Capabilities, capacity and consent

Lindsey, Jaime; Harding, Rosie

DOI:
10.1111/jols.12278

Document Version
Publisher's PDF, also known as Version of record

Citation for published version (Harvard):
Lindsey, J & Harding, R 2021, 'Capabilities, capacity and consent: sexual intimacy in the court of protection', *Journal of Law and Society*, vol. 48, no. 1, pp. 60-83. https://doi.org/10.1111/jols.12278

DOI: 10.1111/jols.12278

ARTICLE

Capabilities, capacity, and consent: sexual intimacy in the Court of Protection

JAIME LINDSEY[1] | **ROSIE HARDING**[2]

[1] School of Law, University of Essex, Wivenhoe Park, Colchester, CO4 3SQ, England

[2] Birmingham Law School, University of Birmingham, Edgbaston, Birmingham, B15 2TT, England

Corresponding author
Jaime Lindsey, School of Law, University of Essex, Wivenhoe Park, Colchester, CO4 3SQ, England
Email: j.t.lindsey@essex.ac.uk

Abstract

This article uses original data from research at the Court of Protection to explore capacity to consent to sex in practice. It argues that the approach under the Mental Capacity Act 2005 fails to place appropriate focus on consent as central to understanding sexual capacity. The capabilities approach to justice is then used to demonstrate the limitations of the existing legal approach to capacity to consent to sex, and to argue that the protective focus of the legal test would be better centred on the social risks resulting from non-consensual sex and exploitation. Finally, the article argues that, rather than focusing on a medicalized approach to understanding sexual intimacy, an analysis based on capabilities theory provides conceptual tools to support arguments for additional resources to help disabled people to realize their rights to sexual intimacy.

1 | INTRODUCTION

Sexuality and intimacy in the context of cognitive disability present a range of challenging social and legal issues. Whereas in the past disabled people were routinely and actively prevented from engaging in sexual activity,[1] or sterilized without consent to avoid unwanted pregnancy,[2] contemporary approaches to intimacy for disabled adults require a more nuanced approach. This article

[1] R. Sandland, 'Sex and Capacity: The Management of Monsters?' (2013) 76 *Modern Law Rev*. 981.

[2] *Re F (Mental Patient Sterilisation)* [1990] 2 AC 1.

focuses on how the Court of Protection (CoP) deals with capacity to consent to sex for disabled people, particularly those with cognitive disabilities, dementia, and mental health difficulties. Recent years have seen increasing attention to these issues within academic literature and CoP practice.[3] Disabled people's rights to develop loving and sexual relationships, and to engage in consensual intimacy, are protected by the UN Convention on the Rights of Persons with Disabilities (CRPD). However, as Arstein-Kerslake and Flynn state, '[t]he right to sexual agency has not perfectly found its place in human rights law'.[4]

English law allows for adults who are assessed to lack the mental capacity to consent to sex to be prevented from engaging in sexual relations. The Mental Capacity Act 2005 (MCA) applies to those whose capacity is limited as a result of 'an impairment of, or a disturbance in the functioning of, the mind or brain'.[5] The MCA uses a functional test, which requires the person to understand, retain, use, and weigh information relevant to the decision, including the reasonably foreseeable consequences, and to communicate their decision.[6] Through analysis of how sexuality and intimacy are dealt with in CoP practice, we argue that the dominant approach to capacity to consent to sex fails to capture the essence of sexual activity as a social practice, and more specifically the central importance of understanding consent. Instead, we show that the CoP medicalizes sex, despite consent having been articulated to form part of the relevant information for assessing capacity to consent to sex since at least 2012.[7] We demonstrate, through original observational data and case file analysis, that in practice, pregnancy and sexually transmitted infections (STIs) remain at the centre of a biologically focused, medicalized approach to capacity. Medicalization is the process by which 'natural' life experiences or events are defined as a medical issue.[8] We argue that the medicalized approach allows the CoP to sidestep the social dimensions of sex, particularly a person's understanding that sex is a choice, and one to which either party can say no.

We build upon the conceptual framework provided by the capabilities approach to justice[9] to explore how the CoP engages with sexual intimacy in practice. The capabilities approach focuses on improving human welfare and development and can be used to identify if individuals in society are being treated justly and, as a result, how resources should be allocated. The function of the mental capacity approach is to protect individuals who are unable to make decisions for themselves. The function of the capabilities approach is to provide individuals with an entitlement to support to enable them to develop the capabilities needed for human flourishing. This distinction will be explored to show what difference a capabilities approach can add to understanding

[3] See, for example, J. Herring, 'Mental Disability and Capacity to Consent to Sex: *A Local Authority* v. *H* [2012] EWHC 49 (COP)' (2012) 34 *J. of Social Welfare and Family Law* 471; B. Clough, 'Vulnerability and Capacity to Consent to Sex: Asking the Right Questions?' (2014) 26 *Child and Family Law Q*. 371; J. Herring and J. Wall, 'Capacity to Consent to Sex' (2014) 22 *Medical Law Rev*. 620; L. Series, 'Sex, Capacity and Forensic Cotton Wool: *IM* v. *LM* [2014] EWCA Civ 37' (2014) 36 *J. of Social Welfare and Family Law* 317; A. Arstein-Kerslake and E. Flynn, 'Legislating Consent: Creating an Empowering Definition of Consent to Sex that Is Inclusive of People with Cognitive Disabilities' (2016) 25 *Social & Legal Studies* 225.

