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'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

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Abstract In 1996, the Royal College of Psychiatrists recommended that all psychiatric facilities in the UK develop policies concerning sexuality and sexual expression for persons contained in those facilities. This paper analyses the prevalence and content of such policies in English forensic psychiatric facilities. While the College recommends an individualised approach to sexual and emotional relationships, most hospitals in fact either prohibit or actively discourage such expression as a matter of policy. The paper considers the advantages and disadvantages of that approach. The paper also considers the legal issues surrounding these policies, and in particular the legal authority for governing the sexual and emotional expression of hospital residents and the relevant human rights implications.

Keywords Emotional expression · Forensic psychiatry · Governance of psychiatric hospitals · Psychiatric hospitals · Sexual expression and human rights · Sexuality

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Introduction

The sexual behaviour of psychiatric inpatients has historically been ignored, both by hospital policies and by the academic literature (Buckley and Wiechers 1999; Civic et al. 1993; Dobal and Torkelson 2004). This exclusion originated from a social climate in which sexual activity was a taboo subject (Krumm et al. 2004) and has been perpetuated by the assumption that people with major mental illnesses are asexual (Buckley and Robben 2000; Buckley and Wiechers 1999; McCann 2000). Consequently little attention has been paid to the sexual needs of psychiatric patients (McCann 2000) and sexual activity is commonly banned in psychiatric institutions, despite the inherent role of sexuality in quality of life (Binder 1985; Dobal and Torkelson 2004; Welch and Clements 1996). The advent of AIDS and HIV in the 1980s forced psychiatrists to look at sexual behaviour more closely and to consider the need for policy guidelines in psychiatric institutions (Chase 1988; McCann 2000; Mossman et al. 1997).

It is now widely recognised that individuals with major mental disorders are sexually active, even in psychiatric institutions where sexual interactions are expressly forbidden (Buckley and Robben 2000; Buckley et al. 1999). Whilst there is evidence to suggest that clinical nursing staff often view inpatients' sexual activity as problematic (Cole et al. 2003; Dobal and Torkelson 2004; Keitner et al. 1986), less is known about hospital policies and management of sexual behaviour in the UK. Ideally, staff responses should be consistent and guided by clear administrative policy (Buckley and Robben 2000); 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 (Buckley and Wiechers 1999; Mossman et al. 1997).

In recent years there have been movements in professional circles to engage with issues of sexuality among psychiatric inpatients. In 1996 The Royal College of Psychiatrists produced a report; *Sexual Abuse and Harassment in Psychiatric Settings*, subsequently revised in 2007 as *Sexual Boundary Issues in Psychiatric Settings*. One of the recommendations arising out of the earlier document was "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" (Royal College of Psychiatrists 1996, p2; 2007, p4). Notably this encourages both general policies and individuation within a clinical paradigm; albeit a policy can be written in terms of either (non) acceptable behaviour or of an approach to deciding clinically what is acceptable for the individual. At a similar time, the Royal College of Nursing issued guidance concerning the sexual health needs of psychiatric service users (Royal College of Nursing 1996).

Notwithstanding these developments, there has been little research to determine how issues of sexuality and relationships are actually dealt with in psychiatric facilities. This paper considers the policies developed in English and Welsh forensic facilities, with particular attention to legal and law-related policy issues. What emerges is a peculiarly confused and contradictory landscape, not merely between policies but within individual policies themselves.

The Current Approach

This paper is based on a study undertaken in 2006. The original study design was exploratory in nature, aimed at investigating the current policies and practices surrounding sexual relationships employed by practitioners working in forensic facilities in England and Wales. The study adopted a mixed-method to collect data: a survey, which included both closed and open-ended questions on sexual relationship policies and practices, and textual data, derived from the policy documents. In order to secure participation a covering letter explaining the study was sent to the Medical Director of every unit, together with the survey questionnaire. This letter specifically asked the recipient to complete the enclosed questionnaire and return it together with a copy of their written policies on sexual relationships with the SAE provided. 60 forensic services from high, medium and low secure were approached. Reminders were sent out at 7 months and at 10 months. A number of unresponsive units were contacted by telephone on a number of occasions where copies of the survey questionnaire were sent again via fax. The last policy document was received as late as the end of 2009. The ethical standard observed in this study prevents us from disclosing the names of the forensic units participating in this study. The data from the questionnaires was analysed for descriptive statistics, while the textual data from the written policies was analysed thematically and comparatively across security levels.

Whilst a detailed statistical analysis of the survey data will be published elsewhere (in progress), this paper is primarily based on an analysis of the policy documents on sexual relationships, which we think will be of relevance to lawyers, clinicians and policymakers specifically in relation to human rights. The response rate from various forensic services can be gauged from Table 1, which illustrates both the response rate for the survey and the policies we requested. This table shows a 65% return rate for questionnaires (No. 39 out of 60), highlighting also the total number of policies received by type of service. Of those responding, 17 hospital units had a written policy (43% of 39 responses), whilst 13 had an overall unwritten approach (33%), and eight had a patient-centred approach presumably of the sort envisaged by the Royal College in its 1996 report (20%). One service did not indicate the type of policy they had in place. The questionnaire also asked how policy was implemented. All three high-security hospitals stated that they rely only on written policy on sexual relationships, where 14 of the 26 medium-security hospitals relied primarily on non-written policies, albeit buttressed by written policy in 12 cases. Similarly, low-security hospitals principally adopt a non-written policy to manage sexual relationships: seven used unwritten, and two written policies.

Table 1 Summary of response rate per type of unit

Unit type	Questionnaires sent out	Questionnaires received	Policies received
High secure	3	3	3
Medium secure	45	26	10
Low secure	12	10	1
Total and response rates (%)	60	39 (65%)	14

Table 2 provides an overview of the main components of the polices on inpatient relationships highlighting variations amongst the three types of forensic hospitals regarding their approach to such policy in their services.

This overview has its limitations. Factors appear only if they are contained in the specific policy the authors were sent. It is difficult to believe that all three high secure facilities do not have a policy on pornography, for example, or who may enter service users' bedrooms and under what circumstances; but such policies are invisible in the overview because they do not appear in the policy related to sexuality and relationships. Further, if the concern is about the people in the institutions, the policy itself may well be less significant than its implementation (or non-implementation). The policies often place considerable discretion in the hands of the multi-disciplinary teams or clinical staff in charge of the service user's care as to whether emotional relationships are permitted to develop. For the service users, the exercise of that discretion will be pivotal, and that is not contained in the current data.

