live together following discharge, agreement is reached to allow them to spend an occasional night together in the unit's rehabilitation flat in between the periods of several days at a time when it is occupied by other patients. This arrangement is incorporated into their care plans and reviewed on a regular basis. When, many months later, supported accommodation is identified for them in the community, they progress to spending several days at a time in the rehabilitation flat. Eventually they are discharged to live together.

Box 9. Staff responsibilities with regard to sexual diversity (from Cheshire County Council and Cheshire and Wirral Partnership NHS Foundation Trust (2015) *Social, personal & sexual relationships good practice guidance*. CP44 Issue number 1)

Staff should

- Be aware of different sexual orientations
- Respect different sexual identities
- Ensure an open and professional relationship is established which enables service users to discuss their sexual orientation if they wish to do so
- Provide information and where appropriate support service users to access relevant community resources and specialist organisations

Box 10. A transgender issue

G is a male to female transgender patient in the female rehabilitation ward of a medium secure unit. She has not completed full physical transition and retains male genitalia. She sexually assaults two other female patients. The assault consists of non-penetrative groping. A request is made by the nursing staff for her transfer to a male ward. The reasons given are that she retains male genitalia and is physically strong. These factors raise the risk to other females. The senior manager, in discussion with nursing staff, agrees that it would be more appropriate for her to be nursed on the male ward as her sexual orientation is heterosexual female. Following case review by the consultant from the male ward, the decision is reversed on the basis of this being direct discrimination. Instead she is transferred to the acute female ward where the staff risk assess and managed her behaviour in the same manner as they would a patient who was born female. There is one further attempt to assault

which is managed with restraint. Thereafter she is managed with 1:1 observations within arms length. The behaviour reduced over a period of 2 weeks, and she was transferred back to the female rehabilitation ward.

#### Box 11. Access to prostitution

Since the age of 35 years, V has suffered from schizophrenia. Initially it was difficult to treat and he had several admissions, most of them under the Mental Health Act 1983. He has greatly improved and is in the process of increasing unescorted leave with a view to discharge in the next few weeks. He is allowed unescorted leave under s.17. Staff learn, from another patient, that on leave he has been visiting a prostitute. V was married up to the age of 25 years and he started visiting this particular prostitute when he was 30 years old. His risk is re-assessed. He has no history of violence and, but for his belief that there is no moral objection to prostitution, he has no attitudes which might be construed as possibly harmful to women. He is aware of the health and legal risks he runs. It is pointed out to him that, although prostitution is not illegal, he is at risk of prosecution if the prostitute has been subjected to exploitative conduct. He says that he has got to know her well over the course of many years and he is sure that she has not been subjected to exploitative conduct. Some team members want his responsible clinician to cancel his s.17 leave. Upon full consideration, the team decides, with some reservations, that there are no grounds for restricting or cancelling his leave. The team sees him and it is documented that his use of the prostitute is not condoned. Some team members have moral objections to his behaviour and at their suggestion, it is put to him that there are members of society who object to prostitution on moral grounds and his acknowledgment of this is documented. A plan is put in place to monitor his sexual health.

#### Box 12. Pornography.

T has a mild intellectual disability. He lives in a group home where his room is cleaned by a member of the domestic staff. One day the cleaner refuses to clean his room because he has pornographic pictures on the wall. The cleaner says that he finds these offensive and, for religious reasons, abhorrent. T's pictures are the centrefold pages of magazines which he has purchased from the local newsagent. Staff review T's history and make enquiry of him sufficiently to confirm that he has no history of sexual offending or of violence towards women and has never been in a sexual relationship. A plan is set in place. T is informed about the circumstances in which some women model for such magazines. Some staff express concerns about the risk to T's morals. His right to pursue an activity that may be morally harmful to him is explained to staff. T agrees to move the pictures to the inside of his wardrobe door.

## MCQs

**(1) The legal basis for policies relating to sexual relations and related matters for people with mental disorder or intellectual disability:**

- (a) is now enshrined in the Care Act 2014
- (b) was enunciated in *McCann v State Hospitals Board for Scotland* [2017] UKSC 31, [2017] MHLO 22
- (c) should be domestic legislation (T)
- (d) is set out in the Equality Act 2010
- (e) is set out in article 8(2) of the European Convention on Human Rights

**(2) Policies concerning sexual relations and related matters for people with mental disorder or intellectual disability:**

- (a) can lawfully necessitate staff changing their own cultural, ethical, moral or religious codes
- (b) should have as their starting point a list of rules and proscribed behaviours
- (c) should recognise the patient's or service user's right to pursue activities perceived to be of a physically or morally harmful or dangerous nature to the patient or service user (T)
- (d) can be readily formulated to apply to every location or situation in a service or institution
- (e) are exempt from compliance with the Mental Capacity Act 2005

**(3) A ban on sexual relationships between patients:**

- (a) has its basis in article 8(1) of the European Convention on Human Rights
- (b) may be justified in order to manage the risks of sexual offending (T)
- (c) in high security hospitals can also be readily implemented in medium and low secure psychiatric facilities
- (d) flows naturally from the power to regulate the frequency and manner of visits to high secure hospital patients
- (e) was proposed by the Royal College of Psychiatrists in 1996

**(4) When a patient with a mental disorder or a service user with an intellectual disability becomes pregnant:**

- (a) the Abortion Act 1967 does not apply
- (b) the father's needs can be disregarded if the couple are not married
- (c) staff may be delighted (T)
- (d) any best interests decision in relation to the termination of pregnancy must make the interests of the unborn child paramount
- (e) staff should have regard to article 12 of the European Convention on Human Rights

**(5) About pornography:**

- (a) it is acceptable for staff to use it for sex education which forms part of the patient's or service user's care plan and has been agreed by the care team
- (b) it refers to magazines, posters, films, DVD's and videos but not books
- (c) for the purpose of policies, no distinction should be made between films classified '18' by the British Board of Film Classification and films classified 'R18'
- (d) assisting a patient or service user to obtain it could be illegal under s.53A of the Sexual Offences Act 2003
- (e) sharing it with other patients should be discouraged (T)