[4] Arstein-Kerslake and Flynn, id., p. 4.

[5] MCA, s. 2(1).

[6] MCA, s. 3.

[7] See *A Local Authority* v. *H* [2012] EWHC 49; *The London Borough of Tower Hamlets* v. *TB and SA* [2014] EWCOP 53.

[8] P. Conrad, *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* (2007).

[9] A. Sen, *Commodities and Capabilities* (1985); A. Sen, *Inequality Reexamined* (1992); A. Sen, *Development as Freedom* (1999); A. Sen, *The Idea of Justice* (2009); M. C. Nussbaum, *Frontiers of Justice: Disability, Nationality, Species Membership* (2007); M. C. Nussbaum, *Creating Capabilities: The Human Development Approach* (2013) 33; M. C. Nussbaum, 'Women and Equality: The Capabilities Approach' (1999) 138 *International Labor Rev*. 227; M. C. Nussbaum, *Women and Human Development: The Capabilities Approach* (2001).

capacity beyond what has been achieved through other ways of analysing this area, such as through the CRPD or vulnerability theory.[10]

The CoP deals with cases that arise under the MCA and hears a wide range of disputes, including cases concerning consent to medical treatment, decisions about property and financial affairs, and general welfare cases. The cases that we focus on here relate to intimate relationships, including cases where the subject of proceedings (referred to as 'P') is the victim of abuse and cases where they are (potential) perpetrators. The role of the CoP under the MCA is to resolve disputes about mental capacity and best interests, which includes making declarations that a person has or lacks capacity under MCA, s. 15. In the case of capacity to consent to sex, the CoP cannot substitute a decision on the individual's behalf because of the operation of MCA, s. 27, which excludes consenting to sexual relationships from the general best interests decision-making framework of the MCA. Instead, where an individual is assessed as lacking capacity to consent to sexual relations, this catalyses a range of potentially restrictive interventions aimed at preventing that person from engaging in such relations, which can involve significant interferences with their rights to respect for private and family life under Article 8 of the European Convention on the Human Rights.[11] Our arguments in this article are focused on improving practice under the MCA, though we recognize that there are some who argue that the MCA needs more fundamental reform.[12] We do not contribute directly to that debate here, but instead consider how the implementation of the current law could be improved within the MCA framework.

We begin with a methodological overview of the CoP research underpinning our arguments, followed by a discussion of the approach to capacity to consent to sex under the MCA, as it has evolved in case law and academic commentary. We then turn to explore how using the tools provided by the capabilities approach to justice could improve outcomes for disabled people. Finally, we apply capabilities theory to findings from our observational and case file research in the CoP to provide an understanding of how CoP practice could be developed to support disabled people, moving away from prioritizing medical risks to focusing more clearly on consensual intimacy.

2 | METHODOLOGY

In this article, we draw on original empirical data from CoP observations and case files to interrogate how the law in this area works in practice, rather than solely relying on reported case law. The persistent 'gap' between how law works in practice and law as written in books has long been a major concern of law and society scholarship,[13] and this article contributes to that literature, while adding perspectives from capabilities theory. CoP data drawn on here were collected from research carried out at the CoP between January and December 2016. Before the research began, ethical approval was granted by a University Research Ethics Committee and approval was

[10] Arstein-Kerslake and Flynn, op. cit., n. 3; Clough, op. cit., n. 3.

[11] Human Rights Act 1998; *A Local Authority* v. *H (No. 2)* [2019] EWCOP 51.

[12] M. Donnelly, 'Best Interests in the Mental Capacity Act: Time to Say Goodbye?' (2016) 24 *Medical Law Rev*. 318; R. Harding, 'The Rise of Statutory Wills and the Limits of Best Interests Decision-Making in Inheritance' (2015) 78 *Modern Law Rev*. 945; W. Martin et al., *The Essex Autonomy Project Three Jurisdictions Report: Towards Compliance with CRPD Article 12 in Capacity/Incapacity Legislation across the UK* (2016).

[13] See, for example, R. Pound, 'Law in Books and Law in Action' (1910) 44 *Am. Law Rev*. 12; A. Sarat, 'Legal Effectiveness and Social Studies of Law' (1985) 9 *Legal Studies Forum* 23; S. Silbey, 'After Legal Consciousness' (2005) 1 *Annual Rev. of Law and Social Science* 323.

also received from Her Majesty's Courts and Tribunals Service (HMCTS), the Ministry of Justice (including a Privileged Access Agreement), and the (then) Vice President of the Court of Protection, Mr Justice Charles. HMCTS authorized in-depth analysis of 20 case files relating to capacity to consent to sex, capacity to marry, and capacity to make decisions about contact. Case files for inclusion in the research were selected by a court officer and set aside for review. A standardized case file review template was used to gather information from the 20 case files set aside. In total, eight of these 20 cases were additionally observed over 14 days throughout the 12-month period.