Emerging Discursive Tensions

Comparison of Policies

It is clear from the overview that there are inconsistencies across institutions as to what is permitted and what not. Thus in one high secure facility, service users may obtain condoms with the approval of their responsible clinician; in another, condoms are expressly considered to be contraband and are to be confiscated if found. Particularly at the medium and low-secure levels, attitudes to sexual or emotional expression vary radically. In at least one medium secure facility, the possibility of conjugal visits is not ruled out, when the multi-disciplinary team consider them appropriate; in others, visits must occur only in public parts of the facility, and strict behavioural restrictions are imposed. In some, physical expressions of affection such as hugging and kissing are expressly permitted; in others, even holding hands is prohibited.

The policies show the extraordinarily controlled nature of institutional life. Certainly, it is reasonable that institutions have sensible rules regarding communal living, to protect the reasonable expectations of all, and 11 of the 15 written policies the authors received contain provisions to this effect. Thus in institutions where pornography is permitted, it is restricted to the service user's bedroom, and six policies expressly note that masturbation was acceptable if and only if it occurred in the privacy of the service user's bedroom. Some policies also provided examples of what constituted acceptable behaviour, with six policies noting that kissing, hugging or cuddling was acceptable in more public environments in the facility. These provisions can be understood as reflecting a broader social consensus as to what conduct is appropriate in a public environment.

Some policies however move well beyond issues of what is required for standards of decency in communal living. One institution for adolescents banned virtually all physical contact between service users: even holding hands was not

Table 2 Summary of main components of policies on inpatients' relationships

	HS [n = 3]	MS [n = 6]	MS/LS [n = 2]	LS [n = 4]
Policy document size				
15 pages or more	3	–	–	–
5–7 pages	–	1	–	2
2–4 pages	–	5	2	2
Overall direction				
Sexual intercourse prohibited	3	3	–	1
Sexual relationships to be actively discouraged	–	1	2	3
Sexual relationships expressly permitted, if appropriate	–	2	1[a]	–
Other behavioural limitations				
Express restrictions on inappropriate behaviour other than sexual intercourse (see next row)	3	5	1	2
Definitions/illustrations of what constitute 'inappropriate' behaviour is provided	3	4	–	1
Dress code	–	3	–	–
Limitations on access to service users' bedrooms	–	3	–	–
Policy expressly affecting user/visitor relationships	3	3	–	–
Response to sexual/affectionate behaviour				
General statement that sexual/affectionate behaviour normal	3	4	1	4
Express concerns with exploitation and sexual abuse of service users	3	6	2	4
Express acknowledgement that notwithstanding restrictive policy, sexual behaviour will occur	1	2	–	2
Considers pregnancy outcome	2	–	–	–
Pornography to be available, subject to controls	–	–	–	2
Pornography contraband, subject to individual exceptions	–	–	–	1
Contraception/condoms available	1	5	1	4
Condoms contraband	1	–	–	–
Relationship counselling/sexual education available	3	6	2	4
Confidentiality/breach of confidentiality policy	2	2	2	–
Issues of capacity of participants expressly a factor for assessment	1	5	–	3
Expressly stated that policy applies equally to heterosexual and homosexual relationships	2	3	1	3
Right to marry expressly affirmed	3	2	–	–
Staff issues				
Service user to have intimate care provided by same-sex member of staff	1	3	1	2
Staff training to be provided on matters related to sexuality/ relationships	–	1	1	2
Staff-service user relationships expressly prohibited	3	5	–	–

[a] N = 3 because one policy appears both actively to discourage and to allow such relationships

permitted. In another, any significant physical contact such as holding hands or kissing, while sometimes acceptable, would trigger investigation and potential intervention of the multi-disciplinary team. This points to a pervasive theme in the policies, that sexual and emotional relationships are appropriately the focus of management by professionals. Even in those facilities where sexual expression was not ruled out completely, the relationship had to be scrutinised by the care team(s) of the service user(s). Occasionally, attempts were made to introduce consistent values to professional decision-making in this regard. Thus nine of the policies expressly stated that they apply equally to gay and straight relationships. Three policies made it clear that while staff had the right to their own ethical views regarding sex and relationships, they could not enforce those views onto service users, although two others noted the right of staff not to witness activity they find indecent. Overall, the policies leave extraordinary discretion to the multi-disciplinary teams as to whether to allow the relationship to continue, even if it is an emotional relationship that complies with a 'no sex' rule. This authority of the multi-disciplinary teams is reflected not merely in the written policies analysed below, but also in the survey responses concerning unwritten policies. This assumes that sex and emotional relationships are clinical matters subject to regulation, as with other aspects of freedom.

Capacity to Consent

Outside the context of psychiatric facilities, such controls are permitted when an individual lacks capacity. In that event, as discussed elsewhere in this special edition, the individual cannot consent to sexual relations, and such relationships become illegal: see Sexual Offences Act 2005, s 30–45; Mental Capacity Act 2005, s 27(1). For nonsexual aspects of relationships, the Mental Capacity Act 2005 will apply, and decisions must be made according to a statutory test of best interests, requiring inter alia consideration of the current and past views of the person lacking capacity, and consultation with careers who would be aware of the persons wishes and beliefs before he or she lost capacity. The criteria under the best interests test of the MCA are not exhaustive, and objective best interests also come into the picture. As such it is not a pure substitute judgment test, but it is has elements of that approach.

Eight of the policies reviewed in this study identify capacity as a matter which must be taken into account, although several other policies note the need for consent, which may import a capacity assessment by implication. Often, the references to consent are however minimal or tangential. Two policies refer to the need to follow the Mental Capacity Act 2005, providing little indication of what that would mean in the context of relationships. In only two policies, identical in this point in their substance, is any reference made to what might need to be understood for a determination of capacity to be made—'ability to comprehend and retain the necessary material to make a decision about a relationship, including the potential consequences of the relationship.' While inevitably this lacks the nuance of some of the case law, it is a reasonable provision. Otherwise, guidance for capacity determination is not contained in the policies. Similarly, the appropriate approach

for determining whether a non-sexual relationship should be permitted to develop is not discussed in any significant way, leaving clinicians essentially with a 'free hand' as to how to approach these relationship [s and activities. Insofar as the Mental Capacity Act 2005 does indeed apply (as it would, for example, for an informal patient admitted outside the forensic context), the continuance of a non-sexual relationship would be determined according to the best interest test in that statute, with its express criteria and processes noted above. These are nowhere referred to in the policies, leaving a potential implication that the continuance of the relationship is a matter for the unbounded discretion of the service user's care team.

