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Capacity to consent to sex reframed: IM, TZ (no 2), the need for an evidence-based model of sexual decision-making and socio-sexual competence

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ABSTRACT

Recent English cases have set a very low threshold for the capacity to consent to sexual activity, and the Court of Appeal in *IM v LM* (2014) has held that "the ability to use and weigh information is unlikely to loom large in the evaluation of consent to sexual relations." Such cases significantly affect the legal status of such activities involving persons diagnosed with a learning disability (LD), an autistic spectrum disorder (ASD) or other neurodiverse (ND) conditions. A principal focus on two cases in particular—*IM v LM* (2014) and *A Local Authority v TZ (no 2)* (2014)—supports the argument that the current test needs reframing from a relationship-centred perspective, in order to reflect an evidence-based model of sexual decision-making. Relevant training for persons diagnosed as LD, ASD, or ND is essential in order to promote socio-sexual competence. This is critical for resolving existing tensions between (1) sexual rights guaranteed in international agreements; (2) criminal law provisions and local authorities' obligations to protect the vulnerable; and (3) sexual health concerns.

1. Introduction

Recent English cases involving those diagnosed as learning disabled and/or on the autistic spectrum or otherwise neurodiverse [LD/ASD/ND] engaging in sexual activities with others highlight the need for clear and reliable means and procedures to assess capacity to consent to sex. We focus principally on two recent cases, the Court of Appeal judgement in *IM v LM and others* [2014] EWCA Civ 37 and Baker J's Court of Protection judgement in *A Local Authority v TZ (no 2)* [2014] EWHC 973 (COP) to identify crucial difficulties with the tests in the judgments. We argue that the current test needs reframing from a relationship-centred approach to reflect an evidence-based model of sexual decision-making. We believe sex and relationship [SRE] training for those diagnosed as LD/ASD/ND is essential to promote socio-sexual competence in order to balance tensions between sexual rights guaranteed in international agreements, criminal law provisions, courts' and local authorities' obligations to protect the vulnerable, and sexual health concerns.

2. LD/ASD/ND peoples' right to sexual expression, legal obligations and capacity

Those with disabilities, including the physically disabled, those who have lost capacity through neurodegenerative disorders or dementia, and those diagnosed as LD/ASD/ND, should be free to express themselves sexually. International agreements such as the European Convention on Human Rights [ECHR] (translated into the Law of England and Wales in the Human Rights Act 1998) and the United Nations Convention on the Rights of Persons with Disabilities [CRPD] aspire to oblige states to recognise various rights as accruing to all humans and to ensure that persons with disabilities are able to exercise them. Various sexual rights form part of this. Article 8 of the ECHR, the right to respect for private life, includes the right to sexual expression as part of a group of reproductive and relationship rights, such as the right to marry and form a family and rights to reproductive autonomy and sexual health. The CRPD explicitly includes this group of rights as nation states are obliged to foster and promote equality amongst persons with disabilities and other citizens. The Valencia Declaration on Sexual Rights, approved at the World Congress of Sexology in 1997, asserts the right to sexual health, to broad, objective and factual information about human sexuality, and the right to comprehensive sexuality education.

In England and Wales, these international obligations are complemented by national laws, such as the Equality Act 2010, which places duties upon local authorities to promote equality, decrease social exclusion and address inequalities. The Health and Social Care Act 2012 devolved commissioning for public health services, including sexual health services (excluding HIV treatment services and pregnancy terminations), onto local authorities, where legal obligations to provide care for disabled people are already in place. Local authorities are obliged to commission contraception (outside of the primary care contract), sexually transmitted infection testing and treatment, sexual health promotion and HIV prevention, with a mandate to provide appropriate access to sexual health services for all. Local Health and Wellbeing Boards

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set up by the Act are responsible for integrating public health, social care and NHS services. Thus from April 2013, when the Act came into force, local authorities became obliged to interpret their obligations under human rights and equality laws to promote the social inclusion of disabled people in keeping with those duties to promote their sexual health and rights to sexual expression.

It is crucial to distinguish between physical and mental disabilities or impairments in this context. People with physical disabilities but intact decision-making ability face different issues when seeking to express themselves sexually than do people who have or may have mental disabilities or impairments, and whose decision-making capacity may come under question as a consequence. This means that the ability of many persons who may be mentally impaired and/or are diagnosed as LD/ASD/ND to exercise their sexual rights has been far from straightforward, particularly as many are affected by co-morbidities so may be diagnosed with several of these conditions. Those coming before the Court of Protection in cases involving their capacity to engage in sexual relations are frequently in this position. For instance, TZ, the subject of two of the cases we discuss below, was diagnosed with mild learning disabilities, atypical autism and hyperactivity disorder. While a significant body of research concerns the lawful sexual expression of the learning disabled (Curtsy and Kelson, 2011; McGuire, 2011; Richards et al., 2009), there is a paucity of studies focused on those diagnosed with ASD/ND (Mackenzie & Watts, 2013). This means that the prominent judicial concern to find a workable and manageable test for consent to sex evident in these cases risks privileging administrative convenience over the need for a test which is sensitive to current sexual practices, as well as to the sexual rights and vulnerabilities of those diagnosed with LD/ASD/ND whose capacity is in question.