Parties to these 20 selected cases were sent information about the study by the court officer, including participant information sheets, consent forms, contact details for the researcher, and information that the researcher may observe hearings in their case. They were also advised that consent to attend the hearing would be sought on the day if not provided in advance.[14] On the day of each hearing, the researcher again sought consent to observe from the participants in attendance. In each case attended, no party objected to the hearing being observed and the judge was also supportive of the observation. Research is only possible with people who lack capacity to participate in research if certain criteria are met, set out under MCA, s. 30. This study did not fall within MCA, s. 30 as it sought only to include participants who had capacity to consent to participate in observational research, which is a relatively low threshold. Capacity was presumed, as required by MCA, s. 1(2), and when seeking consent on the day of each hearing from the parties, no concerns were raised by any person about individual participants' capacity to consent to participate. Verbatim notes were made on the day of the hearings and fieldnotes were also typed up during and after observation. Information accessed as part of the research varied depending on the case. In all but one observed case, additional material was available, including hearing bundles, skeleton arguments, expert reports, and witness statements. This information was not always contained in the case files, as some files were more detailed than others depending on the location of the court.[15] The person at the centre of the proceedings only gave evidence to the court in one observed case, but attended in two others.[16]

Observational research at the CoP facilitated a deeper understanding of the culture of the proceedings,[17] providing a greater insight into CoP practice than doctrinal analysis of reported case law allows. We acknowledge that being an observer is neither a neutral nor a static position and that observational research does not necessarily uncover all of the details about a case. Observational research involves an interaction with the practices of the CoP, including with court officers, judges, and case participants,[18] and is not an entirely objective process. To address these limitations of observational research, our data is complemented by other sources, including case file reviews and relevant reported case law. Summary details about each of the 20 cases analysed can be found in Table 1. All references to CoP participants in this table and throughout the article are anonymized.

[14] For further information about the ethics processes, see J. Lindsey, 'Protecting and Empowering Vulnerable Adults: Mental Capacity Law in Practice' (2018) PhD thesis, University of Birmingham.

[15] For further discussion in more detail about CoP case files, see L. Series et al., 'Welfare Cases in the Court of Protection: A Statistical Overview' (2017) at <http://sites.cardiff.ac.uk/wccop/files/2017/09/Series-Fennell-Doughty-2017-Statistical-overview-of-CoP.pdf>.

[16] See J. Lindsey, 'Testimonial Injustice and Vulnerability: A Qualitative Analysis of Participation in the Court of Protection' (2019) 28 *Social & Legal Studies* 4, for more in-depth analysis of the issues arising from P's participation in CoP proceedings.

[17] M. Jacob, *Matching Organs with Donors: Legality and Kinship in Transplants* (2012).

[18] K. Barad, 'Posthumanist Performativity: Toward an Understanding of How Matter Comes to Matter' (2003) 28 *Signs: J. of Women in Culture and Society* 801, at 816.

TABLE 1 Summary detail of case files analysed

	Anonymized case name	Sex	Age	Disability	Keyword summary	Outcome	Case observed?	Number of days attended court
1.	*K County Council* v. *SL*	F	20	Mild learning disability	Forced marriage	Has capacity to marry and consent to sex. Proceedings withdrawn.	Yes	1
2.	*ML* v. *(1) TL and (2) D County Council*	M	82	Dementia	Domestic abuse	ML died before final hearing.	No	0
3.	*Z County Council* v. *FY*	F	66	Dementia	Domestic abuse	Final order. FY lacks capacity to: conduct proceedings; make decisions about residence, care, and contact.	No	0
4.	*Y County Council* v. *(1) LC (2) GK (3) SC*	F	23	Autism and mild learning disability	Domestic abuse, forced marriage	Final order. LC lacks capacity to: consent to sex, to marry, and to litigate. Case ongoing in relation to contact and residence.	Yes	6
5.	*W County Council* v. *ZR*	F	37	Learning disability	Domestic abuse	Proceedings stayed as ZR detained under MCA, s. 3.	No	0
6.	*C Borough Council* v. *(1) DY (2) B Council*	F	20	Learning difficulties	Disruptive behaviour	Final order. DY lacks capacity to: conduct proceedings, make decisions about residence, care, and contact.	Yes	1
7.	*A County Council* v. *(1) MT (2) KZ*	M	52	Mild to moderate learning disability	Forced marriage	Ongoing. Interim decision that MT lacks capacity to: conduct proceedings; make decisions about residence and care; consent to sex and to marry.	No	0
8.	*H County Council* v. *XC*	M	24	Learning disability and deafness	Forced marriage	Ongoing. Interim decision that XC lacks capacity to: consent to sex and to marry.	Yes	2

(Continues)

TABLE 1 (Continued)

	Anonymized case name	Sex	Age	Disability	Keyword summary	Outcome	Case observed?	Number of days attended court
9.	*M County Council* v. *EV*	M	21	'Mental health problems'	Forced marriage	Final order. EV lacks capacity to: litigate, make decisions about residence, care, and contact; consent to sex, to marry, and to make decisions about finances.	No	0
10.	*T City Council* v. *CY*	F	49	Mild to moderate learning disability, emotionally unstable personality disorder	Relationship with partner	Final order. CY lacks capacity to: conduct proceedings; make decisions about residence and care. She does have capacity to decide on contact.	Yes	1
11.	*J Council* v. *RK*	M	38	Down's syndrome and learning disability	Alleged abuse by wife (on basis of lack of capacity)	Transferred to High Court judge for final hearing as case concerns consent to medical treatment. Awaiting expert evidence and final resolution at time of research end.	No	0
12.	*K County Council* v. *MW*	F	20	Learning disability	Forced marriage	Ongoing. Interim decision that MW has capacity to consent to sex, but lacks capacity in relation to marriage.	Yes	1
13.	*N County Council* v. *(1) GI and (2) DQ*	F	62	Korsakoff's syndrome, personality disorder, depressive disorder, and cerebral atrophy	Domestic abuse	Ongoing. Interim decision that GI lacks capacity to: make decisions about contact, care, and residence.	No	0
14.	*N County Council* v. *CA*	M	57	'Low intelligence'	Sexual offences	Ongoing. Interim decision that CA lacks capacity to conduct proceedings, but has capacity to consent to sexual relations.	No	0

