2015

'Love is Just a Four-Letter Word': Sexuality, International Human Rights, and Therapeutic Jurisprudence

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"Love Is Just A Four-Letter Word": Sexuality, International Human Rights, and Therapeutic Jurisprudence

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One of the most controversial social policy issues that remains underdiscussed in scholarly literature is the sexual autonomy of persons with disabilities. This population has faced a double set of conflicting prejudices: on one hand, people with disabilities are infantilized (as not being capable of having the same range of sexual desires, needs and expectations as persons without disabilities), and on the other hand, this population is demonized (as being hypersexual, unable to control primitive urges). Although attitudes about the capabilities of persons with disabilities are changing for the better, attitudes toward persons with disabilities engaging in sexual behavior have remained firmly in place for centuries. However, the ratification of the United Nations' Convention on the Rights of Persons with Disabilities (CRPD) demands we reconsider these attitudes.

This paper will (1) review the history of how legal and social issues regarding sexuality have been ignored and trivialized by policy makers and the general public; (2) highlight sections of the CRPD that force us to reconsider the scope of this issue; (3) offer suggestions as to how states must change domestic policy to comport with CRPD mandates; and (4) consider the implications of therapeutic jurisprudence insights for the resolution of these issues.

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I. Introduction

One of the most controversial social policy issues that remains dramatically under-discussed in scholarly literature is the sexual autonomy of persons with psychosocial and intellectual disabilities, especially those who are institutionalized. This population – always marginalized and stigmatized – has traditionally faced a double set of conflicting prejudices: on one hand, people with disabilities are infantilized (as not being capable of having the same range of sexual

A portion of this paper was presented (by MLP) at the Biennial Congress of the International Academy of Law and Mental Health, July 2013, Amsterdam, The Netherlands. The authors wish to thank Dr. Maya Sabatello for her sharing of Israeli source materials.

desires, needs and expectations as persons without disabilities), and on the other hand, this population is demonized (as being hypersexual, unable to control base or primitive urges).[1] Although attitudes about the abilities and capabilities of persons with disabilities are changing for the better, it remains true that, "many people still struggle to accept that mentally disabled individuals engage in sexual activity."[2] Even as the "sexual revolution" in the United States recognized sex and sexuality were needs rather than simply desires, persons with disabilities were left out of this shift in perception.[3] Attitudes toward persons with disabilities engaging in

1. See *e.g.* Maya Sabatello, "Disability, Human Rights and Global Health: Past, Present, Future" in Michael Freeman, Sarah Hawkes & Belinda Bennett, eds, *Law and Global Health: Current Legal Issues*, vol 16 (Oxford: Oxford University Press, 2014) ("women with disabilities are … assumed to be a-sexual, sexually inactive or else, that their sexuality and fertility should be controlled" (emphasis added) at manuscript 8) [Sabatello, "Disability, Human Rights and Global Health"]. Compare Doug Jones, "Domestic Violence Against Women With Disabilities: A Feminist Legal Theory Analysis" (2007) 2:1 Florida A&M University Law Review 207 ("[p]erhaps the most significant myth is that women with disabilities are asexual" at 223); Andreas Dimopoulos, "Let's Misbehave: Intellectual Disability and Capacity to Consent to Sex" (paper delivered at the Society of Legal Scholars, Faculty of Law, Brunel University, 1 September 2012), online: SSRN <http://ssrn.com/abstract=2332259> (discussing the "social stereotype for persons with intellectual disability that they should not be having sex, that they should be asexual" at 9); Rangita de Silva de Alwis, "Mining the Intersections: Advancing the Rights of Women and Children with Disabilities Within an Interrelated Web of Human Rights" (2009) 18 Pac Rim L & Pol'y J 293 (women with disabilities are especially vulnerable to "the imposition of social stereotypes of asexuality and passivity" at 296), to Amy Spady, "The Sexual Freedom of Eve: A Recommendation for Contraceptive Sterilization Legislation in the Canadian Post Re Eve Context" (2008) 25 Windsor Rev Legal Soc Issues 33 ("[i]t is accepted that many persons with mental disabilities experience the same, if not greater, sexual urges as other individuals" at 56).
2. Maura McIntyre, "Buck v. Bell and Beyond: A Revised Standard to Evaluate the Best Interests of the Mentally Disabled in the Sterilization Context" (2007) 1:4 U Ill L Rev 1303 at 1309.
3. Oana Georgiana Girlescu, *Sexuality and Disability: An Assessment of Practices Under the Convention for the Rights of Persons with Disabilities* (Master of Laws in Human Rights Thesis, Central European University, 2012) [unpublished]. See Balázs Tarnai, "Review of Effective Interventions for Socially Inappropriate Masturbation in Persons with Cognitive Disabilities" (2006) 24:3 Sexuality and Disability 151 (quoting

sexual behaviour have remained firmly in place for centuries; perhaps the most famous characterization remains US Supreme Court Justice Oliver Wendell Holmes's line in *Buck v Bell*,[4] a case involving sterilization of a woman allegedly intellectually disabled: "[t]hree generations of imbeciles are enough."[5] People with disabilities, simply put, are frequently stripped of their sexuality.[6]

The ratification of the United Nations' *Convention on the Rights of Persons with Disabilities* (CRPD)[7] demands that we reconsider this issue. In light of Convention Articles mandating, *inter alia*, "respect for inherent dignity,"[8] the elimination of discrimination in all matters

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the director of a large German institution: "[s]exual expression is not a problem for people with cognitive disabilities – but for those who work with them" at 151).

4. 274 US 200 (1927).
5. *Ibid* at 207. The underpinnings of Holmes' arguments are eviscerated and shredded in Paul A Lombardo, *Three Generations, No Imbeciles: Eugenics, the Supreme Court, and Buck v. Bell* (Baltimore: John Hopkins University Press, 2008). Beyond the scope of this paper are the issues that are raised in what is known as "growth attenuation surgery" – when parents of young children with severe disabilities choose to have them undergo hysterectomies to avoid the onset of menstruation, mastectomies to prevent breast development, and the administration of high doses of estrogen to ensure that the children remain at a size that would facilitate care. See *e.g.* Alicia R Ouellette, "Growth Attenuation, Parental Choice, and the Rights of Disabled Children: Lessons from the Ashley X Case" (2008) 8:2 Houston Journal of Health Law and Policy 207 at 210-17 (discussing the "Ashley X" case); Ravi Malhotra & Katharine Neufeld, "The Legal Politics of Growth Attenuation" (2013) 34 Windsor Rev Legal Soc Issues 105.
6. Michael Oliver, *Understanding Disability: From Theory to Practice* (New York: Palgrave Macmillan, 1996).
7. 30 March 2007, 2515 UNTS 3 [CRPD]; see generally Michael L Perlin, *International Human Rights and Mental Disability Law: When the Silenced are Heard* (USA: Oxford University Press, 2011) at 143-49 [Perlin, *International Human Rights*].
8. CRPD, *supra* note 7, Article 3. On how dignity is the first "fundamental axiom" upon which the Convention is premised, see Raymond Lang, "The United Nations Convention on the Right and Dignities for Persons with Disability: A Panacea for Ending Disability Discrimination?" (2009) 3 ALTER: European Journal of Disability Research 266 at 273. On the relationship between human dignity and "inner worth," see Amanda Ploch, "Why Dignity Matters: Dignity and the Right (or Not) to

related to interpersonal relationships,[9] and services in the area of sexual and reproductive health,[10] it is time for a radical change of perspective and attitude in how society views the sexuality, and right to express that sexuality, of persons with disabilities. Following the approach already adopted in international law, society as a whole must recognize that "[b]eing deemed a 'person' or sexual is not contingent upon ability."[11] Yet, the literature surrounding the sexual autonomy and issues of sexuality that people with disabilities continue to confront remains remarkably silent on this issue in general,[12] and totally silent about the issue we discuss in this paper: the CRPD's impact on the rights to sexual autonomy for persons institutionalized because of psychosocial or intellectual disability.[13]

This subject is particularly nettlesome in light of another reality.

Rehabilitation from International and National Perspectives" (2012) 44:3 NYU Int'l L & Pol 887 at 895-96.

9. CRPD, *supra* note 7, Article 23.
10. *Ibid,* Article 26.
11. Bethany Stevens, "Structural Barriers to Sexual Autonomy for Disabled People" (2011) 38:2 Human Rights 14 at 16; Girlescu, *supra* note 3 at 16.
12. On how the entire question is often seen as "taboo," see *e.g.* Michael L Perlin, "'Make Promises by the Hour': Sex, Drugs, the ADA, and Psychiatric Hospitalization" (1997) 46:4 DePaul L Rev 947 [Perlin, "Promises by the Hour"] ("[t]he taboo and stigma attached to sexual behaviour is inevitably heightened when it is coupled with and conflated with stereotypes of the meaning of mental disability" at 965); from a clinical perspective, see *e.g.* Eddie McCann, "The Expression of Sexuality in Persons with Psychosis: Breaking the Taboo" (2000) 32:1 Journal of Advanced Nursing 132 [McCann, "Breaking the Taboo"].
13. Special issues may be raised in cases of individuals with autism or those with autism spectrum disorders (ASD). Compare Laura Gilmour, Melike Schalomon & Veronica Smith, "Sexuality and ASD: Current State of Research" in Vanood E Patel et al, eds, *Comprehensive Guide to Autism* (New York: Springer New York, 2014) 569 at 569 (people with ASD have sexual interests and engage in sexual behaviours with others), to Laura Gilmour, Melike Schalomon & Veronica Smith, "Sexuality in a Community Based Sample of Adults with Autism Spectrum Disorder" (2012) 6:1 Research in Autism Spectrum Disorders 313 (although individuals with ASD display an interest in sex and engage in sexual behaviours and showed no significant differences in breadth and strength of sexual behaviours and comprehension of sexual language when contrasted with non-ASD participants, nonetheless, a higher rate of asexuality was found among individuals with ASD).