None of the policies make a clear distinction between sexual and non-sexual relationships as regards mental capacity, notwithstanding that the former are illegal when an individual lacks capacity and the latter not necessarily illegal. Analysing this failure is complex, as in six of the eight policies sexual activity is either prohibited or actively discouraged in any event: arguably, if sex is not permitted anyway, issues of capacity are superfluous. As noted above, however, even in these facilities the attitude to sexual expression is perhaps sometimes more ambiguous than the policy suggests. It is fair to wonder if this ambiguity is carried over into the situation where one of the participants lacks capacity to consent to the activity, and if so, whether sexual relationships are also occasionally considered under some form of best interests approach. Insofar as this is the case, the discussion here intersects with discussion elsewhere in this volume as to whether capacity is necessarily the appropriate approach to the legality of sexual activity. Whatever the ethics of that discussion, of course, the law on the matter is clear: both parties must give capacitous consent for sexual activity to be legal.

Conflicting Roles and Legal Expectations Within Individual Policies

If we move outside the realm of capacity, the policies are best understood in the context of the conflicting roles and legal expectations of forensic hospitals, under the umbrella of mental health legislation. The overview in Table 2, highlighting the diversity of approach between institutional settings, is not sensitive enough to clearly illustrate the contradictions within the individual policies themselves. Sometimes, these tensions are overt, as in the following opening paragraphs of one of the policies:

1.1 Sexuality is a fundamental aspect of the human condition and as such cannot be ignored or dismissed. This policy outlines the attitude at [institution name] towards patients' sexuality and offers guidelines for staff.

1.2 The management of [institution name] actively discourages sexual relationships between patients. As part of the assessment process staff should be aware of patients' views on sexuality, sexual orientation and facilitate open dialogue with patients on issues of sexuality.

Eleven of the policies, including nine of the thirteen where sexual congress is prohibited or actively discouraged, contain an explicit statement such as the one in the first paragraph of the quotation, acknowledging that sexuality is part of what it is to be human. This suggests a positive aspect to such relationships, that is

immediately countered by the prohibition or discouragement of a service user engaging in such relationships. This tension continues in the second sentence of paragraph 1.2: the service user's views on sexuality are to be actively explored in discussion, but as the first sentence of the paragraph makes clear, must not be acted upon.

Other tensions are less overt. Thus even in the thirteen policies where sexual activity is prohibited or discouraged, nine allow for the provision of birth control or condoms, and all provide for sexual education and/or relationship counselling. These provisions might reasonably be taken to be sending positive messages to service users about sexual or emotional relationships, which they are then to be discouraged from pursuing. Some aspects of these policies, such as the availability of birth control or contraception, might reflect the fact that sex may occur notwithstanding an official line discouraging or prohibiting it—a fact acknowledged expressly by nine of the thirteen policies—but if so, the ramifications do not appear to have been thought through. Thus, of the ten policies allowing for the provision of birth control or condoms, none provide an express right of confidentiality for the service user as regards the clinical team, and six expressly involve the clinical team in the provision of these services. The service user is thus required to identify himself or herself as breaking the sexual prohibition in order to get the birth control or condoms, to the people in charge of enforcing that prohibition. It is difficult to see that this is workable.

These tensions may be the result of the persistence of older anxieties about uncontrolled desire that permeate also other policies regulating sexual relationships of the young and young homosexuals.

The Right to Wed

The inclusion of the right to marry in five of the policies raises a slightly different question: what exactly does it mean, when one of the parties is subject to detention in a forensic psychiatric facilities? The criteria for capacity to marry might be expected to provide a possible guide. As discussed elsewhere in this special edition (Hasson, 2010), these tests conceive of marriage as paradigmatically a social and sexual union. *Sheffield County Council v E* [2004] EWHC 2808 (Fam) makes the first of these connections:

> Marriage, whether civil or religious, is a contract, formally entered into. It confers on the parties the status of husband and wife, the essence of the contract being an agreement between a man and a woman to live together, and to love one another as husband and wife, to the exclusion of all others. It creates a relationship of mutual and reciprocal obligations, typically involving the sharing of a common home and a common domestic life and the right to enjoy each other's society, comfort and assistance. [para 132]

X City Council v MB, NB and MAB [2006] EWHC 168 (Fam), extends this definition by acknowledging that a sexual relationship is usually implicit in marriage. While these may only be indicative criteria, it is notable that marriage with a person on long stay in a high secure psychiatric facility will import none of

these characteristics, as the policies state that a married partner is subject to the same restrictions on behaviour as any other visitor to an institution. All of the high secure facilities expressly prohibit sexual activity. Cohabitation between the married partners will be impossible, as will participation in a common domestic life and the enjoyment of each other's society. Even during visits, expressions of meaningful affection are strictly limited, including in one case the prohibition of open-mouthed kissing (hence the title of this article). In some cases, policies require constant supervision of the individuals by a member of staff throughout the visit, allowing no privacy and in practice no doubt discouraging intimacy. All three of these facilities specifically acknowledge the right to marry; but in what sense, one might ask, is the relationship on offer a marriage?

The right to marry may well have been included in the policies because of its inclusion in Article 12 of the European Convention on Human Rights (ECHR). To date, the issue of what constitutes a marriage under that article has received minimal discussion. In *UK v Hamer* (no. 7114/75, Commission report of 13 December 1979), a case concerning the right of prisoners to marry, the European Commission[1] referred to marriage as 'the formation of a legally binding association between a man and a woman', and this has been cited by the European Court of Human Rights without criticism: see e.g., *Frasik v Poland*, (no. 22933/02, decision of 5 January 2010, para 83). By this minimal standard, the marriages provided under the policies comply. At the same time, *Hamer* also referred to the potentially 'stabilizing and rehabilitative influence' of marriage (para 72). It is difficult to see that such effects are likely to occur as effectively as they might, unless some of the substantive benefits of marriage precluded by the policies are somehow introduced into the relationship.

The policies form an inconsistent and somewhat incoherent landscape, both as between institutions and indeed within policies themselves. The remainder of this paper will look at some of the legal and socio-legal issues that flow from these incoherencies.