(Continues)

TABLE 1 (Continued)

	Anonymized case name	Sex	Age	Disability	Keyword summary	Outcome	Case observed?	Number of days attended court
15.	*YS* v. *E District Council*	M	52	Heavy alcohol consumption and brain injury	Sexual offences	Ongoing. Interim decision that YS lacks capacity to: make decisions about contact, care, residence, and treatment. At the time of research end, transfer of placement was due to take place with further review four months after date of order.	No	0
16.	*OD* v. *R City Council*	M	46	Mild learning disability and schizophrenia	Sexual offences	Order that OD lacks capacity to: make decisions about contact, care, and residence.	Yes	1 (hearing vacated on the day)
17.	*P County Council* v. *(1) SE (2) TM*	F	80	Dementia	Domestic abuse	Final order. SE lacks capacity to: conduct proceedings; make decisions about care and residence; manage her property and affairs. Capacity evidence indicated that she does not lack capacity to make decisions about contact and sexual relations.	Yes	1

(Continues)

TABLE 1 (Continued)

	Anonymized case name	Sex	Age	Disability	Keyword summary	Outcome	Case observed?	Number of days attended court
18.	*V Borough Council* v. *AY*	M	35	Significant learning disability, autism, and sensory processing disorder	Domestic abuse	Order that AY lacks capacity to: make decisions about residence and matters of care and support. Order that it is in AY's best interests to have contact with his mother and any other members of extended family in accordance with wishes and feelings.	No	0
19.	*P CCG* v. *QB*	M	43	Mild learning disability and autism	Sexual offences	Order that QB lacks capacity to: litigate; make decisions about residence and care. Order that it is in QB's best interests to reside at placement and receive care package. Matter stayed until deprivation of liberty (DOL) expires in 2017.	No	0
20.	*O City Council* v. *(1) AW (2) FW (3) YW (4) TW*	F	34	Emotionally unstable personality disorder, borderline learning difficulties, and paranoid schizophrenia	Domestic abuse	Final order. AW lacks capacity to: conduct proceedings; make decisions about contact. Order that it is in P's best interests not to have any contact, either directly or indirectly, with father and brothers.	No	0

As can be seen in Table 1, while the selection criteria for case files were focused on disputes about capacity to make decisions about sex, marriage, or contact, the majority (n = 18, 90 per cent) of these cases involved allegations of abuse in some form, including domestic abuse (n = 8), forced marriage (n = 6), and alleged perpetrator of sexual offences (n = 4). In 16 (80 per cent) of the case files, the disabled person at the centre of the proceedings was the victim or potential victim of abuse or non-consensual sex; in the remaining four cases (20 per cent), the person at the heart of proceedings was thought to be at risk of perpetrating sexual offences. As we show in our analysis below, the CoP's approach to capacity to consent to (or engage in) sex continues to emphasize the medical risks of sexual relations, rather than the risks associated with non-consensual sex, despite the prevalence of abuse across the case files reviewed and CoP hearings observed.

3 | DISABILITY AND CONSENT TO SEX: SOCIO-LEGAL APPROACHES

A systematic review of available evidence found that '[a]dults with disabilities are at a higher risk of violence than are non-disabled adults, and those with mental illnesses could be particularly vulnerable'.[19] The lack of protection from violence exposed by this elevated risk is even starker for disabled women, particularly those subjected to sexual assault.[20] This increased risk is part of the rationale for additional duties placed on State Parties by CRPD, Article 16 to protect disabled people's rights to freedom from exploitation, violence, and abuse. We consider that this backdrop of abuse shapes the application of the test for capacity to consent to sex. In this section, we set out the legal test for capacity to consent to sex as it has developed in the CoP. Specifically, we agree with the Court of Appeal decision in *A Local Authority* v. *JB*,[21] which requires that consent is a central part of the test for sexual capacity.

3.1 | The legal test for capacity to consent to sex

Under the MCA, lack of capacity to make a decision arises when a person (after being provided with all practicable steps to support them) is, as a result of an impairment or disturbance in the functioning of their mind or brain, unable to understand, use or weigh, or retain information relevant to the decision, or to communicate their decision.[22] What constitutes that 'relevant information' has been the subject of significant jurisprudence of the CoP. The initial decision setting out the test for capacity to consent to sex is surprisingly recent,[23] but draws, implicitly, on a long history of seeking to manage and control the sexuality of intellectually disabled people.[24] The

[19] K. Hughes et al., 'Prevalence and Risk of Violence against Adults with Disabilities: A Systematic Review and Meta-Analysis of Observational Studies' (2012) 379 *Lancet* 1621, at 1621.

[20] J. Benedet and I. Grant, 'Sexual Assault and the Meaning of Power and Authority for Women with Mental Disabilities' (2014) 22 *Feminist Legal Studies* 131.

[21] *A Local Authority* v. *JB* [2020] EWCA Civ 735.

[22] MCA, ss. 1–3.

[23] *X City Council* v. *MB, NB and MAB* [2006] EWHC 168.