One of the authors (MLP) has spent over 40 years involved with mental disability law as a legal practitioner, advocate, academic and scholar. The other author (AJL) has just embarked on her career as a lawyer on behalf of these populations. Through our careers, one thing has been clear. *Nothing* has ever touched as raw of a nerve as our discussion concerning whether persons with mental disabilities have a right to voluntary sexual interaction, especially when such individuals are institutionalized.[14] Why is this? And how does this relate to "sanism" – an irrational prejudice of the same quality and character as other irrational prejudices that cause and are reflected in prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry[15] – that permeates all aspects of mental disability law and affects all participants in the mental disability law system: litigants, fact finders, counsel, and expert and lay witnesses.[16] Consider this conclusion:

> Society tends to infantilize the sexual urges, desires, and needs of the mentally disabled. Alternatively, they are regarded as possessing an animalistic hypersexuality, which warrants the imposition of special protections and

14. For a discussion of hostile audience reaction to presentations about this topic, see Michael L Perlin, "'Limited in Sex, They Dare': Attitudes Toward Issues of Patient Sexuality" (2005) 26:3 American Journal of Forensic Psychiatry 25. Eddie McCann has speculated that this may be because of a fear that simply *addressing* this issue "will be seen as actively encouraging widespread institutional promiscuity"; see McCann, "Breaking the Taboo", *supra* note 12 at 133. On how institutionalization may be a "compounding" problem in this context, see McCann "Breaking the Taboo", *supra* note 12 at 133.
15. The word "sanism" was, to the best of our knowledge, coined by Dr. Morton Birnbaum. See Morton Birnbaum, "The Right to Treatment: Some Comments on Its Development" in Frank Ayd, ed, *Medical, Moral and Legal Issues in Mental Health Care* (Balitmore: Williams & Wilkins, 1974) 97 at 105; see also *Koe v Califano*, 573 F (2d) 761 at 764, n 12 (2d Cir 1978). We believe it best explains the roots of our attitudes towards persons with mental disabilities. See *e.g.* Michael L Perlin, "'Half-Wracked Prejudice Leaped Forth': Sanism, Pretextuality, and Why and How Mental Disability Law Developed as it Did" (1999) 10 J Contemp Legal Issues 3; see generally, *e.g.* Michael L Perlin, *The Hidden Prejudice: Mental Disability on Trial* (Washington, DC: American Psychological Association, 2000).
16. On the way that sanism affects lawyers' representation of clients, see Michael L Perlin, "'You Have Discussed Lepers and Crooks': Sanism in Clinical Teaching" (2003) 9:2 Clinical L Rev 683 at 689-90.

> limitations on their sexual behavior to stop them from acting on these "primitive" urges. By focusing on alleged "differentness," we deny their basic humanity and their shared physical, emotional, and spiritual needs. By asserting that theirs is a primitive morality, we allow ourselves to censor their feelings and their actions. By denying their ability to show love and affection, we justify this disparate treatment.[17]

The foregoing observation may best explain the difficulty so many of us have in dealing with the question of the sexual autonomy of persons with disabilities, and explains why policymakers are often unable to approach such issues thoughtfully, even-handedly, and with clear heads. There is no question that Dr. Julie Tennille's observation – "individuals with mental health conditions face additional obstacles to exploring their sexuality and forging satisfying intimate relationships"[18] – must be "center stage" for this entire investigation. We must accept the reality that virtually all people are "sexual beings."[19]

This paper will (1) briefly review the history of how significant legal and social issues regarding sexuality have been ignored and trivialized by legislators, policy makers, and the general public; (2) highlight those sections of the CRPD that force us to reconsider the scope of this issue; (3) offer some suggestions as to how ratifying and signatory states must change domestic policy so as to comport with CRPD mandates; and (4) consider the implications of therapeutic jurisprudence insights for the resolution of these issues.

The article title draws, in part, on Bob Dylan's song *Love Is Just a Four-Letter Word,*[20] a song that Dylan has never sung (although it remains

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17. Michael L Perlin, "Hospitalized Patients and the Right to Sexual Interaction: Beyond the Last Frontier?" (1994) 20:3 NYU Rev L & Soc Change 517 at 537 [Perlin, "Beyond the Last Frontier?"]. For a subsequent consideration of the impact of this infantilization, see Janine Benedet & Isabel Grant, "Hearing the Sexual Assault Complaints of Women with Mental Disabilities: Evidentiary and Procedural Issues" (2007) 52:3 McGill LJ 515.
18. Julie Tennille & Eric Wright, *Addressing the Intimacy Interests of People with Mental Health Conditions: Acknowledging Consumer Desires, Provider Discomforts, and System Denial* (2013) at 2 [unpublished monograph, archived at <http://tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/relationships_family_friends_intimacy/intimacy.pdf>].
19. McCann, "Breaking the Taboo", *supra* note 12 at 134.
20. Bob Dylan, "Love is Just a Four-Letter Word", online: The Official Bob

a frequent staple in Joan Baez's repertoire).[21] The standard "take" on the song is that it is "the bridge between his [Dylan's] end-of-relationships blues and his giddy poetic streaks."[22] Yet, consider these lines in the context of the arguments we make in this paper:

> She sat with a baby heavy on her knee
> Yet spoke of life most free from slavery

and

> To you I had no words to say
> My experience was limited and underfed
> You were talking while I hid

and

> Drifting in and out of lifetimes
> Unmentionable by name.[23]

We believe that there is a deep "fit" between these lyrics, the song's title, and the points we seek to make in this paper. Persons with disabilities seeking sexual autonomy are in a kind of emotional and physiological "slavery"; their experiences are certainly "limited and underfed," and what they wish for is seen, by so many, as "unmentionable by name." The idea that persons with disabilities can love and be loved *is* a "four letter word" to many. We use this lyric here to stress the sadness of that reality.

Dylan Site <http://www.bobdylan.com/us/home>.

21. See *e.g.* Scott Johnson, "Love is Just a Four-Letter Word", (blog), online: Power Line <http://www.powerlineblog.com/archives/2012/01/love-is-just-a-four-letter-word.php>. One of the authors (MLP) last saw her sing it on 11 November 2011. See online: Joan Baez <http://www.joanbaez.com/tourschedule11.html>.
22. Tim Riley, *Hard Rain: A Dylan Commentary* (New York: Random House, 1992) at 109.
23. Dylan, *supra* note 20.

II. How Sexuality Issues Have Been Treated by Law and Society

A. In Psychiatric Institutions[24]

1. An Overview

Before we can analytically approach the question of whether institutionalized persons with mental disabilities have the right to engage in consensual sexual activity, we must attempt some modest deconstruction. No doctrinal or theoretical formulation can be seriously undertaken until we articulate our perspective. Are we looking for a legal answer, a clinical answer, a social answer, an administrative answer, or a behavioural answer (or, as we should, a combination of all of these)? Surely we must consider each area of analysis separately, and in concert with each other, if we wish to construct a meaningful, multi-textured, and comprehensive response.

2. What is Meant by "Sex"?

Twenty years ago, one of the authors (MLP) noted:

> We must consider whether any of these answers depends upon our definition of sex. Do we need to consider every possible permutation of sexual behavior? Does it make a difference if we are discussing monogamous heterosexual sex, polygamous heterosexual sex, monogamous homosexual sex, polygamous homosexual sex, or bisexual sex? Does sex mean intercourse? What about oral sex? Anal sex? Masturbation? Voyeurism? Exhibitionism?[25]

It probably makes sense, at the outset, to keep in mind that any consideration of the issues under discussion here must, at the least,

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24. This section is largely adapted from Perlin, "Beyond the Last Frontier?", *supra* note 17 at 522-28.
25. Perlin, "Beyond the Last Frontier?", *supra* note 17 at 527, citing in part to Michael L Commons et al, "Professionals' Attitudes Towards Sex Between Institutionalized Patient" (1992) 46:4 American Journal of Psychotherapy 571 (discussing ways that mental health professionals' attitudes towards sex are influenced by the nature of the sexual activity and the patients' sexual orientation). See *e.g.* Stevens, *supra* note 11 ("[i]n the limited amount of cases where sexual activity is permitted, it is generally only heterosexual marital sex that is allowed" at 16).

take into account the realities that "sex" means much more than simply heterosexual intercourse. Although an exhaustive discussion of all permutations is not possible here, we will discuss briefly the question of sexual-contact-other-than-"standard"-intercourse, the surprisingly nettlesome issue of masturbation, and the most controversial question of compensated sexual assistance.

i. Other kinds of Sex

A recent article – about a civil law suit that followed litigation over a long-term relationship between a man with a psychosocial disability (schizophrenia) and a priest with AIDS – questions whether sex can be ordered like a "Guttman scale,"[26] involving a "unidimensional behavioral hierarchy from French kissing to penetrative intercourse,"[27] and wonders if "someone has consented to touching genitals over clothing … implies consent to French kissing,"[28] asking whether "consent to one step automatically insure[s] consent to others below it?"[29] This article does not begin to answer the preceding question, but the perspective of ordering is raised here to clarify that sex and sexual activities are not "unidimensional" questions, and that policymakers should be aware of the complexity of these issues.

With non-normative sexual behaviour (including sexual activities engaged in with and without a partner) come other discriminatory beliefs by the majority of society that sub-cultures practicing such behaviours are "different" and "abnormal." While there are many variations of sexual behaviour, we will briefly examine the issues surrounding masturbation

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26. In which items are arranged in an order so that an individual who agrees with a particular item also agrees with items of lower rank-order. See *e.g.* Judy A Andrews et al, "The Construction, Validation and Use of a Guttman Scale of Adolescent Substance Use: An Investigation of Family Relationships" (1991) 21:3 Journal of Drug Issues 557; Andreas Mokros et al, "Pychopathy and Sexual Sadism" (2011) 35:3 Law & Human Behavior 188 at 192.
27. Paul R Abramson, Terry Gross & Annaka Abramson, "Consenting to Sex and Severe Mental Illness: *Terra Incognita* and a Priest with AIDS" (2012) 30:3 Sexuality and Disability 357 at 362.
28. *Ibid.*
29. *Ibid.*

and sexual surrogates, since some amount of research has been done in evaluating their impact on the community of persons with disabilities.

ii. Masturbation[30]

Although at least one study has found that staff workers at a medium-security facility for persons with intellectual disabilities generally held "liberal attitudes" toward masturbation,[31] and another article has called for "masturbation training,"[32] much controversy swirls around the question of *facilitated* masturbation and the role of the caregiver in the facilitation process.[33] It goes without saying that this is an issue that must

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30. On the roots of the 19th century view that masturbation was a cause of mental disorder, see EH Hare, "Masturbatory Insanity: The History of an Idea" (1962) 108 Journal of Mental Science 1.

31. Linda Yool et al, "The Attitudes of Medium-Secure Unit Staff Toward the Sexuality of Adults with Learning Disabilities" (2003) 21:2 Sexuality and Disability 137. On the needs of staff in dealing with sexuality issues, see generally Sharon Foley & Grace Kelly, *Friendship and Taboos: Research on Sexual Health Promotion for People with Mild to Moderate Intellectual Disabilities in the 18-25 Age Range: Results of a Consultation Process and Literature Review* (Cork: Health Service Executive South, 2009); see also Mental Welfare Commission for Scotland, *Consenting Adults? Guidance for Professionals when Considering Rights and Risks in Sexual Relationships Involving People with a Mental Disorder* (Edinburgh: Mental Welfare Commission for Scotland, 2011).

32. Michael Gill, "Sex Can Wait, Masturbate: The Politics of Masturbation Training" (2012) 15:314 Sexualities 472; see generally Frederick Kaeser, "Developing a Philosophy of Masturbation Training for Persons with Severe or Profound Mental Retardation" (1996) 14:4 Sexuality and Disability 295. Virtually all of the literature focuses solely on issues of *males* masturbating as "the sexuality and sexual experiences of women with … disabilities have remained relatively hidden," see Paul Cambridge, Steven Carnaby & Michelle McCarthy, "Responding to Masturbation in Supporting Sexuality and Challenging Behaviour in Services for People with Learning Disabilities" (2003) 7:3 Journal of Learning Disabilities 251 at 253. See also, *e.g.* Dorothy M Bell & Lois Cameron, "The Assessment of the Sexual Knowledge of a Person with Severe Learning Disability and a Severe Communication Disorder" (2003) 31:3 British Journal of Learning Disabilities 123 at 128 (discussing a woman with limited verbal communication who "appeared to have no recognition of female masturbation").