The Authority to Regulate

Many of the policies do appear on their face to be extraordinarily intrusive into what would normally be considered private situations. They generally do not purport merely to control sexual relationships, but emotional relationships as well. They allow for minute controls on what service users can and cannot do: whether hand-holding or open-mouth kissing will be permitted will depend on the facility to which one is admitted, for example.

To justify such intrusive rules, one would reasonably expect a clear legal rule-making authority, based in statute and, perhaps, secondary legislation. Such an authority exists for prisons, where the Prison Act 1952 provides a legal framework

[1] Until 1998, the European Commission of Human Rights was a gateway body to the European Court of Human Rights, providing an initial view to the Court. As such, its opinions are relevant for interpreting the ECHR, but not as convincing as those of the Court itself.

for regulation, buttressed by a power under s 47(1) on the Secretary of State to make additional rules 'for the regulation and management of prisons, remand centres, detention centres and youth custody centres, respectively, had for the classification, treatment, employment, discipline and control of persons required to be detained therein.' This section provides the statutory authority for the Prison Rules 1999 (SI 1999, No 728, as amended). These are in turn overlaid by a body of international law, most notably the European Prison Rules (Council of Europe Rec (2006) 2; see also Van Zyl Smit and Snacken 2009). In the prison context, such rule-making thus has a clear legal authority and contextual basis.

Such a structure is conspicuously absent in the context of psychiatric facilities. For the three high secure facilities, some regulatory authority is created by the Safety and Security in Ashworth, Broadmoor and Rampton Hospital Directions 2000 issued by the Secretary of State.[2] The main thrust of these directions is the regulation of searches in the high secure facilities, although they also contain rules regarding locking up of service users at night, access to the outdoors, access to (and interception of) telephone calls, and the requirement to perform risk assessments. While the content of these directions may of course indirectly affect the pursuit of emotional relationships by service users (as, for example, by the restriction of telephone calls except to pre-programmed numbers approved by the institution), the directions do not expressly refer to the governance of sexual or emotional relationships.

Outside the high secure facilities, even this minimal framework is absent. The case law to establish an authority for governance rules in institutions has taken two paths. One flows from the case of *Pountney v Griffiths* [1976] AC 314 (HL). In that case, it was alleged that a nurse at Broadmoor Hospital struck a service user who was not returning to the wards quickly enough following visiting hours. The nurse was convicted by the Bracknell magistrates of common assault, but the leave of a High Court Judge had not been sought prior to the commencement of the prosecution, as was required by s 141 of the Mental Health Act 1959 (now s 139 of the Mental Health Act 1983). Such leave would be required if the blow struck was 'an act purporting to be done' in pursuance of the Mental Health Act. The House of Lords held that the blow was covered by these words, and thus leave was required. Forensic detentions were made when the individual had a mental disorder warranting detention for medical treatment, and 'that necessarily involves the exercise of control and discipline. (*Pountney* at 335) By *R v Broadmoor Special Hospital Authority and Secretary of State for Health* (1998 WL 1044171, CA), and notwithstanding the absence of any express rule-making authority under the Mental Health Act 1983, this had expanded into a general power of control:

> [The Mental Health Acts 1959 and 1983] leave unspoken many of the necessary incidents of control flowing from a power of detention for treatment, including: the power to restrain patients, to keep them in seclusion…, to

[2] These directions were issued originally pursuant to s 17 of the National Health Service Act 1977 as amended and s 4(5) of the Regulation of Investigatory Powers Act 2000. The power in s 17 of the 1977 Act has now been replaced by s 8 of the National Health Service Act 2006.

> deprive them of their personal possessions for their own safety and to regulate the frequency and manner and manner of visits to them….

While this approach may make some sense for necessary corollaries to the fact of detention, it is difficult to see that it is defensible for rules of governance not directly related to detention, into which category the policies on sexual and emotional expression arguably fall, at least in some of their aspects. While not directly relevant to the forensic patients covered by the policies in the current study, it is also difficult to see that it can apply to policies governing informal patients. Is it really the court's intention that policies regarding personal possessions or the wearing of sexually provocative clothing will be different for formal and informal patients? Institutions must have some of these powers, quite apart from the legal status of their residents. Thus there must be an authority somewhere to set meal times and visiting hours or, more relevant to this paper, ensure appropriate standards of decency on hospital wards, whatever the legal status of the patients.

The second approach flows from property law. *R (N) v Secretary of State for Health* [2009] EWCA Civ 795 concerned the legality of a policy by Rampton Hospital to ban smoking. In that case the majority of the court noted the view expressed in *Kay v Lambeth LBC* [2006] UKHL 10 at 36 that 'The public authority owner or landlord has, broadly speaking, a right to manage and control its property within bounds set by statute'. Following this approach, the court in *N* held:

> There can be no issue but that the policy is in accordance with the law. When it was introduced there was no statute or other legal instrument or principle preventing the Trust from banning smoking. The Trust owns and operates Rampton (and other hospitals in its area) and, subject to duties owed to patients or staff, it can set the rules for the operation of the site. [61]

This would suggest that, subject to general law and most significantly the Human Rights Act 1998,[3] any institution can set up pretty much any set of rules it wants. While this makes more sense of the mundane rules such as the setting of visiting hours, it has its problems in other contexts. *Kay* was a housing case, where at least in theory the relationship was contractual or quasi-contractual: if the tenants did not like the landlord's rules, they could leave. This is not the case for people detained under forensic sections or civil sections in psychiatric facilities. The result under this theory of authority is a marked disproportion of power in setting institutional rules. This is appropriately a matter of serious concern when significant intrusions into the lives of individuals are at issue.

While this approach certainly allows security issues to be taken into account, it is more flexible than the *Pountney* approach in taking into account other factors or priorities. It is easier under this theory to include broad issues of service user health and psychological well-being, for example. *N* itself identifies these as specific priorities:

[3] Private psychiatric facilities that contain detained patients are nonetheless considered to be exercising functions of a public nature, and are therefore within the scope of the Human Rights Act 1998: see *R (A) v Partnerships in Care Ltd.* [2002] EWHC 539.

> The Trust exists to deliver health care to its patients in Rampton in a secure and clinically appropriate environment. It owes a duty of care to them which covers both their physical and their psychological health and which includes a duty to take reasonable steps to prevent patients from causing themselves self harm. (para 62)

Such factors could be introduced to some degree in the *Pountney* approach—the patients are, after all, admitted for treatment—but the case may be harder to make in specific instances. *N* itself provides a good example: the ban on smoking would be difficult to justify as a necessary corollary to the detention powers, given that smoking had been permitted without compromising security or mental health treatment for time immemorial. Under the approach adopted in *N*, that issue was not relevant.