[24] Sandland, op. cit., n. 1.

current test, developed through a line of cases,[25] suggests that the information relevant to capacity to consent to sex may include:

a. the sexual nature and character of the activity (including the mechanics of the sexual act);
b. that there are health risks involved, particularly the acquisition of sexually transmitted and sexually transmissible infections;
c. that sex between a man and a woman may result in the woman becoming pregnant;
d. that sex is a choice and therefore that P can say yes or no to sexual relations;
e. that the other person must have capacity to engage in sexual relations and must consent.[26]

The first part of the test has focused predominantly on the functional and physical aspects of sex. It is understood to be a very low threshold and is rarely problematic in CoP cases. The second part of the test, understanding health risks, most often requires an understanding that sexual activity can result in STIs. The third aspect requires an understanding of the possibility of pregnancy, though not the more remote consequences of pregnancy, like midwifery care, giving birth, or the possibility of a child being removed.[27]

Through these first three requirements, the test focuses on a particular type of sexual act: vaginal heterosexual intercourse between fertile males and females. This has led to the test for capacity to consent to sex, for the purposes of the MCA, to be described as 'act-specific' or 'issue-specific' rather than 'person-specific' or 'situation-specific'.[28] This is, of course, in contrast to the central importance of consent in criminal proceedings about sexual offences, where Baroness Hale said:

> [I]t is difficult to think of an activity which is more person- and situation-specific than sexual relations. One does not consent to sex in general. One consents to this act of sex with this person at this time and in this place. Autonomy entails the freedom and the capacity to make a choice of whether or not to do so.[29]

A more individualized approach, which places act-specific understandings of capacity in a particular situational context, gained further traction in the CoP recently through Hayden J's decision in *The London Borough of Tower Hamlets* v. *NB*. In that case, Hayden J's approach was that the information relevant to the decision should be variable depending on the particular circumstances of the case. He stated 'that there is no need to evaluate an understanding of pregnancy when assessing consent to sexual relations in same-sex relationships or with women who are infertile or post-menopausal strikes me as redundant of any contrary argument'.[30]

While a variable test has some intuitive appeal, it sits uneasily with the act-specific approach to capacity to consent to sexual relationships that has developed through previous case law.[31] The

[25] Recent cases include *Re NB* [2019] EWCOP 17; *Re B (Capacity: Social Media: Care and Contact)* [2019] EWCOP 3.

[26] Affirmed in *A Local Authority* v. *JB*, op. cit., n. 21, building on a list of authorities including: *Local Authority X* v. *MM* [2007] EWHC 2003; *D Borough Council* v. *AB* [2011] EWHC 101; *The London Borough of Tower Hamlets* v. *TB and SA*, op. cit., n. 7; *IM* v. *(1) LM (2) AB (3) Liverpool City Council* [2014] EWCA Civ 37.

[27] *In Re A (Capacity: Refusal of Contraception)* [2011] Fam 61; *In Re M (An Adult) (Capacity: Consent to Sexual Relations)* [2015] Fam 61, [2014] EWCA Civ 37.

[28] See Herring and Wall, op. cit., n. 3 for discussion of the reasoning in the Court of Appeal in *In Re M*, id. on this issue.

[29] *R* v. *Cooper* [2009] UK HL 42, at [27].

[30] *The London Borough of Tower Hamlets* v. *NB* [2019] EWCOP 27, at [54].

[31] *In Re M*, op. cit., n. 27 confirmed the act-specific approach.

act-specific approach requires that a person must understand sex *in general* rather than in relation to a *specific person*. It is therefore difficult to reconcile with a variable test, which inevitably turns, to some degree at least, on the characteristics of the sexual partner (in other words, sex/gender, fertility, and disease status), even where these have an impact on the level or nature of the risk.

The fourth and fifth features of the test are essentially about the importance of consent.[32] Taken together, they require that P understands that sex is a choice to which both parties must consent, and to which either party can say no. This is, in our view, fundamental to sexual capacity even though these consent parts of the legal test have had much less influence in CoP practice,[33] despite consent forming some part of the test for assessing sexual capacity since at least 2012.[34] To some extent, this is because of the developing nature of the legal test in this area, as we outline in the following section, but we also consider the socio-legal question of the failure to focus on consent in the final part of this article.

3.2 | Towards a consent-focused test for engaging in sex

The relevance of understanding consent as a part of sexual capacity was recently considered by the Court of Appeal in two cases. First, in brief *obiter* comments in *B* v. *A Local Authority*,[35] the Court of Appeal quoted the earlier decision in *London Borough of Southwark* v. *KA & Ors* to explain that understanding that you can say no to sex is an issue that goes 'to the root of capacity itself' and is 'more than just an item of relevant information'.[36] Yet, if understanding that a person can say no to engaging in sexual relations was not part of the relevant information, the legal status of consent in the test for sexual capacity was unclear. This approach was, in our view, rightly rejected in the Court of Appeal decision in *A Local Authority* v. *JB*, where the issue of consent was central. That case concerned a mental capacity declaration sought in relation to a 36-year-old man who was perceived to be a risk to others and had significant limitations placed on his independence 'primarily in order to prevent him from behaving in a sexually inappropriate manner towards women'.[37] At first instance, Roberts J held that understanding that the other party must consent to sex is not relevant to the legal test for sexual capacity, though it might be relevant to how that capacity is exercised in practice.[38] The Court of Appeal, overturning Roberts J's decision, held that the test was actually whether or not a person had capacity to *engage* in sexual relations. When the test is framed that way,

> it becomes clear that the 'information relevant to the decision' inevitably includes the fact that any person with whom P engages in sexual activity must be able to consent to such activity and does in fact consent to it. Sexual relations between human beings are mutually consensual. It is one of the many features that makes us unique. A person

[32] See *A Local Authority* v. *JB*, op. cit., n. 21.