33. See *e.g.* Sara Earle, "Disability, Facilitated Sex, and the Role of the Nurse" (2001) 36:3 Journal of Advanced Nursing 433.

be subject to discussion in an "open and value-free environment."[34]

iii. Care Workers

Perhaps the most controversial question – in a *sea* of controversial questions – is the appropriateness of using care workers as sexual surrogates in cases involving persons with disabilities. Such surrogacy can involve masturbation or intercourse.[35] Several European nations – including The Netherlands, Germany, Denmark, and Switzerland – allow "limited 'touching' services for [persons with severe disabilities] through non-profit organizations."[36] Elsewhere, there are organizations in Canada,[37] Australia,[38] Japan,[39] and New Zealand,[40] that, in the words of the Australian-based Touching Base website, "developed out of the need to assist people with disability and sex workers to connect with each other, focusing on access, discrimination, human rights and legal issues and the attitudinal barriers that these two marginalised communities can face."[41] An administrative decision in Denmark has approved the payment of social welfare funding for an "escort girl" as a "handicap benefit."[42]

It has been suggested by one medical ethicist that "jurisdictions that

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34. Clive Glass & Bakulesh Soni, "Sexual Problems of Disabled Patients" (1999) 318:7182 British Medical Journal 518. At least one academic consideration of the issue has noted that, concern within services often returns to the question of "whether such interventions, if successful, will then lead to the person spending too much time masturbating, as they may have learnt how to do it well and effectively," see Cambridge, Carnaby & McCarthy, *supra* note 32 at 260.
35. See online: Touching Base Inc <http://www.touchingbase.org/>.
36. Jacob Appel, "Sex Rights for the Disabled?" (2010) 36:3 Journal of Medical Ethics 152 at 153.
37. See online: EASE Canada <http://easecanada.org/>.
38. See Touching Base, *supra* note 35; online: Scarlet Road <http://www.scarletroad.com.au>.
39. See online: White Hands <http://www.whitehands.jp/e.html>.
40. See online: Paths Together <https://www.facebook.com/pages/PathsTogether/552620 361438711>.
41. See Touching Base, *supra* note 35.
42. See email from Professor Kirsten Ketscher, WELMA – Centre for Legal Studies in Welfare and Market, Faculty of Law, University of Copenhagen (30 December 2013) (discussing the decision in Escort Girl C-106 Danish Social Appeals Board).

prohibit prostitution should carve out narrow exceptions for individuals whose physical or mental disabilities make sexual relationships with non-compensated adults either impossible or highly unlikely."[43] Although there is at least one report of this having been done using Social Security funds in the USA,[44] it is clearly an idea that has not gained significant traction in that jurisdiction. In fact, any such use of sexual surrogacy has been sharply criticized as "distort[ing] sympathies for the situations of people with disabilities to promote prostitution."[45]

This question, out of all those that arise when looking at sexual autonomy for persons with disabilities, is compounded by societal views about prostitution, exacerbated by the often-sanist thinking about the sexual needs of persons with disabilities.[46] It is not surprising to see that nations that have legalized the profession of sex worker are more likely to have opportunities for sexual surrogacy.[47] These nations are allowing some of the stigma surrounding sex (and in particular, sex for people with disabilities) to be lifted, leading to a more honest discussion about meeting the basic needs of people, including the need for sex.

Sexual surrogacy also challenges society to imagine that a non-disabled person would be willing to engage in sexual activity with a disabled person. Entrenched sanism and long-standing fear of "contamination" or

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43. Appel, *supra* note 36 at 153. But see Ezio Di Nucci, "Sexual Rights and Disability" (2011) 37:3 Journal of Medical Ethics 158 (criticizing Appel's position).
44. See David J Lillesand & Gina M Nguyen, SSI Trust and Transfer Rules, 17 NAELA Q 3 (Spring 2004) (recounting case where a "sympathetic sister/trustee purchased 'entertainment services,' consisting of nursing home visits by 'escort services' personnel to the nursing home where her severely disabled and dying brother resided").
45. Dianne Post, "Legalization of Prostitution Is a Violation of Human Rights" (2011) 68:2 National Lawyers Guild Review 65 at 92.
46. See generally Perlin, "Beyond the Last Frontier?" *supra* note 17; Michael L Perlin, "'Everybody Is Making Love/Or Else Expecting Rain': Considering the Sexual Autonomy Rights of Persons Institutionalized Because of Mental Disability in Forensic Hospitals and in Asia" (2008) 83:4 Wash L Rev 481 [Perlin, "Everybody is Making Love"].
47. See *e.g.* The Legal Status of Prostitution by Country, online: Charts Bin <http://chartsbin.com/view/snb> (listing nations in which sex work is legal, overlapping in a large part with nations in which surrogates may be used, as discussed in *supra* notes 35-42 and accompanying text).

disability as a "contagion" also make this concept a difficult one to grasp for many who may be confronted with this form of sexuality.[48]

Although surrogacy is not identical to engaging in an emotional relationship in which sex is a component, it is yet another option for people with disabilities to gain some autonomy in their decision making about their own needs. Under the CRPD, they have the same right to engage in sex that non-disabled people do,[49] and surrogacy may afford an opportunity to those people who are, for many reasons, unable to or uninterested in engaging in a non-surrogate sexual relationship.

The differences between nations' views on the "acceptability" of masturbation and sexual surrogacy are also indicative of those nations' dominant norms and values. Professor Elaine Craig has discussed the danger of regulating activity based on the dominant norms of a society, stating that if legal standards are applied based only on dominant belief systems, they "[privilege] dominant social, cultural and religious practices."[50] Further, in the context of consent laws, she notes that "[s]ocial approval is not an equitable basis upon which to criminalize particular sexual activities."[51] Although the disability rights movement has made great strides, persons with disabilities continue to remain a minority group, rather than a part of the dominant culture in most nations.[52] Their

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48. See *e.g.* Judith S Neaman, *Suggestion of the Devil: The Origins of Madness* (Garden City, NY: Anchor Press, 1975) at 31, 144 (addressing the stereotype of persons with mental illness as evil), cited in Michael L Perlin, "'She Breaks Just Like a Little Girl': Neonaticide, The Insanity Defense, and the Irrelevance of Ordinary Common Sense" (2003) 10:1 Wm & Mary J Women & L 1 at 9, n 54 [Perlin, "Neonaticide"].
49. See CRPD, *supra* note 7, Article 23 (discussed in this context, see text accompanying note 103).
50. Elaine Craig, "Capacity to Consent to Sexual Risk" (2014) 17:1 New Criminal Law Review 103 at 117.
51. *Ibid.*
52. Interestingly, much of the literature about the CRPD has focused upon persons with disabilities as the "world's largest minority," see *e.g.* Rosemary Kayess & Phillip French, "Out of Darkness into Light? Introducing the Convention on the Rights of Persons with Disabilities" (2008) 8:1 Human Rights Law Review 1 at 4, n 16, discussed in this context in, *inter alia*, Michael L Perlin, "'Striking for the Guardians and Protectors of the Mind': The Convention on the Rights of Persons with Mental Disabilities and the Future of Guardianship Law" (2013) 117:4 Penn St L Rev 1159

rights and needs may not be legislated away by that dominant culture because majority populations believe sexual activities of persons with disabilities do not produce "socially desirable cultural products."[53]

B. Current Laws Relating to Sexual Autonomy of Persons with Disabilities

As noted previously, discussion of sexual autonomy relating to persons with disabilities are few and far between in scholarly journals. In the United States, the law has followed this trend, with very little attention paid to the legal rights of persons with disabilities to exercise their autonomy, especially in an institutional setting. Many critical questions remain unanswered in the law, leaving hospitals and community treatment facilities to decide for themselves how to best deal with these issues. Often, these decisions are made with no clear guidelines and carried out on a case-by-case basis. Remarkably, none of the respondents questioned in a British study were even *aware* that they had *any* "sexual rights."[54] And we virtually never consider the argument posited by the medical ethicist Jacob Appel in this context that sexual *pleasure* is a *fundamental* human right.[55]

The United States Supreme Court, federal district courts, and state courts have all addressed the range of constitutional rights held by involuntarily committed individuals, such as the right to counsel,[56]

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at 1173, n 62 [Perlin, "Striking for the Guardians"].

53. Craig, *supra* note 50 at 117.
54. McCann, "Breaking the Taboo", *supra* note 12 at 136.
55. Appel, *supra* note 36 at 154. See also Stevens, *supra* note 11 ("[p]oliticizing sexual pleasure and oppression of disabled people through enacting cripsex is a powerful way to affirm our humanity," where author defines "cripsex" to "express the political nature of the sexuality of disabled people" at 16). Compare Di Nucci, *supra* note 43 at 160 (responding to Appel, and disagreeing with this thesis, in large part, because, if Appel's theory was to be adopted, "we would end up with a situation in which severely disabled people have their sexual satisfaction paid for them by the state, while everybody else will have to pay for it, or go through the trouble of finding willing non-compensated sexual partners").
56. *In the matter of the Mental Health of KGF*, 29 P (3d) 485 at 491 (Mont Sup Ct 2001).

the right to refuse medication,[57] and the right to be treated in the least restrictive environment,[58] to name but a few.[59] The number of cases litigated by persons with disabilities has grown exponentially since the 1970s.[60] However, the right to sexual autonomy has remained an elusive topic, with very few references to it in any major state or federal court decision involving persons with disabilities.[61]

Legislation has also failed to adequately address issues of sexual autonomy both in and out of mental health facilities. A case may be made for regulations or laws allowing sexual activity in certain settings based on domestic disability anti-discrimination laws. If sexual activity is banned for no other reason than the "disabled" status of the consenting adults wishing to engage in such activity, it may be argued that this sort of *per se* discrimination violates the *Americans with Disabilities Act* or other similar pieces of legislation.[62]

C. The Effects of Institutionalization on Persons with Disabilities and Sexual Autonomy

Next, we must consider the practical implications of sexual relationships in a closed institution like a psychiatric hospital.[63] Under the best of