A third approach is also possible, based on common law rights and duties contained elsewhere in law. There is for example an obligation to ensure the reasonable safety of people an institution has in its care: see, e.g., *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74, *Keenan v United Kingdom* (ECHR, application no. 27229/95, judgment of 3 April 2001), *D v South Tyneside Health Care NHS Trust* [2003] EWCA Civ 878, *Drake v Pontefract Health Authority* [1998] Lloyd's Rep. Med. 425. This obligation is reflected in a right to restrain individuals to prevent harm or a breach of the peace (*R (Munjaz) v Mersey Care NHS Trust* [2003] EWCA 1036; *R (Laporte) v Chief Constable of Gloucestershire Constabulary* [2006] UKHL 55). The Mental Capacity Act 2005 allows interventions to be made in the best interests of persons lacking capacity, subject to procedures contained in that act. While certainly not all persons in psychiatric facilities will lack capacity for all decisions, this Act does provide a framework for intervention in cases where capacity for a decision is lacking. While the justification for each of these rights and duties is individually stronger than the theories adopted by the court to date, they are limited in their scope, and do not necessarily form a coherent or sufficiently extensive package to be practicable.

Traditionally, there was little scope for challenge of institutional rules. *R v Home Secretary, ex p Leech* [1993] 3 WLR 1125 (CA) did provide some potential. That case involved searches of correspondence between a prisoner and his lawyer. The court held that such correspondence was a common law right that could only be removed if such removal was contemplated either expressly or by necessary implication in statute, and the necessary implication would be imputed only if an objective need for the rule could be demonstrated. Absent such necessary implication, broadly permissive rule-making authority, even if contained in statute, could not allow the creation of rules that curtailed fundamental rights. In that case, the relevant statutory instrument was struck down as ultra vires. Insofar as they remove or limit fundamental rights, the policies of psychiatric institutions ought in theory to be more vulnerable, as they are supported by no express rule-making authority. Nonetheless, the case was interpreted remarkably narrowly. For example, in *R v Broadmoor Special Hospital and Health Secretary* [1998] WL 1044171 (CA), the court allowed a policy of random searches in a high secure facility on the basis that there a sufficiently self-evident and pressing need for the power had been shown

based on the detention powers of the Mental Health Act 1983, notwithstanding that this statute has no express rule-making power at all.

The traditional position was nonetheless extremely restricted. The introduction of the Human Rights Act 1998 created a new mechanism to challenge based on the European Convention on Human Rights (ECHR). It is clear that institutions containing detained patients are covered by the Human Rights Act, whether they are owned publicly or privately (*R (A) v Partnerships in Care Ltd.* [2002] EWHC 539). The specifics of HRA challenges will be discussed as they arise, but two general points should be noted here.

First, a number of ECHR articles (most significantly for current purposes article 8) allow restriction of the relevant ECHR right, when necessary in a democratic society in the interests of national security, public safety or the economy or well-being of the country, for the prevention of crime or disorder, for the protection of health or morals, or for the protection of the rights and freedom of others. The interference in question must also, however, be 'in accordance with the law'. It would appear that rules embodied only as orders or directions do not come within this phrase: *Silver v the United Kingdom* (No. 5947/72, judgment 25 February 1983, (1983) 5 EHRR 347) para 89. The rules in *Silver* were formal directives issued by the minister, analogous to the Safety and Security Directions for the high secure hospitals, noted above. It is difficult to imagine that the policies at issue in this paper would be sufficient to satisfy the requirement. They are institutional policies, based either in an implied authority in the Mental Health Act 1983, or in the rights of a landlord to control his or her premises. It is difficult to see that this is sufficiently robust law to satisfy article 8(2) and similar provisions.

Second, the ECHR issues raise two related but separate questions. The first is whether the policy itself is consistent with the ECHR; the second is even if the policy is consistent with the ECHR, whether the effect of the policy on the individual breaches the ECHR. It is clear that if a policy is alleged to breach the ECHR, judicial review of that policy may be taken: see, e.g., *R (RH) v Ashworth Hospital Authority* [2001] EWHC Admin 972 regarding the provision of condoms in Ashworth Hospital, and *R (N) v Secretary of State for Health* [2009] EWCA Civ 795 regarding the prohibition of smoking at Rampton Hospital.

It also seems, however, that an individual may allege that the application of a policy to himself or herself gives rise to an ECHR violation, even when it is not alleged that the policy itself is in violation of the ECHR. Thus a service user was permitted to challenge a plan of medication that was to be imposed under the Mental Health Act 1983, without challenging the acceptability of the law under which it was being imposed: see *R (Wilkinson) v Broadmoor Special Hospital Authorities* [2001] EWCA Civ 1545. The thrust of the argument, reasonably enough, would appear to be that when an ECHR violation is alleged, some judicial or quasi-judicial body must be in a position to determine the merits of the case. If this is the case for compulsory treatment, there is no obvious reason that an analogous argument would not apply for other alleged ECHR violations.

This is potentially of particular relevance to those aspects of policies that apply across the board in facilities. If the application of such a policy to an individual raises ECHR issues regarding that individual, he or she may press that individual

violation. By way of example, consider *Dickson v the United Kingdom* (No 44362/04, judgment of 4 December 2007), where a prisoner and his wife wished to start a family. Conjugal visits were not permitted in the prison, and the time remaining on Dickson's sentence was such that by his release date, his wife would be likely to be beyond child-bearing years. The Secretary of State had refused to permit artificial insemination, and Dickson challenged this refusal, based on article 8 (right to family life) and 12 (right to found a family) of the ECHR. The European Court of Human Rights upheld his challenge, on the basis that the Secretary of State had not given adequate weight to the interests of those involved. The same result would presumably apply to a similar factual situation in a psychiatric context.

Towards Coherent Policy?

Whether or not the makers of the policies considered in this paper looked to the legal authority for regulation prior to creating their policies, the policies reflect the some of the themes and ambiguities of those theories of authority. Analysis of some of the themes that cut across both the policies and these justifications for regulatory authority may provide some potential to develop a more coherent approach.

Issues of Protection and Safety

All the written policies consulted in this study contained provisions reflecting concern for the safety of service users, and emphasising the need to protect them from exploitation. This is one of only two categories in Table 2 that is present in every policy.