[33] Affirmed recently by the Court of Appeal in id.

[34] See *A Local Authority* v. *H*, op. cit, n. 7 and subsequent case law such as *The London Borough of Tower Hamlets* v. *TB and SA*, op. cit., n. 7.

[35] *B* v. *A Local Authority* [2019] EWCA Civ 913.

[36] Id., para. 51, quoting from the judgment in *London Borough of Southwark* v. *KA & Ors* [2016] EWCOP 20.

[37] *A Local Authority* v. *JB* [2019] EWCOP 39, para. 3.

[38] Id., para. 80.

> who does not understand that sexual relations must only take place when, and only for as long as, the other person is consenting is unable to understand a fundamental part of the information relevant to the decision whether or not to engage in such relations.[39]

This Court of Appeal decision makes clear that consent (both in respect of giving and receiving consent) forms part of the legal test for capacity to engage in sexual relations. Incorporating consent in this way does not require that the individual understands all of the possible criminal implications of sexual contact. Rather, it protects the individual from the serious consequences that follow from criminal prosecution for sexual assault, rape, or other offences under the Sexual Offences Act 2003. As Baker LJ perceptively stated:

> [a]s illustrated by the background history to this application, which includes an incident of alleged sexual abuse in respect of which the police decided to take no action, the criminal justice system does not necessarily deal with such cases … [T]o leave such matters to the criminal justice system would be an abdication of the fundamental responsibilities of the Court of Protection.[40]

The *JB* decision aligns with our argument in this article because it reflects the fact that many cases on sexual capacity that reach the CoP are fundamentally about allegations of abuse. Of the 20 CoP case files analysed, 18 involved allegations of abuse, even though the criteria for inclusion in the sample was sex, marriage, and contact cases, not specifically cases of abuse.[41] Of the ten case files reviewed where capacity to consent to sex was investigated, five expressly used a three-stage test for capacity covering only the first three elements.[42] Of the remaining five cases, only one (*Y County Council* v. *LC*) expressly used the four-stage test incorporating the ability to say no. Further, almost all reported capacity to consent to sex cases from the CoP or Court of Appeal in recent years have included some allegations of exploitation or abuse.[43] This suggests that the primary concerns in sexual capacity cases have never been about the risks of pregnancy or STIs, but about the abuse of vulnerable adults who are at risk of non-consensual sex.[44] While *JB may* change this position in respect of Ps who are unable to understand that *the other party* needs to consent, we think that it is less likely to change the interpretation in cases where P herself is the person at risk. This socio-legal question of *why* consent has not been considered more centrally

[39] *A Local Authority* v. *JB*, op. cit., n. 21, para. 94.

[40] Id., para. 97.

[41] Cases that included capacity to make decisions about contact were also included within the sample, as it became clear that many cases where there were concerns around sexual relationships were dealt with using alternative means of intervention.

[42] *K County Council* v. *MW*; *W County Council* v. *ZR*; *K County Council* v. *SL*; *H County Council* v. *XC*; *A County Council* v. *MT*.

[43] *A Local Authority* v. *H*, op. cit., n. 7; *A Local Authority* v. *TZ* [2013] EWCOP 2322; *PC* v. *York City Council* [2013] EWCA Civ 478; *Derbyshire County Council* v. *AC* [2014] EWCOP 38; *The London Borough of Tower Hamlets* v. *TB and SA*, op. cit., n. 7; *IM* v. *(1) LM (2) AB (3) Liverpool City Council*, op. cit., n. 26; *Re P* [2018] EWCOP 10; *Manchester City Council* v. *LC* [2018] EWCOP 30; *Re NB*, op. cit., n. 25; *A Local Authority v. JB*, op. cit., n. 21.

[44] For further discussion of this point, see J. Lindsey, 'Protecting Vulnerable Adults from Abuse: Under-Protection and Over-Protection in Adult Safeguarding and Mental Capacity Law' (2020) 32 *Child and Family Law Q*. 2.

in the cases that reach the CoP, even when the legal position was that consent goes to the root of capacity, is an important one to which we return in the second half of this article.

There have been concerns expressed that a consent-focused test for capacity would raise the threshold of who is able to engage in intimacy in practice. We disagree that this would necessarily follow. First, it would require asking whether a person understands consent. This includes understanding that they can communicate yes or no and can make their own choice about whether and what sexual practices they, and the other person, engage in. This would involve being able to describe, in simple terms, what consent is and give examples of how a person may give or withhold consent in practice. This is not necessarily a higher threshold that expects them to understand the criminal law, but it is a test that gets closer to the heart of the issue. Furthermore, decisions about contact, care, and residence are regularly used as mechanisms for controlling the sexual lives of disabled people who are found to have capacity to consent to sex under the original three-part test. For example, in a number of reported cases, the courts have reached a different conclusion in regard to a person's capacity to consent to contact compared to their capacity to consent to sexual activity.[45]