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57. *Riggins v Nevada*, 504 US 127 (1992).
58. *Olmstead v LC*, 527 US 581 (1999).
59. The broad range of topics also includes competency evaluations for mentally ill criminal defendants (*Dusky v United States*, 362 US 402 (1960); *Drope v Missouri*, 420 US 162 (1975); *Pate v Robinson*, 383 US 375 (1966)); illegality of indefinite confinement of persons found incompetent to stand trial (*Jackson v Indiana*, 406 US 715 (1972)); prisoners' rights (*Estelle v Gamble*, 429 US 97 (1976); *Washington v Harper*, 494 US 210 (1990)); the civil commitment process (*Addington v Texas*, 441 US 418 (1979)); and rights of civilly committed patients (*Youngberg v Romeo*, 457 US 307 (1982); *O'Connor v Donaldson*, 422 US 563 (1975)).
60. See Michael L Perlin, *Mental Disability Law: Civil and Criminal*, 2d ed, vol 1 (Charlottesville, VA: Lexis Law Publishing, 1998) at § 1-1, 1 [Perlin, *Mental Disability Law*] (discussing the "astonishing development of mental disability litigation" over past decades).
61. But see *Foy v Greenblott*, 190 Cal Rptr 84 (Ct App 1983) discussed below and notes 91-95 and accompanying text.
62. See generally Perlin, "Promises by the Hour", *supra* note 12.
63. On the issues of sexual autonomy in *forensic* facilities in general, see

circumstances, entering into a new sexual relationship can be stressful and confusing. Are these stresses "inappropriately" exacerbated when the universe in question is that of institutionalized mental patients? To what extent should the differing stress management abilities of institutionalized individuals be factored into any policy ultimately adopted? Conversely, can preoccupation with sex systemically distort all matters involving ward behaviour? How does this focus affect questions of individual versus group needs? Might an excessive concern with sex blunt the consideration of other related issues, such as self-esteem, the importance of developing a full range of interpersonal relationships, and the ability to deal with intimacy? We impose significant barriers that prevent institutionalized persons with mental disabilities from establishing intimacy.[64] Yet, one study showed that most patients in *high-security* hospitals "valu[ed] being in a caring relationship [while] in the hospital,"[65] and that there was likely "an ongoing desire for intimacy regardless of gender, diagnosis or offense group."[66]

A closed institution, by its nature, places substantial limits on individuals' mobility and freedom of action. In considering how best to allow individuals to express their autonomy, it is important to consider all aspects of a relationship, including issues indirectly raised by sexual intimacy. For example, when people in the "free world" terminate a

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Perlin, "Everybody is Making Love", *supra* note 46. On the relationship between the CRPD and forensic facilities in general, see Michael L Perlin & Meredith R Schriver, "'You That Hide Behind Walls': The Relationship between the Convention on the Rights of Persons with Disabilities and the Convention Against Torture and the Treatment of Institutionalized Forensic Patients" in *Torture in Healthcare Settings: Reflections on the Special Rapporteur on Torture's 2013 Thematic Report* (American University: Center for Human Rights & Humanitarian Law, 2013) at 195; Michael L Perlin & Alison J Lynch, "'Toiling in the Danger and in the Morals of Despair': Risk, Security, Danger, the Constitution, and the Clinician's Dilemma" (2015) 26 Stan L & Pol'y Rev – [in press].

64. On the "false assumptions" made by many care providers about the "fundamental importance of intimacy to consumer well-being," see Tennille & Wright, *supra* note 18 at 9.

65. See Heidi Hales et al, "Sexual Attitudes, Experience and Relationships Amongst Patients in a High Security Hospital" (2006) 16:4 Criminal Behaviour and Mental Health 254 at 260.

66. *Ibid.*

stormy love affair, frequently they can adjust their lives so as not to have much contact with their former lovers. What happens if that ex-lover lives on the same floor of an inpatient hospital (especially if it is a locked ward hospital), and neither patient can leave without a court order? Conversely, what happens when a couple is split up by a court order transferring one patient to another ward or facility for clinical or legal reasons?[67] These are decisions that must be considered in order to allow individuals confined in an institution the ability to engage in a relationship just as they would in the "free world." Although an institution may need to restrict some privileges based on safety or treatment concerns, it will be critical for institutions to consider a "least restrictive environment" approach when dealing with patients' sexual autonomy, as it is undoubtedly part of their rights under the CRPD.

Another series of issues to consider comes from differences in the status of institutionalized persons.[68] Those institutionalized after being civilly committed, ordered confined for a competency evaluation, or held in a locked facility after a plea of not guilty by reason of insanity each have rights and aspects of law that are unique to each particular status. Assuming the individuals wishing to engage in sexual activity are competent to consent,[69] are all patients to be treated in the same way, or are there differences between voluntarily and involuntarily committed

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67. This is made more complicated by decisions such as *Kulak v City of New York*, 88 F (3d) 63 at 73 (2d Cir 1996) (no liberty interest created by court recommendation that mental hospital transfer involuntarily-committed patient to less restrictive environment because transfer was not mandatory).

68. See *e.g.* Michael L Perlin, "'Too Stubborn To Ever Be Governed By Enforced Insanity': Some Therapeutic Jurisprudence Dilemmas in the Representation of Criminal Defendants in Incompetency and Insanity Cases" (2010) 33:5-6 Int'l J L & Psychiatry 475 at 480 (discussing significance of patients' "litigational status" on questions involving right to refuse treatment).

69. The topic of competency to consent to sexual activities in a psychiatric institution is an extremely complex topic that should be addressed separately, in great depth. See generally Michael L Perlin & Alison J Lynch, "'All His Sexless Patients': Persons with Mental Disabilities and the Competence to Have Sex" (2014) 89:2 Wash L Rev 257 [Perlin, "All His Sexless Patients"]. For the purposes of this paper, the authors choose to assume the individuals discussed are legally competent to consent.

patients that are relevant to this inquiry? Further, should involuntary commitment implicitly restrict one's freedom to engage in sexual activity? Is it justifiable, or even legally required, to place different restrictions on patients who have been committed following their involvement in the criminal justice system, in comparison to those imposed on civilly committed patients? If competency to consent is not at issue, disallowing sexual activity solely based on legal status appears punitive, rather than therapeutic.

Ultimately, the lingering question when considering sexual autonomy of institutionalized persons is, in any event, can patients be stopped from having sex?

D. Clinical Questions Regarding Sexual Autonomy of Persons with Disabilities

Next, we must consider clinical questions. A patient's treatment team is charged with finding the most therapeutic treatment in the least restrictive environment. For many patients, this involves therapy intended to help them transition back to living in the "real world." That can include behavioural therapy and group programs that encourage social interaction. Questions of sexual autonomy should also be considered within that context in developing and assessing a treatment plan and long-term goals for a patient both in and out of a treatment facility. For example, clinicians should note whether the patient in question ever expressed any wish to engage in sexual activity, and then discuss whether it is clinically beneficial or anti-therapeutic to allow institutionalized patients autonomy in sexual decision-making.[70] In answering this question, to what extent should clinicians consider research on the therapeutic value of touching and physical intimacy?[71] Should the projected length of a patient's

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70. On how interpersonal relationships among patients can help further treatment goals, see Edmund G Doherty, "Social Attraction and Choice Among Psychiatric Patients and Staff: A Review" (1971) 12:4 Journal of Health & Social Behavior 279 at 287. See also Stevens, *supra* note 11 ("[r]ecognition and expression of sexual autonomy has many health benefits, including analgesic effects, hypertension reduction, and increased relaxation" at 23).

71. See McCann, "Breaking the Taboo", *supra* note 12 (quoting patient,

hospitalization affect the restrictions placed on their sexual autonomy? If so, how?[72] What is the impact of sexual activity on different methods of treatment? On the overall ward milieu? What correlative responsibilities come with the assertion of rights? [73]

These questions also lead to a consideration of patient sexual autonomy from the perspective of hospital officials, and the reasons for their discomfort with the subject. Why are hospital administrators resistant to expanded sexual activity on the part of patients? Is it more than simple inconvenience, or even the fear of unwanted pregnancies? How much does a fear of a potential hospital-wide AIDS epidemic contribute to this resistance?[74] How realistic and genuine is this fear? The expansion of provider liability is the source of realistic concerns on the part of therapists that an ever-expanding range of clinical decisions may lead to ever-expanding personal liability.[75] One commentator has suggested that the threat of litigation has led hospital administrators to

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responding to survey question on the meaning of intimacy: "[s]ex, love, caring, *and sharing* … things like that" [emphasis added] at 136). There has been academic literature available about this for over 40 years, though it is rarely cited in the *legal* literature. See *e.g.* Ashley Montagu, *Touching: The Human Significance of Skin*, 2d ed (USA: Harper & Row, Publishers, 1971); Harry F Harlow, Margaret K Harlow & Stephen J Suomi, "From Thought to Therapy" (1971) 59:5 American Scientist 538. Professor Heather Ellis Cucolo has focused on this in her recent work on sex offenders. She asks why we fail to acknowledge that the concept of intimacy is "the key to preventing and minimizing re-offense." See Heather Ellis Cucolo, "Right to Sex in the Treatment and Civil Commitment of Sexual Violent Predators" (2007) [unpublished, on file with authors]. This is a reality that must be considered as we further explore this issue.

72. See generally Douglas J Mossman, Michael L Perlin & Deborah A Dorfman, "Sex on the Wards: Conundra for Clinicians" (1997) 25:4 Journal of the American Academy of Psychiatry and the Law 441.
73. Mossman, Perlin & Dorfman, *supra* note 72.
74. On the fear of an AIDS epidemic in the context of disability rights issues, see Samuel R Bagenstos, "The Americans with Disabilities Act as Risk Regulation" (2001) 101:6 Colum L Rev 1479 at 1492.
75. See *e.g.* Allison Faber Walsh, "The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations" (1997) 31:1 J Marshall L Rev 207; Robert John Kane, "Illinois Legal Developments Affecting Physicians and Hospitals" (2010) 31:1 J Legal Med 73.

"attempt to minimize the complexity of patient sexuality by focusing on the symbolic, simplistic reassurance of written procedures."[76] Was this response idiosyncratic to the circumstances at a particular hospital, or is this practice more common? Professor Bernadette McSherry and Professor Margaret Somerville note on this point:

> [E]ven if a written policy on sexual activity is put in place, the fear of litigation by institution administrators may still lead to the "policing" of such activity in case some form of harm may be taking place. The threat of litigation may therefore lead to staff members erring on the side of caution in relation to sexual activity among those in institutions.[77]

E. Cultural Issues Surrounding Sexual Autonomy of Institutionalized Patients

The nature of this topic makes it, inevitably, a contentious point among the various groups that will debate it, legislate it, and implement it. Beliefs and values beyond law and legislation are intertwined with attitudes toward sexual activity. Culture, politics, religion, and senses of "morality" are all elements that must be addressed in order to realistically work through these difficult issues and come to a consensus on the proper way to address them. Even if policies are promulgated to protect and respect the sexual autonomy of institutionalized individuals, what happens when individual line staff at a hospital, the people to whom the implementation of the policy inevitably falls, simply refuse to cooperate with the policy because their own sense of religious "morality" forbids it?[78] For example, their religion may teach that unmarried persons – of

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76. Terry Holbrook, "Policing Sexuality in a Modern State Hospital" (1989) 40:1 Hospital & Community Psychiatry 75 at 79 (discussing the results of a psychiatric hospital's failure to notify the police of the sexual assault of one patient by another).
77. Bernadette McSherry & Margaret A Somerville, "Sexual Activity Among Institutionalized Persons in Need of Special Care" (1998) 16 Windsor YB Access Just 90 at 124. On how the avoidance of anticipated prospective harm has become central to much of disability law policy in this area, see generally Dimopoulos, *supra* note 1 (Dimopoulos argues that, "[b]y seeking to avoid harm to self we are perpetuating oppressive social and legal responses which presented persons with disabilities as asexual, or worse still, as individuals who should be asexual" at 8).
78. In general, on the significance of care provider *discomfort* around sexual

any mental capacity – should not have sex, or that married persons – of any mental capacity – should not have extramarital sex. Is it justifiable for private facilities that are church-affiliated, or private nonsectarian facilities that retain units specially designated for practitioners of specific religions, to apply different restrictions in these areas?[79]

F. Conclusion

The issues discussed above should underscore the point that this topic is complex and under-considered in the literature and laws regarding persons with disabilities.[80] These complexities are compounded by society's generally irrational attitudes towards persons with mental disabilities.[81] The lack of attention, litigation, and commentary on this subject appears anomalous. Institutionalized persons self-evidently do not lose their sexuality or sexual desires when they lose their liberty. There is some added irony to be found in the fact that litigation over antipsychotic medication refusal – the most contentious aspect of institutionalized patients' rights law – centers on drug side effects, and the loss of sexual desire is one of the most highly-noted amongst them.[82] Thus, the law

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expression by persons with mental disabilities, see Tennille & Wright, *supra* note 18 at 8-9.