This is perhaps unsurprising, as it lies at the intersection of a variety of administrative themes. Certainly, law is concerned about the safety of service users. Psychiatric institutions have a duty of care over service users in their care, and the failure adequately to protect inpatients is one of the few areas where courts have been prepared to find against health care professionals and mental health trusts in civil cases (see cases cited above).

Safety is further a part of the political agenda regarding mental health services. The Safety and Security Directions for the high secure facilities, introduced in 2000, can be seen as a manifestation of this priority, and the increasingly intensive surveillance that it entails. Indeed, the perception in the field was that much of the impetus surrounding mental health law reform over the decade 1998–2007 was based on a desire better to protect the public and, less obviously, service users. Dangerousness has long been a part of the concern in English mental health legislation (see Bartlett and Sandland 2007, 120–1), and in a world that is meant to be increasingly risk-obsessed (Beck 1992), it is unsurprising that safety concerns are part of the political policy agenda.

Issues of patient safety were also key to the approach of the Royal College, which entitled its 1996 report on sexual issues *Sexual Abuse and Harassment in Psychiatric Settings* (Royal College of Psychiatrists 1996). While the title was changed to the more rounded *Boundary Disputes* for the second edition in 2007,

the original concern was clear: this was about protecting patients. Sometimes, at the institutional level, this apparently flows from particular incidents. Thus for example in 1990, at a time when Ashworth Hospital was apparently less firm in its enforcement of a no sex policy, a homicide resulted in a period when two patients were left unsupervised. This apparently continued to affect the administration's prohibition of sexual behaviour between patients more than 10 years later: see *R (RH) v Ashworth Hospital Authority* [2001] EWHC Admin 872, para 18.

RH is a peculiar case, in that it is ostensibly about a challenge to the refusal of Ashworth Hospital to provide condoms to patients who wish to be sexually active, in violation of the no sex rule. That said, a considerable part of the case is spent analysing the justification for the no sex policy itself, presumably on the basis that if that policy could not stand, the no condoms policy would also not be defensible; and a key aspect of the finding that the policy is justified relates to issues of risk. On this point, the court is not particularly convincing. It notes that the high incidence of sexual offending in the patient population:

> A high proportion of patients have previously committed offences of a sexual nature (some 266 offences altogether). Dr James (the medical director) states that there are 138 convictions of a sexual nature attributable to a total of 101 male patients suffering from personality disorder, and 128 such offences attributable to a total of 259 male patients suffering from other mental illness or impairment, in both cases including the unrestricted patients among those totals. There is thus, broadly speaking, 1.3 convictions for a sexual offence for every one male patient suffering from a personality disorder, and 1 such conviction for every two male patients suffering from other mental illness. [para 15]

Sadly, this is statistical nonsense. Even assuming that all the offences were of sufficient severity that they would raise concerns as to whether the perpetrator should be sexually active in the future, one cannot average out numbers across populations this way. Assume (admittedly rather improbably) that all 138 of the offences by the personality disordered offenders were committed by the same person. The average offences per person on that ward would remain unchanged, but 100 of the 101 patients would have no record of sexual offences. In that event, it would be difficult to argue that a blanket prohibition of sexual activity was justified by the statistic. What might well be relevant is not the average number of sexual offences, but the number of people with at least one conviction for a serious sexual offence. Sadly, that statistic was not provided in the judgment. It may be that the nature of the service users at Ashworth is such that sexual conduct can reasonably be prohibited; but the statistics above are not an argument to that effect.

In the remainder of the judgment, the court does not look behind the evidence of the Ashworth staff, and Dr James in particular. It accepts the vulnerability of Ashworth patients, and the significant risk that they will be subject to abusive relationships. It accepts that this risk can be effectively managed in high secure psychiatric facilities, unlike in prisons, and it accepts that virtually no sexual activity occurred in Ashworth, notwithstanding the contrary evidence of the applicant and the contrary acknowledgement in its policy itself (quoted at para 4.3

of the judgment). The court therefore accepts the view of the Ashworth staff that risk of sexual offending and sexual abuse could be appropriately managed by the prohibition of sexual conduct.

Whether the nature of the service user populations warrants a blanket no sex policy at the high secure facilities is a moot point. Certainly, the reasoning in *RH* is not unproblematic. In any event, several points should be made.

First, whatever its strengths and weaknesses, the case does not stand as a precedent that a blanket no sex policy is justified outside the high secure realm. As patient populations are less ill and less dangerous, as they will be likely to be in less secure environments, the logic of the *RH* case becomes harder to sustain. This is not to say that vulnerability and abuse cease to be issues. Significant numbers of service users feel unsafe on hospital wards. In the 2009 Survey by the Care Quality Commission, only 45% of psychiatric inpatients felt always safe on acute wards, and 16% responded that they did not feel safe on these wards even sometimes (Care Quality Commission 2009, q6). In Mind's *Ward Watch* survey of 2004, 18% of inpatients reported experiences of sexual harassment (Mind 2004). Patients do have a reasonable expectation that they will feel safe on wards, and it is appropriate for the hospital administration to make reasonable efforts to ensure that this is the case. It does not necessarily follow from this that blanket no sex policies, and the intrusive emotional relationship policies will be justified; but it is equally true that the safety-related issues must be considered with care.

Second, while a no sex policy may reduce the frequency of sexual activity, it will not eliminate it. This is acknowledged in five of the thirteen written policies in which sexual behaviour is either forbidden or actively discouraged, and is consistent with the evidence of the applicant in the *RH* case. It is also consistent with the findings of Hales et al. (2006), who found that 15 of the 25 service users interviewed in English high secure hospitals had been in or were currently having a relationship, and four reporting intimacy involving genital contact. The prohibition strategy places any congress that does occur outside any risk control. This is most easily seen regarding risks of venereal disease. A no sex rule means that it is unlikely that people who intend to be sexually active will request condoms, even in institutions where they are at least in theory available. To do so means identifying oneself as a person who is intending on breaking the 'no sex' rule, and the suspicion is bound to be that such an identification will result in closer surveillance, and correspondingly fewer opportunities to engage in the sexual activity. The failure to request the condoms, however, will place the individual and his or her partner at greater risk of venereal disease and, if the relationship is heterosexual, pregnancy. Because of the enforced movement of the sexual activity 'underground', it is placed outside any risk management. While this is the clearest example, a similar argument applies regarding emotionally dependant relationships involving vulnerable people. If the parties understand that they must keep the relationship secret, any vulnerabilities in a weaker partner may be preyed on by an abusive partner until the relationship is discovered. The relationship will not be discussed with the clinical staff because it is required to be secret; and the failure to discuss it with the clinical staff means that the more vulnerable party will not receive relevant support during the period of secrecy. The 'no sex' policy thus carries risks of its own.