In the literature, this has been framed as a conflict between act-specific and person-specific approaches to sexual consent.[46] That is, the courts have found that under the act-specific approach P has capacity to consent to sex but under the person-specific approach P has been found to lack capacity to decide with whom she should have (sexual) contact. Unlike sex and marriage, capacity to make decisions about contact can be person-specific.[47] Clough has argued that having an act-specific approach to sex and marriage, but a person-specific approach to contact, promotes liberty by maximizing the number of people who are able to enjoy intimate relationships without interference.[48] This approach means that individuals are able to have intimate relationships but it provides the state with some ability to supervise their contact with abusive others. However, this distinction has been criticized by others who see it as unprincipled and illogical.[49]

Our argument is rather different. We consider that approaching capacity to consent to sex as a low threshold that can be undermined by setting a higher threshold for making decisions about contact creates a mere illusion of respect for the sexual and autonomy rights of intellectually disabled people. Through this approach, those individuals found to have capacity to consent to sex are subjected to intrusive monitoring and filtering of their contact with others, not only prospective sexual partners. This then seeks to move sexual consent, which is rightly excluded from the third-party decision-making framework of the MCA, back into the best interests framework of the Act. As a consequence, disabled people's sexual lives are subjected to supervision, interference, and vetting by professionals, potentially leading to breaches of their rights to privacy and family life.

Instead, the legal test for capacity to consent to sex must (and to some extent now does) focus explicitly on consent (of all parties), both in respect of giving consent and withholding it. This would better deal with the issues before the court in sexual capacity cases and more accurately

[45] *Local Authority X* v. *MM*, op. cit., n. 26; *Derbyshire County Council* v. *AC*, op. cit., n. 43; *A Local Authority* v. *TZ (No. 2)* [2014] EWHC 973.

[46] See Herring, op. cit., n. 3; Series, op. cit., n. 3.

[47] *York City Council* v. *C and another* [2013] EWCA Civ 478 para. 35.

[48] Clough, op. cit., n. 3.

[49] A. Ruck Keene et al., 'Carrying Out and Recording Capacity Assessments' (2020) at <https://www.39essex.com/mental-capacity-guidance-note-brief-guide-carrying-capacity-assessments/>.

capture why there is a need for a capacity test in relation to sex at all: to provide protection for disabled adults who may be sexually assaulted or abused, or be perpetrators of sexual offences. In the remainder of this article, we seek to demonstrate, using our empirical data and informed by the capabilities approach to justice, how an approach to capacity to consent to sexual relations that focuses on consent would better respond to the problems identified above and reflect a more honest approach to these issues.

4 | CAPABILITIES AND CAPACITY

In this section, we respond to the challenges identified above through the lens of the capabilities approach to justice. We argue that the capabilities approach provides a different way of viewing sexual intimacy, which can help to justify a more explicit focus on the social risks of intimate relationships in CoP cases, such as non-consensual sex, while balancing against inappropriate paternalism through setting too high a threshold for capacity. We argue that there is a need to provide contextual support to improve understanding before decisions about capacity are made. As Clough explains, 'promoting autonomy and resilience through responsive and appropriate support can be contrasted from an approach which sees non-interference as preferable'.[50] Legally, this is already provided for by the principles within the MCA, which include a requirement that 'all practicable steps' be taken to help a person to make their own decision before a finding of incapacity is made and that the least restrictive option must be taken.[51] Yet research on the implementation of the MCA has consistently found that this entitlement to support has not been realized in practice.[52] Here, we argue that the capabilities approach provides a convincing social justice argument to underpin the claim for the resources necessary to help a person to achieve capacity, something that has not been achieved through the MCA alone, notwithstanding that there is a right to support embedded in the foundational legal principles of the Act.

The capabilities approach does not map directly onto a capacity analysis and we are not seeking to suggest that it can change mental capacity law. However, capacity is likely to be facilitated through professionals and practitioners taking a capabilities approach to these issues. This is because the capabilities approach encourages those working with disabled people to view the issue of sexual intimacy from a different perspective: one that promotes the development of the capability to protect bodily health and integrity, develop emotional affiliations, develop an understanding and practice of intimacy, and be supported to achieve all of these in context. While it may not ultimately lead to a different outcome in all CoP cases (because capacity is still the legal requirement), the capabilities approach might help to shift the focus away from impairments and towards the need to provide support and the opportunity to develop the necessary capabilities to lead a fulfilled intimate life.

[50] Clough, op. cit., n. 3, p. 13.

[51] MCA, s. 1(2)–(6).

[52] House of Lords, *Mental Capacity Act 2005: Post-Legislative Scrutiny* (2014); R. Harding and E. Taşcıoğlu, *Everyday Decisions Project Report: Supporting Legal Capacity through Care, Support and Empowerment* (2017); R. Harding and E. Taşcıoğlu, 'Supported Decision-Making from Theory to Practice: Implementing the Right to Enjoy Legal Capacity' (2018) 8 *Societies* 25.

4.1 The capabilities approach

In common with a rising number of disability scholars, we argue that the capabilities approach has much to offer in advancing understandings of intellectually disabled people's rights to form rewarding, consensual, intimate relationships.[53] The capabilities approach, particularly in the form espoused by Amartya Sen,[54] has been influential in international human rights contexts. As Mitra has stated, '[i]n Sen's approach, *capability* means "practical opportunity"'.[55] By focusing on the opportunities, and freedom, that individuals have to *do* and *be* what they choose, capabilities require a more substantive approach to equality and justice than other forms of protecting individuals from discrimination and oppression.