An ongoing search for infrastructure to provide maximum recognition for the sexual rights of disabled people while protecting the vulnerable from sexual exploitation and abuse may be found in government policy documents and reports, in particular *Setting the Boundaries* (Home Office, 2000), *Valuing People Now* (Department of Health, 2009) and *A Life Like Any Other* (Joint Committee on Human Rights, 2008). These acknowledge the mandates placed upon states in the group of reproductive and relationship rights sketched out above. Yet, as we will now demonstrate, the parallel aims to preserve citizens from wrongdoing through the criminal law, and the inherent jurisdiction of the High Court to protect the vulnerable and the operation of the Court of Protection, which has jurisdiction over adults who lack decision-making capacity, do not mesh smoothly with rights to sexual expression or a holistic view of sexual health.

3. Evaluating decision-making capacity: the legislative infrastructure

An infrastructure of legislation, policy and practice to distinguish between decisions which the law will respect and those which it will not has been created in most jurisdictions. Decisions which adults and some children make are recognised by the law only where the decision-makers are accepted as having legal capacity, or the ability to make autonomous decisions about their own lives. In England and Wales, adults and young people aged sixteen and over are presumed to have decision-making capacity by the Mental Capacity Act 2005 (MCA), and children under sixteen may show that they do in relation to medical treatment by demonstrating Gillick competence (*Gillick v West Norfolk and Wisbech Area Health Authority and Department of Health and Social Security* [1986] A.C. 112). The MCA and accompanying Code of Practice applies to all personal welfare, healthcare and financial decisions taken on behalf of those over sixteen who temporarily or permanently lack the decision-making capacity to decide for themselves resulting from an impairment or disturbance in the mind or brain. The test for decision-making capacity in the MCA is located in s3(1), which provides that for the powers of the MCA to apply, a person must be suffering from an impairment or disturbance in the functioning of their mind or brain that causes them to be unable to (a) understand information relevant to the decision; (b) retain that information; (c) use or weigh that information as part of the process of making that decision; or (d) communicate that decision. The Act stipulates that efforts should be made to assist the person concerned to demonstrate decision-making capacity, but should these fail, the person will be found to lack capacity.

Should the person in question be found to lack decision-making capacity in relation to a specific decision, or to be legally incompetent, decisions may be taken on his or her behalf by those previously appointed to do so by being granted Lasting Power of Attorney over financial and/or healthcare decisions, or by appropriate clinicians, the courts, or an otherwise appointed Independent Mental Capacity Advocate (IMCA). These decisions should be guided by the incompetent person's best interests, in keeping with his or her past and present wishes, feelings, beliefs and values, or follow an applicable advance decision when this fits the circumstances. There is a duty to support the incompetent person's input into the decision and to enhance his or her decision-making capacity.

This infrastructure seeks to be value-neutral, protecting the incompetent person's wishes, in keeping with their past and present wishes, feelings, beliefs and values, as well as their right to make decisions others may find unwise or irrational. While different requirements apply to different decisions, the mechanisms for ensuring that decisions are taken on behalf of the incompetent person are oriented towards decisions involved in such matters as managing one's financial or daily affairs, consenting to medical treatment, or to participating in research. These areas are conducive to assessment in terms of their involving one-off discrete decisions, which may be readily preceded by an assessment process. Moreover, the process of arriving at decisions made by others in the best interests of a person lacking capacity, or in keeping with their past and present wishes, feelings, beliefs and values, or advance decisions, is relatively straightforward. However, the Code of Practice provides that the common law tests of capacity may continue to apply in some situations, such as making a will or gift, entering a contract, carrying out litigation and marrying (DCA, 2007, paragraphs 4.32–3).

Section 27 of the Mental Capacity Act specifies that decisions on intimate relationships which involve considerations of decision-making capacity, such as whether to marry or to engage in sexual activity, may not be taken on behalf of an incompetent person. Declarations on whether a person has the decision-making capacity to consent to sex or marriage, along with other decisions about their health, welfare and financial affairs, may be sought from the Court of Protection. The implications of this exclusion, coupled with extant uncertainties about finding an appropriate test for the ability to consent to sex, will form the focus of the remainder of this article.

4. The capacity to consent to sexual activity in context

Traditionally, the capacity to make decisions about intimate relationships has been enshrined in law in relation to general rather than specific decisions. While a family or criminal law case requiring the court to decide whether A has the capacity to marry X, or to have consented to sexual activity with Y, may have provoked judicial inquiry into A's capacity, A is likely to have been found to either have, or lack, the capacity to marry, or to engage in sexual activity, in a general sense, rather than in relation to a specific decision at a particular time, such as whether or not to marry X, or to engage in sexual activity with Y. Historically, this reflects the person-centred, as opposed to relationship-centred, nature of legal inquiry into the decision-making capacity of vulnerable persons, as well as a current commitment to allowing the vulnerable to take risks and to make mistakes from which they may learn to make better decisions like the rest of us. A comparable narrow focus on the individual, and the imparting of information, inherent in the person-centred approach, in healthcare is giving way to an acceptance that relational factors and tacit, experiential knowledge should be included in the emerging concept of the