79. *Ibid* ("[f]aith-based provider services … often care for consumers who do not share the same religious traditions or spiritual beliefs about expressions of sexuality" at 11).

80. Suzanne Doyle, "The Notion of Consent to Sexual Activity for Persons with Mental Disabilities" (2010) 31:2 Liverpool Law Review 111.

81. See Tom Koch, "The Ideology of Normalcy: The Ethics of Difference" (2005) 16:2 Journal of Disability Policy Studies 123 at 125 (individuals with disabilities are thought to be "different" by society. The ideology of normalcy, which applies to issues facing individual with disabilities, is based on the idea that "persons of difference necessarily possess a diminished level of personhood" which extends to every aspect of their daily lives).

82. The loss of sexual desire as a side effect to be considered in determining the scope of patients' right to refuse treatment is weighed in, *inter alia*, *In re Orr*, 531 N E (2d) 64 at 74 (Ill App Ct 1988); *In re Roe*, 421 N E (2d) 40 at 54 (Mass Sup Ct 1981); *Jarvis v Levine*, 418 N W (2d) 139 at 145-46 (Minn Sup Ct 1988). See also Tennille & Wright, supra note 18 ("[b]eyond having difficulty merely meeting someone interesting with whom to become sexually intimate, an important part of the story for many consumers is the frustrating sexual dysfunction

acknowledges that sexual desire of a person in need of medication is a sufficiently important personal trait so that its diminution must be weighed into the formulation of a medication refusal policy. Yet the law simultaneously denies patients the power and importance of sexual desire with respect to hospital ward life.[83]

Most states do not recognize a patient's right to personal or interpersonal sexual relationships. In practice, a patient's right to sexual interaction often depends on the whim of line-level staff or on whether such interaction is seen as a feature of the patient's treatment plan. It has even been suggested that "sexual activity between psychiatric inpatients should be strictly prohibited and when it occurs patients should be isolated … and tranquilized if necessary."[84] One hospital's guidelines counsel patients as follows: "[i]f you develop a relationship with another patient, staff will get together with you to help decide whether this relationship is beneficial or detrimental to you."[85] Hospital staff are often hostile to the idea that patients may be sexually active in any way.[86]

However, many institutional mental health professionals and

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that occurs from adhering to prescribed psychotropic medication regimes" at 6-7); Peter Bartlett, "'The Necessity Must Be Convincingly Shown to Exist': Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983" (2011) 19:4 Med L Rev 514 (antipsychotic medications "cause impotence or other sexual dysfunction in approximately 45% of individuals" at 518); McCann, "Breaking the Taboo", *supra* note 12 at 133 (discussing how full range of antipsychotic medication side-effects "may greatly affect the potential to form relationships").

83. On the ways that the stigma of mental illness increases isolation, and its impact on sexual behaviour and autonomy, see Eric Wright et al, "Stigma and the Sexual Isolation of People with Serious Mental Illness" (2007) 54:1 Social Problems 78. On how neglecting consumer sexuality issues reinforces stigma, see Tennille & Wright, *supra* note 18 at 13.

84. Renee Binder, "Sex Between Psychiatric Inpatients" (1985) 57:2 Psychiatric Quarterly 121 at 125.

85. Gabor Keitner & Paul Grof, "Sexual and Emotional Intimacy Between Psychiatric Inpatients: Formulating a Policy" (1981) 32:3 Hospital & Community Psychiatry 188 at 193. See also Tennille and Wright, *supra* note 18 at 9 (discussing false belief of care providers that "[i]t is the providers' role to protect consumers from romantic rejection").

86. See *e.g. Rogers v Okin*, 478 F Supp 1342 at 1373-74 (Mass D 1979) (noting that patients are secluded for engaging in sexual behaviour).

behaviourists now recognize that patients "are and wish to be sexually active,"[87] and that sexual freedom often has therapeutic value.[88] Writing about this recently, Andreas Dimopoulos has argued forcefully that, "[b]y seeking to avoid harm to self we are perpetuating oppressive social and legal responses which presented persons with disabilities as asexual, or worse still, as individuals who should be asexual."[89]

Others call attention to our societal obligation to provide family planning assistance to women institutionalized in psychiatric hospitals.[90] Nonetheless, many hospitals remain reluctant to promulgate such policies. This is not surprising, given the aforementioned paucity of legal authority requiring them to do so. Moreover, there is a near complete lack of literature generally available to guide hospitals and their staff, should they even desire to formulate such procedures.

There is little case law on the questions addressed in this paper. Of the few litigated cases, the most important is *Foy v Greenblott*.[91] There, an institutionalized patient and her infant child (conceived and born while

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87. Steven Welch et al, "Sexual Behavior of Hospitalized Chronic Psychiatric Patients" (1991) 42:8 Hospital & Community Psychiatry 855 at 855.
88. Binder, *supra* note 84 at 122.
89. Dimopoulos, *supra* note 1 at 8.
90. See *e.g.* Virginia Abernethy et al, "Family Planning During Psychiatric Hospitalization" (1976) 46:1 American Journal of Orthopsychiatry 154. On the ways that coercive family planning is sometimes imposed in facilities in China, see Sean D Murphy, "Criticism of PRC's Human Rights Practices" (2000) 94:3 Am J Int'l L 526 at 527. On the question of forced contraception, see Carolyn Frohmader & Stephanie Ortoleva, "The Sexual and Reproductive Rights of Women and Girls with Disabilities" (Paper prepared for the ICPD Human Rights Conference on Sexual and Reproductive Health, sponsored by OHCHR, UNFPA, and the Government of the Netherlands, 1 July 2013), online: Women Enabled <http://womenenabled.org/publications.html> ("[f]orced contraception, recognised as a form of torture, is commonly used on women and girls with disabilities to suppress menstruation or sexual expression for various purposes, including eugenics-based practices of population control, menstrual management and personal care, and pregnancy prevention (including pregnancy that results from sexual abuse)" at 5). On the relationship of feminist legal theory to disability theory, see Doyle, *supra* note 80.
91. 190 Cal Rptr 84 (Ct App 1983) [*Foy*]. See generally Perlin, "Make Promises by the Hour", *supra* note 12 at 966-67.

the mother was a patient in a locked psychiatric ward) sued the mother's treating doctor for his failure to either maintain proper supervision over her so as to prevent her from having sex or to provide her with contraceptive devices and/or sexual counseling.[92]

The Court rejected the plaintiff's claims of improper supervision, finding that institutionalized patients had a right to engage in voluntary sexual relations as an aspect of either the "least restrictive environment" or "reasonably non-restrictive confinement conditions" and that that right (to less or reasonably non-restrictive confinement) included suitable opportunities for the patient's interactions with members of the opposite sex.[93] On the other hand, the Court did characterize the defendant's failure to provide the plaintiff with contraceptive devices and counseling as a deprivation of her right to reproductive choice.[94] It also rejected a claim for "wrongful birth" by the infant child, concluding that "[o]ur society has repudiated the proposition that mental patients will necessarily beget unhealthy, inferior or otherwise undesirable children if permitted to reproduce."[95]

While *Foy* has been applauded as "a model exposition of the reproductive rights of institutionalized women,"[96] it is an isolated case. A reading of the case law reveals that this area simply does not exist as an active area of patients' rights litigation.[97]

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92. *Foy*, *ibid* at 87.
93. *Ibid* at 90, n 2.
94. *Ibid* at 91-92.
95. *Ibid* at 93.
96. Susan Stefan, "Whose Egg is it Anyway?: Reproductive Rights of Incarcerated, Institutionalized and Incompetent Women" (1989) 13:2 Nova L Rev 405 at 433.
97. See Perlin, *Mental Disability Law*, *supra* note 60 at § 3C-5.1, 416-21 (reviewing developments). See also Dimopoulos, *supra* note 1, discussing – and sharply criticizing – recent British cases of *A Local Authority v H* [2012] EWHC 49 (COP), and *D Borough Council v AB* [2011] EWHC 101 (COP), both of which concluded that individuals with intellectual disabilities did not have the capacity to consent to sexual interaction. A recent case in Israel has found that a person with schizophrenia has a right to family, and that sperm retrieval for this purpose is allowed. See *Ploni v Israel Legal Attorney*, Case # 6036-10-08 (Haifa Family Ct, 29 Dec 2013) (decision, in Hebrew, and explanatory email from Dr. Maya Sabatello, on file with authors).

At the same time, there is little in the way of legislation. By way of example, although many American jurisdictions have enacted "patients' bills of rights" providing a broad array of civil rights and liberties for persons institutionalized in psychiatric hospitals, only a few jurisdictions mandate a limited right to sexual interaction.[98]

In general, the lack of statutory authority and case law logically leads to the next question: since we are, by all accounts, a fairly litigious group of people, why not? Why hasn't this area – one that deals with the most personal of rights[99] – been the subject of greater scrutiny or of court decrees (or even of substantial scholarly writings)?[100] Although there *has*

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98. See *e.g.* Ohio Rev Code, § 5122.29(I) ("[t]he right to social interaction with members of either sex, subject to adequate supervision, unless such social interaction is specifically withheld under a patient's written treatment plan for clear treatment reasons."); Mont Code Ann, § 53-21-142(10) ("[p]atients have the right to be provided, with adequate supervision, suitable opportunities for interaction with members of the opposite sex except to the extent that a professional person in charge of the patient's treatment plan writes an order stating that the interaction is inappropriate to the treatment regimen."); NJ Stat Ann, § 30:4-24.2(10) ("[[p]atients have the right to] suitable opportunities for interaction with members of the opposite sex, with adequate supervision").