Third, it is interesting to note the divergence of the discourse of dangerousness within the hospital setting to that outside the hospital field. As noted above and elsewhere in this volume, there is a trend elsewhere in case law to uphold the rights of persons with capacity to engage in sexual conduct. Thus in *Re MM, Local Authority X v MM and KM* [2007] EWHC 2003 (Fam), an incapacity case, MM was able to consent to sexual activity but lacked capacity to decide with whom she would associate. She had an ongoing relationship with a man, who had subjected her to violence in the past and encouraged her to cease her psychiatric medications. At the time of the case, MM was resident in supported accommodation, from which her partner had been banned. While the court supported the ban, it also required the local authority to make arrangements to ensure periodic unsupervised time away from the supported accommodation, for sexual congress to occur with her partner. In this context, the court refers to MM's right to sexual intercourse (para 149), holding

> Given the importance rightly attached by the Strasbourg jurisprudence to this most "fundamental" and "essential" aspect of the private life respect for which is mandated by Article 8, any public body which proposes to interfere with the sexual life of someone who, like MM, has capacity faces a heavy burden. "Particularly serious reasons" must exist. Indeed where the relationship has lasted as long as this one has, especially pressing reasons must surely be shown to exist. In the present case, in my judgment, they do not. (para 159)

This is a markedly different tone to *RH* and other hospital cases regarding article 8 rights.

Therapeutics

A number of the policies cite therapeutic concerns in defence of a restrictive policy towards sexual conduct. Often, this is placed in the context of the frequency of histories of sexual abuse among service users. The evidence of Dr Diane James in the *RN* case provides a good example of this concern:

> We already have concerns about physical and emotional reaction by patients who have been emotionally hurt. I believe that this would be made worse if sexual relationships were allowed to develop. It is for these reasons that no sexual activity whatsoever is allowed under the Hospital's Policy pursuant to that no condoms are permitted. [para 17]

Another policy warns of the risks of physical contact, both in terms of reliving the abuse and in terms of creating perpetrators of abuse:

> Physical contact may be experienced as sexually exciting. It may be a repetition of behaviour that in the past was part of an abusive relationship and there may be excitement, confusion and fear about what will happen next.
> * * *
> What once was suffered passively in situations of physical or sexual abuse is repeated actively in order to shift from the intolerable position of helpless victim to the more powerful one of perpetrator.

Certainly, the complexities related to past sexual abuse, and the potential antitherapeutic effects must be acknowledged. When this is the case, sexual or emotional involvements may sometimes be at best problematic and at worst actively destructive.

Once again, however, it is fair to ask whether a simply prohibitive policy is necessarily the right way forward. As noted above, that risks driving the relationship into secrecy, so that those involved are effectively precluded from talking about the relationship and its effects on them. It would seem that all the facilities in this study would view this as a bad thing: all the policies in this study state that counselling or a similar service regarding relationships should be available to service users. It is difficult to see how this policy is to be implemented in institutions that are restrictive of relationships, however: once again, in order to get the service, the patient needs to identify himself or herself as a potential transgressor of the relationship policy.

The approach is also problematic, in that most people in forensic facilities will not remain in total institutions for life. When some form of absolute or conditional release occurs, the service user will be in a position to form emotional and sexual relationships. Clearly, for sake of the well-being, and potentially the safety, of the parties involved in such relationships, some preparation must be offered prior to release. That is now provided by counselling and similar programmes, including psychotherapy. It is fair to ask, however, as Heather Ellis Cucolo has argued in a slightly different context (Cucolo 2007), whether sexual conduct ought to be prohibited in the facility, particularly in the period in the lead-up to the individual's release, at a time when markedly closer observation of the relationship is possible, and more immediate support or intervention can be provided as required.

Upon release, it is of course highly desirable that the individuals have a secure social system in the community, typically provided through family relationships. Once again, the policies that are particularly restrictive on relationships may be problematic in this context. In Hales' sample, six people were married or in long-term relationships at the time of admission to high secure facilities; in no case did the relationship survive the detention (Hales et al. 2006, 258). Relationships fail for many reasons, but it is fair to ask whether the deprivations of privacy and intimacy that flow from intrusive sex and relationship policies may be a relevant factor. If this is the case, then the policies may well be working against the eventual well-being of patients in some instances.

As twelve of the fifteen policies note in some form or other, sexuality and relationships are part of what it is to be human. In the background to the therapeutic arguments for an intrusive sex and relationship policy is the deeper question of what is meant by 'cure', and whether, if cure is understood in terms of the recovery model and the ability to live happily in the world, this can sensibly be divorced from interpersonal relationships, be they sexual or emotional. This is consistent with the views expressed by service users in Hales' study:

> All patients were able to think of good and bad aspects of a relationship with someone outside the hospital. Four positive themes emerged: someone from 'outside' providing contact with the 'outside world' (12 patients); having

> someone 'stand by them' (eight patients); the pleasure of a visit or telephone call (seven patients); and providing practical support (two patients). The three main negative themes that arose were: the pain of insufficient contact with a loved one (16 patients); distress caused by breakdown of the relationship (six patients) and jealousy if the partner did not visit or call (four patients). Four patients could not see any problems with having a relationship. (Hales et al. 2006, 259)

These views seem sensibly perceptive. Certainly, there will be negative issues that may attach to relationships when one or both parties are institutionalised; but it is fair to ask how different those problems will be to relationships outside institutions, and to ask the corollary question, is it the role of therapeutics to protect patients from encountering those very human complexities. The fact that all policies included the provision of education or counselling relating to sexual and emotional relationships suggests an acknowledgement of this; but the negative or prohibitive attitudes to sexual or emotional expression in many of the policies suggest a hesitancy to engage with real situations. In this context, it is worth noting the hesitancy of courts in other contexts at restricting the rights of competent individuals to engage in sexual or emotional relationships, even when the individuals appear extremely vulnerable and where the relationship does seem to put the individual at risk: see, e.g., *Local Authority X v MM and KM* [2007] EWHC 2003; *Sheffield City Council v E* [2004] EWHC 2808 (Fam); but cf *A Local Authority v Ma* [2005] EWHC 2942.