99. This is especially ironic in that we acknowledge the significance of sexual autonomy in other related areas of law, but ignore it here, see Perlin, "Beyond the Last Frontier?", *supra* note 17 ("the law acknowledges that sexual desire is a sufficiently important personal trait so that its diminution must be weighed into the formulation of a medication refusal policy. Yet the law simultaneously denies the power and importance of sexual desire with respect to hospital ward life" at 531).

100. There are remarkably few modern law review articles on the global issue of mental patient sexuality published in the US. See *e.g.* Winiviere Sy, "The Right of Institutionalized Disabled Patients to Engage in Consensual Sexual Activity" (2001) 23:2 Whittier Law Review 545; and Evelyn M Tenenbaum, "To Be or to Exist: Standards for Deciding Whether Dementia Patients in Nursing Homes Should Engage in Intimacy, Sex, and Adultery" (2009) 42:3 Ind L Rev 675. See also, discussing Professor Tenenbaum's work, J Richard Lindsay, "The Need for More Specific Legislation in Sexual Consent Capacity Assessments for Nursing Home Residents" (2010) 31:3 J Legal Med 303 at 306. For a transnational perspective, see Hella von Unger, "The Meaning and Management of Women's Sexuality in Psychiatric vs. Community Psychiatric Settings in Berlin, Germany" (Paper delivered at the Thirtieth International Congress on Law and Mental Health, in Padua, Italy, 26 June 2007), [unpublished,

been attention paid to this issue in nursing and psychiatric literature,[101] there has been virtually no "carryover" to the question of the legal implications of the policies for clinicians (or lack of policies).[102] And, of course, our attitudes exhibit willful blindness to the reality that patients *are* – and likely always have been – sexually active.[103]

We also need to consider how we set priorities in defining the underlying question of how we, as a society, can restructure our laws regarding the autonomy of individuals with disabilities to engage in sexual activities of their choice. What do we look at first: autonomy rights, civil libertarian concerns, due process requirements, privacy interests, competency criteria, clinical needs, therapeutic jurisprudential concerns, tort liability worries, voluntariness constructs, or the immutable fact that sexual interaction, by its very description, entails the participation of more than one individual? No resolution of the underlying issues can be contemplated unless we distinguish these approaches and carefully

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powerpoint on file with author], cited in Perlin, "Everybody is Making Love", *supra* note 46 at 489, n 33.

101. See *e.g.* Diane J Torkelson & May T Dobal, "Sexual Rights of Persons with Serious and Persistent Mental Illness: Gathering Evidence for Decision Making" (1999) 5:5 Journal of the American Psychiatric Nurses Association 150; May T Dobal & Diane J Torkelson, "Making Decisions about Sexual Rights in Psychiatric Facilities" (2004) 18:2 Archives of Psychiatric Nursing 68; Eddie McCann, "Exploring Sexual and Relationship Possibilities for People with Psychosis – A Review of the Literature" (2003) 10:6 Journal of Psychiatric and Mental Health Nursing 640; Ronald WD Stevenson, "Sexual Medicine: Why Psychiatrists Must Talk to Their Patients about Sex" (2004) 49:10 Canadian Journal of Psychiatry 673.

102. See Perlin, "Beyond the Last Frontier?", *supra* note 17 ("many hospitals remain reluctant to promulgate such policies" at 532); but compare Dobal & Torkelson, *supra* note 101 at 68 (60% of psychiatric facilities polled reported having such policies).

103. Perlin, "Beyond the Last Frontier?", *supra* note 17 at 532; Welch et al, *supra* note 87 at 855. See Susan Stefan, "Joshua's Children: Constitutional Responsibility for Institutionalized Persons after Deshaney v. Winnebago County" (2013) 70:1 Wash & Lee L Rev 793 ("[s]exual activity in institutional settings is more common than outsiders might imagine, and runs that gamut from mutual and supportive relationships between patients through exploitation, coercion, and rape by other patients and staff" at 800).

articulate their interrelationships, their potential conflicts, and their relative values as competing social choices. In short, this is a very difficult project.

III. Other Approaches

A. International Human Rights

Scholars have begun in recent years to focus more carefully and thoughtfully on the relationship between mental disability law and international human rights law.[104] In our own writing, we have explored this connection in the context of forensic facility conditions, correctional law, appointment of counsel, psychological evaluations in criminal cases, and how the law shames and humiliates persons with mental disabilities.[105]

104. See *e.g.* Aaron Dhir, "Human Rights Treaty Drafting Through the Lens of Mental Disability: the Proposed International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities" (2005) 41:2 Stan J Int'l L 181; Paul Harpur, "Time to Be Heard: How Advocates Can Use the Convention on the Rights of Persons with Disabilities to Drive Change" (2011) 45:3 Val U L Rev 1271; Bryan Y Lee, "The U.N. Convention on the Rights of Persons with Disabilities and Its Impact upon Involuntary Civil Commitment of Individuals with Developmental Disabilities" (2011) 44:3 Colum JL & Soc Probs 393; István Hoffman & György Könczei, "Legal Regulations Relating to the Passive and Active Legal Capacity of Persons with Intellectual and Psychosocial Disabilities in Light of the Convention on the Rights of Persons with Disabilities and the Impending Reform of the Hungarian Civil Code" (2010) 33:1 Loy LA Int'l & Comp L Rev 143.

105. See *e.g.* Perlin, *International Human Rights*, *supra* note 7; Perlin & Schriver, *supra* note 63; Michael L Perlin, "'A Change Is Gonna Come': The Implications of the United Nations Convention on the Rights of Persons with Disabilities for the Domestic Practice of Constitutional Mental Disability Law" (2009) 29:3 N Ill UL Rev 483; Michael L Perlin & Valerie R McClain, "'Where Souls Are Forgotten': Cultural Competencies, Forensic Evaluations and International Human Rights" (2009) 15:4 Psychol Pub Pol'y & L 257; Astrid Birgden & Michael L Perlin, "'Tolling for the Luckless, the Abandoned and Forsaked': Therapeutic Jurisprudence and International Human Rights Law As Applied to Prisoners and Detainees by Forensic Psychologists" (2008) 13:2 Legal & Criminological Psychology 231; Michael L Perlin, "'I Might Need a Good Lawyer, Could Be Your Funeral, My Trial': Global Clinical Legal Education and the Right to Counsel in Civil Commitment Cases" (2008) 28 Wash UJL & Pol'y 241; Perlin & Lynch, *supra* note

We believe that the ratification of the *Convention on the Rights of Persons with Disabilities* demands that society and legislators alike reconsider this entire issue. First, the CRPD mandates nations to "[p]rovide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes."[106] Beyond that, the other Convention Articles referred to above speak to dignity, the absence of discrimination, and the provision of sexual/reproductive health services.[107] The Convention goes further than most legislation and court decisions, directly addressing not only the freedom to engage in sex, but *outcomes* of sexual activity, by codifying the disabled person's right to form a family, right to information and services for sexual health, and notably, the right to "retain their fertility on an equal basis with others."[108] Yet, even given the specific and detailed language of the CRPD, the literature has been remarkably silent on these issues in general, especially as they relate to the CRPD's impact on the rights of persons institutionalized due to psychosocial or intellectual disability, to sexual autonomy.[109] This

63; Michael L Perlin & Naomi Weinstein, "'Friend to the Martyr, a Friend to the Woman of Shame': Thinking About The Law, Shame and Humiliation" (2014) Southern California Review of Law and Social Justice [in press].

106. CRPD, *supra* note 7, Article 25.
107. See *supra* notes 8-10 and accompanying text.
108. CRPD, *supra* note 7, Article 23.
109. There has been only sporadic attention paid to sexuality issues in the country reports issued by the UN Committee on the Rights of Persons with Disabilities; see Committee on the Rights of Persons with Disabilities, *Implementation of the Convention on the Rights of Persons with Disabilities*, online: United Nations High Commissioner for Human Rights <http://www.ohchr.org/en/hrbodies/crpd/pages/crpdindex.aspx>; Committee on the Rights of persons with Disabilities, *Implementation of the Convention on the Rights of Persons with Disabilities*, OHCHR, 10th Sess, CRPD/C/AUS/1, (2012) (Australia, the sole mention of sexuality issues: "[t]he WA Department of Health funds the Sexuality Education Counselling and Consulting Service, which develops and implements health promotion programs to enhance the health and wellbeing of persons with disabilities and educate the wider community in areas of sexuality and disability" at 33, para 152); Committee on the Rights of Persons with Disabilities, *Implementation of the Convention on the Rights*

takes on even more significance when we consider how, in at least one CRPD signatory nation (China), the prevailing governmental policy is to prevent "pre-birth disabilities" via compelled abortion.[110]

Three scholarly articles in the literature stand out as lone examples of what scholars should focus their attentions on: (1) Maya Sabatello's paper on the intersection between infertility, reproductive technologies and disability rights law;[111] (2) Sabatello's paper on how sexuality was considered in the debate on the CRPD;[112] and (3) most directly, Marta Schaaf's article on sexuality in the context of the CRPD.[113] Drawing on

of Persons with Disabilities, OHCHR, 10th Sess, CRPD/C/AUT/1, (2011) (Austria: "[several disability organizations] stress that people with disabilities also have a right to sexuality, partnership and family. Education and information on the issues of sterilisation and abortion is often insufficient" at 35, para 235); Committee on the Rights of Persons with Disabilities, *Implementation of the Convention on the Rights of Persons with Disabilities*, OHCHR, 10th Sess CRPD/C/SLV/1, (2011) (El Salvador: "[i]n order to enhance the effectiveness of the Government's sexual and reproductive health programmes, it is nonetheless important to provide for the various means of personal expression used by persons with disabilities, such as Braille or Salvadoran sign language, thereby ensuring that everyone has the information they need to make informed decisions" at 29, para 153); Committee on the Rights of Persons with Disabilities, *Implementation of the Convention on the Rights of Persons with Disabilities*, OHCHR, 9th Sess, CRPD/C/PRY/1, (2011) (Paraguay: no mention of sexuality issues).

110. See Yee-Fui Ng, "Disability Rights v. Quality Birth Rhetoric: The Construction of Disability in China" (2012) LAWASIA Journal 1 at 1-2. On forced or coerced abortion in this context in general, see Frohmader & Ortoleva, *supra* note 90.

111. Maya Sabatello, "Who's Got Parental Rights? The Intersection Between Infertility, Reproductive Technologies, and Disability Rights Law" (2010) 6:2 Journal of Health & Biomedical Law 227 [Sabatello, "Who's Got Parental Rights?"]. See generally Stevens, *supra* note 11 ("[a]nother crucial issue in the lives of disabled people is the experience of legal intervention to deny parental rights. Denial of parental rights occurs across types of disabilities but occurs perhaps most fervently with intellectually and developmentally disabled people – as in many cases they lack the autonomy to consent to sexual activity, the choice to reproduce, and the ability to retain children after birth" at 16).

112. Sabatello, "Disability, Human Rights and Global Health", *supra* note 1.

113. Marta Schaaf, "Negotiating Sexuality in the Convention on the Rights of Persons with Disabilities" (2011) 8:14 Sur International Journal on Human Rights 113.

Articles 2 (one of the "reasonable accommodation" articles), 23, and 26, Sabatello concludes that the CRPD provides a "possible venue to further advance a right to found a family through "assisted reproductive technologies."[114] In assessing the drafting process, Sabatello notes how all conversations about sexuality "raised acute debates,"[115] and that, as a result, sexuality *per se* "was not elevated to a right."[116] Schaaf – who frontally notes that disabled sexuality is often perceived as a "threat to others"[117] – discussed the "tension" that underlay the negotiations leading to the adoption of the CRPD "between efforts to promote sexual rights and efforts to protect PWDs [persons with disabilities] from unwanted sterilization."[118] Further, Schaaf notes that disability-focused NGOs "continue to be reluctant to engage sexuality,"[119] but concludes that "[s]exual rights as a rubric of rights' claiming will likely continue to grow, providing greater and better opportunities to move beyond current understandings of sexual citizenship to include disabled and all other bodies."[120]

Professor Michael Stein and Professor Janet Lord have written eloquently about how *another* Article in the convention – Article 30, setting out social rights of participation in cultural life – "serves as a vital channel of engagement with society when such participation is embraced by the community," and increases "self-reliance and empowerment."[121]

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114. Sabatello, "Who's Got Parental Rights?", *supra* note 111 at 259.
115. Sabatello, "Disability, Human Rights and Global Health", *supra* note 1 at manuscript 23.
116. *Ibid* at manuscript 25. On the opposition of the Arab Group of nations, the Holy See and Yemen to expanded mention of sexuality – unmoored from traditional marriage – see *ibid* at manuscript 23-24.
117. Schaaf, *supra* note 113 at 114.
118. *Ibid* at 124.
119. *Ibid*.
120. *Ibid* at 125.
121. Michael Ashley Stein & Janet E Lord, "Jacobus tenBroek, Participatory Justice, and the UN Convention on the Rights of Persons with Disabilities" (2008) 13:2 Texas Journal of Civil Liberties & Civil Rights 167 at 182, discussed extensively in Michael L Perlin, "'Through the Wild Cathedral Evening': Barriers, Attitudes, Participatory Democracy, Professor tenBroek, and the Rights of Persons with Mental Disabilities" (2008) 13:2 Texas Journal of Civil Liberties & Civil Rights 413 at 413-16.

Other commentators have concluded that the Convention "is regarded as having finally empowered the 'world's largest minority' to claim their rights, and to participate in international and national affairs on an equal basis with other minority groups who have achieved specific treaty recognition and protection."[122]

The CRPD Committee has already begun to outline legislation and policies required to ensure implementation, a process that may prove useful in addressing the many unanswered questions posed in this paper. The Committee has worked on issuing recommendations for services and programs aimed at people with disabilities to assist them in informed decision-making, regardless of whether they are institutionalized or not.[123] These programs would work on mainstreaming disability issues into legislation, and disseminating information about sexual and reproductive health in an accessible format for individuals who want to become informed about their right to engage in sexual activity.[124] Further, the Committee supports teaching sexual health to children with intellectual disabilities.[125]

If the Convention is taken seriously – if it is, in fact, more than

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122. See *e.g.* Kayess & French, *supra* note 52 ("[s]ee, for example, statements made by the High Commissioner for Human Rights, Louise Arbour, and the Permanent Representative of New Zealand and Chair of the Ad-Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, Ambassador Don Mackay, at a Special Event on the Convention on Rights of Persons with Disabilities … convened by the UN Human Rights Council, 26 March 2007, available at http://www.unog.ch/80256EDD006B9C2E/(httpNewsByYearen)/7444B2E219117CE8C12572AA004C5701?Open Document" at 4, n 17).
123. UN Committee on the Rights of Persons with Disabilities, Guidelines on Treaty-Specific Document to Be Submitted by State Parties Under Article 35, Paragraph 1, of the Convention on the Rights of Persons with Disabilities (UN Document CRPD/C/2/3, October 2009) [Guidelines on Treaty-Specific Document], online: United Nations High Commissioner for Human Rights <http://www.ohchr.org/Documents/HRBodies/CRPD/CRPD-C-2-3.pdf>.
124. Girlescu, *supra* note 3 at 21; Guidelines on Treaty-Specific Document, *ibid* at 123.
125. Guidelines on Treaty-Specific Document, *ibid.*

a "paper victory"[126] – then, perhaps, it can be a vehicle to uproot that aspect of sanism that continues to deny the institutionalized persons the rights to their own sexuality.[127] Throughout the CRPD, it is apparent that the preferences and decisions of persons with disabilities must be respected and promoted. Expanding on this idea of self-determination, it follows that decisions about sex, sexuality, and reproduction are to be made by the person with a disability, rather than a "caretaker" or a facility superintendent. This kind of decision-making is a core element of self-determination and empowerment that is promoted by the CRPD.[128] However, in order to bring about such a dramatic shift in thinking (and translating that to concrete action which will allow for such decisions to be made by persons with disabilities) on this issue, it is necessary that other scholars follow the lead of Professors Sabatello and Schaaf to

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126. Michael L Perlin, "'What's Good is Bad, What's Bad is Good, You'll Find out When You Reach the Top, You're on the Bottom': Are the Americans with Disabilities Act (and *Olmstead v. L.C.*) Anything More Than 'Idiot Wind?'" (2002) 35:1-2 U Mich JL Ref 235 ("[m]ental disability law is strewn with examples of 'paper victories'" at 246), quoting Michael Lottman, "Paper Victories and Hard Realities" in Valierie J Bradley & Gar J Clarke, eds, *Paper Victories and Hard Realities: The Implementation of the Legal and Constitutional Rights of the Mentally Disabled* (Washington, DC: Georgetown University, 1976) at 93. In the specific context of other United Nations Conventions, see Sara Dillon, "What Human Rights Law Obscures: Global Sex Trafficking and the Demand for Children" (2008) 17:1 UCLA Women's LJ 121 ("[a] specialized human rights convention does not in itself guarantee substantial change" at 154).

127. There is some evidence that in other jurisdictions, parallel rights are being taken seriously. See *e.g. Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols No. 11 and No. 14, Nov. 1*, Art 8(1), online: Council of Europe <http://conventions.coe.int/>; as construed in *X v Iceland*, (1976) 5 DR 86 at 87 (Article 8 prohibiting public authorities from interfering with a person's right "to respect for his private and family life, his home and his correspondence" is broad enough to encompass an entitlement "to establish and to develop relationships with other human beings, especially in the emotional field for the development and fulfillment of one's own personality"). This issue is discussed in Lawrence O Gostin & Lance Gable, "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health" (2004) 63:1 Md L Rev 20 at 94.

128. Girlescu, *supra* note 3 at 19.

seriously engage this topic.[129]

B. Therapeutic Jurisprudence

Another important lens through which to view this issue is that of therapeutic jurisprudence (TJ). Therapeutic jurisprudence "asks us to look at law as it actually impacts people's lives"[130] and focuses on the law's influence on emotional life and psychological well-being.[131] It suggests that "law should value psychological health, should strive to avoid imposing anti-therapeutic consequences whenever possible, and when consistent with other values served by law, should attempt to bring about healing and wellness."[132] The ultimate aim of therapeutic jurisprudence is to determine whether legal rules, procedures, and lawyers' roles can or should be reshaped to enhance their therapeutic potential, while refraining from subordination of due process principles.[133] There is an

129. See *e.g.* Willene Holness, "Informed Consent for Sterilisation of Women and Girls with Disabilities in the Light of the Convention on the Rights of Persons with Disabilities" (2013) 27:4 Agenda: Empowering Women for Gender Equity 35 (questioning whether South Africa's sterilization law meets the requirements of the CRPD, and concluding that the enhancement of the decision-making capacities of the population in question will require "demystifying the sexuality of women with disabilities"). On how sexual health for persons with intellectual disabilities is a rights issue under the CRPD, see Foley & Kelly, *supra* note 31 at 20.

130. Bruce J Winick, "Foreword: Therapeutic Jurisprudence Perspectives on Dealing With Victims of Crime" (2009) 33:2 Nova L Rev 535 at 535.

131. See David B Wexler, "Practicing Therapeutic Jurisprudence: Psycholegal Soft Spots and Strategies" in Daniel P Stolle, David B Wexler & Bruce J Winick, eds, *Practicing Therapeutic Jurisprudence: Law as a Helping Profession* (Durham, NC: Carolina Academic Press, 2000) at 45.

132. Bruce J Winick, "A Therapeutic Jurisprudence Model for Civil Commitment" in Kate Diesfeld & Ian Freckelton, eds, *Involuntary Detention and Therapeutic Jurisprudence: International Perspective on Civil Commitment* (Great Britain: Ashgate Publishing, 2003) 23 at 26.

133. See Michael L Perlin, "'And My Best Friend, My Doctor, Won't Even Say What it is I've Got': The Role and Significance of Counsel in Right to Refuse Treatment Cases" (2005) 42:2 San Diego L Rev 735 at 751 [Perlin, "Role of Counsel"]; Perlin & Lynch, "All his Sexless Patients", *supra* note 69 at 277-78; Perlin, "Everybody is Making Love", *supra* note 46 at 510, n 139; Perlin, "Striking for the Guardians", *supra* note 52 at 1184. See also Michael L Perlin, "'Baby, Look Inside Your Mirror':

inherent tension in this inquiry, but David Wexler clearly identifies how it must be resolved: the law's use of "mental health information to improve therapeutic functioning [cannot] impinge upon justice concerns."[134] As one of the authors (MLP) has written elsewhere, "an inquiry into therapeutic outcomes does not mean that therapeutic concerns 'trump' civil rights and civil liberties."[135] In its aim to use the law to empower individuals, enhance rights, and promote well-being, TJ has been described as "a sea-change in ethical thinking about the role of law … a movement towards a more distinctly relational approach to the practice of law … which emphasises psychological wellness over adversarial triumphalism."[136] That is, TJ supports an ethic of care.[137]

The Legal Profession's Willful and Sanist Blindness to Lawyers with Mental Disabilities" (2008) 69:3 U Pitt L Rev 589 at 591 [Perlin, "Sanist Blindness"] (discussing how TJ "might be a redemptive tool in efforts to combat sanism, as a means of 'strip[ping] bare the law's sanist façade'"); Bernard P Perlmutter, "George's Story: Voice and Transformation through the Teaching and Practice of Therapeutic Jurisprudence in a Law School Child Advocacy Clinic" (2005) 17:2 St Thomas L Rev 561 at 599, n 111; Ian Freckelton, "Therapeutic Jurisprudence Misunderstood and Misrepresented: The Price and Risks of Influence" (2008) 30:2 Thomas Jefferson L Rev 575 at 585-86.

134. See David B Wexler, "Therapeutic Jurisprudence and Changing Concepts of Legal Scholarship" (1993) 11:1 Behav Sci & L 17 at 21; see also David Wexler, "Applying the Law Therapeutically" (1996) 5:3 Applied & Preventive Psychology 179.