A Patient-Centred Approach?

All of this suggests that appropriate approaches to sexual and emotional relationships may differ considerably between individual service users. That in turn suggests the desirability of a patient-centred approach to relationships. This is entirely consistent with the direction taken by the Royal College reports, which require not merely formation of an overall policy for institutions, but also that 'sexuality and sexual issues are considered as part of individual care plans' (Royal College of Psychiatrists 1996, p2; 2007, p4). The combined observation suggests that policies should describe proper approaches to clinical individuation rather than 'institution related' general policies.

Certainly, administrative complications may result from such an approach. It would be likely to mean that some (but not all) service users could enter relationships with some other (but not any other) service users, leading to what would be perceived by patients as an inconsistency of privileges on a ward. It might well be very difficult to explain to service users the basis for those differences, particularly to service users of marginal capacity flowing from significant learning disability or dementia, and particularly when confidentiality would preclude explaining rationales for specific decisions taken about specific individuals. That said, certainly regarding relationships with visitors to the institution, it is not obvious that these difficulties would be unmanageable. Even regarding relationships

between inpatients, considerable hesitancy is appropriate. Basic rights should only be curtailed for administrative reasons when those reasons really are compelling.

This is not merely an ethical point, but also a legal one. It is clear that curtailment of sexual activity or the right to form relationships with people engages article 8(1) of the ECHR: *Niemietz v Germany* (1993) 16 EHRR 97 at 29; *Re MM; Local Authority X v MM and KM* [2007] EWHC 2003, 100–106. Such a practice can only be sustained, therefore, if it is justified under article 8(2). This will be the case only if the practice is 'in accordance with the law' and 'necessary in a democratic society' in the interests of stated factors, most relevant for current purposes being the prevention of disorder or crime, health, and the protection of rights and freedoms of others. Potential difficulties of institutional policies being 'in accordance with the law' where noted above. In terms of the substantive factors, a policy will be upheld only if (1) the objective was sufficiently important to justify limiting a fundamental right, (2) the measures designed to meet the objective were rationally connected to it; and (3) the means used to impair the right or freedom were no more than was necessary to accomplish the objective: *R (N) v Secretary of State for Health* [2009] EWCA Civ 795 at 67. Whether this test is met will no doubt depend on the circumstances of individual hospitals, or even individual hospital wards. In *R (RH) v Ashworth Hospital Authority* [2001] EWHC Admin 872, it was held that Ashworth's policy refusing the distribution of condoms was defensible under article 8(2), a finding that makes no sense unless the hospital's no sex policy was also so defensible. As noted above, aspects of that case are problematic, however. While it may well be that restrictive policies can be defended under article 8(2), the precedential value of *RH* should be approached with some care. Its precedential value further decreases for institutions that do not resemble Ashworth, such as those outside the high secure sector.

To date, the European Court of Human Rights has itself declined to require conjugal visits in prisons: *Aliev v. Ukraine*, No. 41220/98, judgment of 29 July 2003, para 188. It does not appear to have decided on relationships between individuals in institutions, nor about the right to pursue emotional as distinct from sexual relationships. It further has not addressed the issue of conjugal visits in a psychiatric context. How far *Aliev* applies in this context is an open question. The Court holds that 'it is an essential part of a prisoner's right to respect for family life that prison authorities assist in maintaining effective contact with his or her close family members', but also that 'some measure of control of prisoners' contacts with the outside world is called for and is not of itself incompatible with the convention.' (para 187) It is not clear, however, whether this final statement flows from the complexities of managing difficult individuals (which might apply to at least some forensic psychiatric facilities), or from the punitive nature of prisons (which would not be the case for psychiatric facilities).

Restrictive policies may thus be defensible under article 8(2) for some institutions, but particularly outside the high secure sector, the case would need to be made out with considerable care. If a policy of blanket prohibition does not meet this standard, however, an individualised, patient-centred approach will effectively be required as a matter of law.

A more flexible policy does not necessarily preclude judicial review. In *R (Wilkinson) v Broadmoor Special Hospital Authority* [2001] EWCA Civ 1545, the applicant did not challenge an overall policy (in this case, the statutory regime regarding the imposition of involuntary psychiatric treatment) as contrary to the ECHR, but alleged that the question of whether the implementation of the policy in his case violated the ECHR. The court held that this was, indeed, judicially reviewable. The case has had a somewhat chequered history, with some courts attempting to minimise its effect, but the logic appears solid: if a credible case can be made out that an ECHR right is being violated, some court must be able to determine whether such a violation is actually taking place and to provide an appropriate remedy.

If this is the case, then service users would be able to challenge decisions made restricting their rights to engage in sexual and emotional relationships. In that event, an individualised approach will effectively become necessary, as an institution would have to be in a position to explain why it had reached the correct decision regarding an individual service user.

Winds of Change?

This is not an article that purports to present solutions, but rather to identify tensions in the status quo, and to bring to light a dimension of sexual citizenship that is often neglected. It is meant to begin a discussion, rather than to end one.

The discussion arises at a time when pressures are circling. The revision of the Royal College report (Royal College of Psychiatrists 2007) suggests that from a therapeutic perspective, the issue is not going to go away. While the approach of the courts in England and Wales has been deferential to psychiatric hospitals in any challenges to their policies, they have been much more supportive of sexual and relationship rights outside the high secure setting, and particularly for people with mental health problems in the community. At some point, these diverse strands of case law must collide.

The ECHR position similarly cannot be considered static. While the Strasbourg court has so far declined to require the provision of conjugal visits by partners, it has certainly left the possibility open that its position may change, as in the following comment from *Aliev v. Ukraine* (No. 41220/98, judgment of 29 July 2003):

> Whilst noting with approval the reform movement in several European countries to improve prison conditions by facilitating conjugal visits, the Court considers that the refusal of such visits may for the present time be regarded as justified for the prevention of disorder and crime within the meaning of the second paragraph of Article 8 of the Convention…. [para 188]

As noted above, *Aliev* is a case about prisons, but a finding that conjugal visits were required in a prison context would bring considerable and fairly immediate pressure to bear on psychiatric institutions to reconsider their policies, and to develop much more robust defences of them than appear to be in place now. It would, it is submitted, be wise to begin that discussion before a Strasbourg axe falls.

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