135. Michael L Perlin, "A Law of Healing" (2000) 68:2 U Cin L Rev 407 at 412; Michael L Perlin, "'Where the Winds Hit Heavy on the Borderline': Mental Disability Law, Theory and Practice, Us and Them" (1998) 31:3 Loy LA L Rev 775 at 782.

136. Warren Brookbanks, "Therapeutic Jurisprudence: Conceiving an Ethical Framework" (2001) 8 Journal of Law & Medicine 328 at 329-30; see also Bruce J Winick, "Overcoming Psychological Barriers to Settlement: Challenges for the TJ Lawyer" in Marjorie A Silver, ed, *The Affective Assistance of Counsel: Practicing Law as a Healing Profession* (Durham, NC: Carolina Academic Press, 2007) 341; Bruce J Winick & David B Wexler, "The Use of Therapeutic Jurisprudence in Law School Clinical Education: Transforming the Criminal Law Clinic" (2006) 13:1 Clinical L Rev 605 at 605-06. The use of the phrase dates to Carol Gilligan, *In a Different Voice* (Cambridge, Mass: Harvard University Press, 1982).

137. See *e.g.* Winick & Wexler, *supra* note 136 at 605-07; David B Wexler, "Not Such a Party Pooper: An Attempt to Accommodate (Many of) Professor Quinn's Concerns about Therapeutic Jurisprudence Criminal

One of the central principles of TJ is a commitment to dignity.[138] Professor Amy Ronner describes the "three Vs" as voice, validation, and voluntariness,[139] arguing:

> What "the three Vs" commend is pretty basic: litigants must have a sense of voice or a chance to tell their story to a decision maker. If that litigant feels that the tribunal has genuinely listened to, heard, and taken seriously the litigant's story, the litigant feels a sense of validation. When litigants emerge from a legal proceeding with a sense of voice and validation, they are more at peace with the outcome. Voice and validation create a sense of voluntary participation, one in which the litigant experiences the proceeding as less coercive. Specifically, the feeling on the part of litigants that they voluntarily partook in the very process that engendered the end result or the very judicial pronunciation that affects their own lives can initiate healing and bring about improved behavior in the future. In general, human beings prosper when they feel that they are making, or at least participating in, their own decisions.[140]

The question to be addressed here is this: given the way we deny the sexuality rights of persons with disabilities, is it remotely possible that Professor Ronner's vision – of voice, voluntariness and validation – will be fulfilled? In a thoughtful analysis of the underlying issues, Professor Julie Tennille has listed multiple benefits of a "communicative climate" for consumers with regard to sexuality issues.[141] Janine Benedet

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Defense Lawyering" (2007) 48:3 BCL Rev 597 at 599; Brookbanks, *supra* note 136; Gregory Baker, "Do You Hear the Knocking at the Door? A "Therapeutic" Approach to Enriching Clinical Legal Education Comes Calling" (2006) 28:1 Whittier Law Review 379 at 385.

138. See Bruce J Winick, *Civil Commitment: A Therapeutic Jurisprudence Model* (Durham, NC: Carolina Academic Press, 2005) at 161.

139. Amy D Ronner, "The Learned-Helpless Lawyer: Clinical Legal Education and Therapeutic Jurisprudence as Antidotes to Bartleby Syndrome" (2008) 24:4 Touro L Rev 601 at 627. On the importance of "voice," see Freckelton, *supra* note 133 at 588.

140. Amy D Ronner, "Songs of Validation, Voice, and Voluntary Participation: Therapeutic Jurisprudence, Miranda and Juveniles" (2002) 71:1 U Cin L Rev 89 at 94-95.

141. See Tennille & Wright, *supra* note 18 ("[h]ealthy sexual relationships can foster development and maintenance of new relationships, a key element in social integration; positive sexual partnerships can increase quality of life, and those with mental health conditions who maintain relationships often have better treatment outcomes; some research indicates that hospital readmission rates dropped if consumers were able to develop romantic relationships; and stigma of mental illness may be reduced" at 13-14).

and Isabel Grant have also used a therapeutic jurisprudential filter in weighing these issues.[142] Both commentators have considered how to define "capacity to consent"[143] and "engage in sexual activities,"[144] and how to ensure that such definitions remain person-centered and allow for a "situational approach"[145] to each case. They write: "incapacity can and should be defined situationally – in a functional manner that maximizes [a person's] sexual self-determination."[146] However, Benedet and Grant's thoughtful analysis and emphasis on the individual and his or her self-determination – two concepts linked with dignity – have not been greatly expanded upon in case law or legislation so as to give life to the therapeutic jurisprudential lens that they employ to view these issues of sexuality.

Twenty years ago, one of us (MLP) wrote the following about sexuality issues in the domestic context, and we believe that little has changed in the intervening two decades:

> We must also question the therapeutic or antitherapeutic implications of official hospital policies that control the place, manner, and frequency with which such individuals can have sexual interactions. We must consider the implications of these policies on ward life and their implications for patients' post-hospital lives. These questions are difficult ones, but we must ask them nonetheless if we wish to formulate a thoughtful, comprehensive response to the wide range of questions this subject raises.[147]

How does this all "fit" with the CRPD? We believe that the Convention "is a document that resonates with TJ values,"[148] and that it reflects the three principles articulated by Professor Ronner – voice, validation and voluntariness,[149] by looking at law "as it actually impacts people's lives."[150] Each section of the CRPD empowers persons with mental disabilities, and one of the major aims of TJ is explicitly the empowerment of those

142. Janine Benedet & Isabel Grant, "A Situational Approach to Incapacity and Mental Disability in Sexual Assault Law" (2013) 43:1 Ottawa L Rev 447.
143. *Ibid* at 456.
144. *Ibid* at 453.
145. *Ibid* at 466.
146. *Ibid* at 450.
147. Perlin, "Beyond the Last Frontier?", *supra* note 17 at 547.
148. Perlin, "Striking for the Guardians", *supra* note 52 at 1188.
149. Ronner, *supra* note 140 at 94-95.
150. Perlin, *International Human Rights*, *supra* note 7 at 21.

whose lives are regulated by the legal system.[151] The CRPD is, in many ways, a TJ blueprint. It privileges autonomy, promotes dignity, and values psychological health. If TJ encourages the law to "enhance [its] therapeutic potential,"[152] enforcement of the CRPD serves that enforcement role in the way that persons with mental disabilities are treated with regard to their sexual being. If a TJ perspective is adopted, that will also be the best way to ensure that the sanism that pervades the law's treatment of persons with mental disabilities on questions of sexuality and sexual expression is rooted out of the system.[153]

If institutionalized persons with mental disabilities are granted the same sexual autonomy that the rest of us have, the former population will be given a voice. If persons with mental disabilities are allowed voluntary sexual interaction, that, by definition, provides the sort of participatory experience that leads to a sense of voluntariness within a therapeutic jurisprudence framework. And together, the grant of sexual autonomy and the concomitant right to voluntary sexual interaction help increase the self-validation of those in question.

We hope that scholars and advocates take seriously the intersection between sexuality issues, TJ issues and human rights issues, and turn their attention more fully to this question in future years.

IV. Conclusion

As society in general becomes increasingly open and direct about sex and sexuality, "[a]ided by the values of a consumer culture and encouraged by the growing visibility of sex in the public realm, many now regard sexual pleasure as a legitimate component of their lives."[154] This openness and

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151. *Ibid.* See also, *e.g.* Astrid Birgden & Michael L Perlin, "'Where the Home in the Valley Meets the Damp Dirty Prison': A Human Rights Perspective on Therapeutic Jurisprudence and the Role of Forensic Psychologists in Correctional Settings" (2009) 14:4 Aggression & Violent Behavior 256.
152. See *e.g.* Perlin, "Role of Counsel", *supra* note 133 at 751.
153. Perlin, "Neonaticide", *supra* note 48 at 25. On "[t]he peculiar interplay between sanism and sexuality" see Perlin, "Everybody is Making Love", *supra* note 46 at 506; see generally Perlin, "Sanist Blindness", *supra* note 133 at 591 (discussing how TJ "might be a redemptive tool in efforts to combat sanism, as a means of 'strip[ping] bare the law's sanist façade").
154. Raie Goodwach, "Sex Therapy: Historical Evolution, Current Practice.

directness must be allowed to extend to persons with disabilities if full equality for this population is to be achieved.

Given the lack of statutory authority, case law, and scholarly articles within this topic, we can only offer conclusions based on our beliefs on the rights of persons with disabilities to their sexual autonomy. There is minimal research to analyze, few statutes to interpret, and few articles to debate; rather, we must rely on the school of thought that upholds equality in every aspect of life for persons with disabilities. The CRPD and the guidelines of therapeutic jurisprudence offer us a starting point from which to offer recommendations for scholars, lawmakers, clinicians, and those with mental disabilities.

First, sexual issues must be seen as multi-textured, and the meaning of "sex" must be carefully defined.

Second, we ignore cultural attitudes at our own risk.

Third, many of the critical issues – behavioural, legal, social, and political – remained unanswered, in large part because of the taboos that surround this entire area of law, policy, and social inquiry. This all remains very under-discussed because we are still so astonishingly uncomfortable thinking about the questions at hand. We desire to close our eyes to the reality that persons with mental disabilities are sexual beings, and close our minds to the fact that their sexuality may be much more like "ours" than it is different.

Fourth, the UN Convention – finally – forces us to reconsider how myopic we continue to be about these issues, and realize that sexuality rights are rights that must be enforced.

Fifth, application of a therapeutic jurisprudence lens to this question forces us to confront how the core principles of TJ are regularly disregarded in our social responses to these issues, and that the three V's articulated by Professor Ronner are rarely, if ever, honoured.

Sixth, the use of the TJ filter – in the context of the articulated principles of international human rights law – offers us a means of approaching these questions in a new and, potentially, socially redemptive

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Part I" (2005) 26:3 Australian & New Zealand Journal of Family Therapy 155 at 157; see also Appel, *supra* note 36 at 154 (on the fundamentality of sexual pleasure as a right).

way, and in a way that, optimally, erases sanist attitudes.

In *Love Is Just a Four- Letter Word*, Bob Dylan characterizes love, in the context of the relationship about which he is singing as "unmentionable by name."[155] Love and sex have forever been "unmentionable by name" when we discuss persons with mental disabilities, especially those who are institutionalized, notwithstanding the revolutions that we have seen in the past four decades: sexual revolutions, civil rights revolutions, and disability rights revolutions.[156] And these issues – in the context of this paper – have become even more pointed in the years since the international human rights movement and the mental disability law movement have been joined, and the CRPD ratified.[157] Perhaps, now, we can finally devote to this area of law and policy the attention it deserves.

155. Dylan, *supra* note 20.
156. Perlin, *International Human Rights*, *supra* note 7 at 547.
157. See *e.g.* Michael L Perlin & Eva Szeli, "Mental Health Law and Human Rights: Evolution and Contemporary Challenges" in Michael Dudley, Derrick Silove & Fran Gale, eds, *Mental Health and Human Rights: Vision, Praxis, and Courage* (Oxford: Oxford University Press, 2012) 80 at 98.