At its core, the capabilities approach is a theory of justice that provides a framework for identifying how resources should be fairly distributed. It provides a political justification as to why and how resources should be used in particular ways. The approach is based on respect for dignity and ensuring that humans can achieve certain core capabilities. Nussbaum's approach to capabilities theory draws on the Rawlsian conception of justice,[56] but does so in a way that she says gives 'shape and content to the abstract idea of dignity'.[57] In advancing this approach, Nussbaum argues that it is possible to set out a list of capabilities that form 'minimum core social entitlements' that are 'compatible with different views about how to handle issues of justice and distribution … above the threshold level'.[58] Nussbaum's central capabilities list covers: life; bodily health; bodily integrity; senses, imagination, and thought; emotions; practical reason; affiliation; other species; play; and control over one's political and material environment.[59] Sexuality, intimacy, and relationships engage many of these central capabilities. Emotions, for example, includes support for the development of positive emotional attachments to others. Affiliation includes important dimensions of living in social relationships and engaging in social interaction. Bodily health includes reproductive health.[60] The capability for bodily integrity includes 'being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction'.[61] Importantly, Nussbaum argues that these capabilities are *all* required. Through the lens of the capabilities approach, it would not be sufficient to protect bodily health and bodily integrity by preventing disabled people from forming emotional attachments, intimate relationships, or affiliations.

In using the capabilities approach, we are attentive to its limitations and critiques, particularly in the ways in which some capabilities scholars have engaged with the challenges posed by

[53] A. Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2006) 34 *Syracuse J. of International Law and Commerce* 429; Clough, op. cit., n. 3; B. Clough, '"People Like That": Realising the Social Model in Mental Capacity Jurisprudence' (2015) 23 *Medical Law Rev.* 53; A. Arstein-Kerslake, *Restoring Voice to People with Cognitive Disabilities: Realizing the Right to Equal Recognition before the Law* (2017).

[54] Sen, op. cit., n. 9.

[55] S. Mitra, 'The Capability Approach and Disability' (2006) 16 *J. of Disability Policy Studies* 236, at 238.

[56] J. Rawls, *A Theory of Justice* (2005).

[57] Nussbaum, op. cit. (2007), n. 9, p. 75.

[58] Id.

[59] Nussbaum, op. cit. (2013), n. 9.

[60] Nussbaum, op. cit. (2007), n. 9, p. 76.

[61] Id.

cognitive disability. For example, many scholars active in disability studies or who agree with the recommendations of the Committee on the Rights of Persons with Disabilities about Article 12[62] would seriously object to the threefold classification of cognitively disabled people proposed by Nussbaum,[63] which suggests that guardianship and substituted decision making is the appropriate response for anyone who requires decision-making support. Harnacke, for example, argues that while the capabilities approach holds potential for helping to realize the rights in the CRPD, it fails because it does not prioritize or differentiate between the capabilities in a way that would guide procedural implementation of those rights.[64] Others have used the capabilities approach effectively in the disability context. For example, Mitra has used it to show how disability can develop from personal characteristics of the individual, resources, and environmental factors rather than being viewed as an inherent characteristic.[65] By this, she means that what is required to achieve a particular capability depends on the range of factors, and how they interact, in an individual context. Similarly, as Clough explains, the focus of the capabilities approach is

> on the way in which the environmental, cultural, political, and economic context can hinder or facilitate an individual's enjoyment of certain capabilities. Without paying attention to these factors, claims about particular individuals' enjoyment of certain rights and freedoms are incomplete.[66]

Building on capabilities theory, we consider that an individual is generally entitled, as a matter of justice, to be supported to develop internal capabilities *and* be given opportunities and experiences to exercise them (which Nussbaum calls combined capabilities), which are sensitive to their own needs, differences, characteristics, and circumstances.[67] This means responding to the different needs of individuals differently to ensure that they are able to develop their capabilities to health, bodily integrity, and intimacy in ways that suit the pursuit of their own life goals.[68] Strong realization of the capabilities approach in this context would require that individuals are provided with the opportunity to develop an understanding of models of intimacy that are *relevant for them*, rather than being subject to declarations of incapacity from the CoP to justify restrictive care plans. In the area of intimacy, this would mean being supported to develop the internal capacity to understand sexual activity and being situated within external conditions that provide the opportunity to develop capacity for sexual intimacy relevant to that individual's own intimate

[62] See, for example, A. Arstein-Kerslake and E. Flynn, 'The General Comment on Article 12 of the Convention on the Rights of Persons with Disabilities: A Roadmap for Equality before the Law' (2016) 20 *The International J. of Human Rights* 471; R. Harding, 'The Rise of Statutory Wills and the Limits of Best Interests Decision-Making in Inheritance' (2015) 78 *Modern Law Rev*. 945.

[63] M. C. Nussbaum, 'The Capabilities of People with Cognitive Disabilities' in *Cognitive Disability and Its Challenge to Moral Philosophy*, eds E. F. Kittay and L. Carlson (2010) 75.

[64] C. Harnacke, 'Disability and Capability: Exploring the Usefulness of Martha Nussbaum's Capabilities Approach for the UN Disability Rights Convention' (2013) 41 *J. of Law Medicine & Ethics* 768.

[65] Mitra, op. cit., n. 55.

[66] Clough, op. cit., n. 53, p. 68.

[67] Nussbaum, op. cit. (2001), n. 9, pp. 84–85; L. Terzi, 'Beyond the Dilemma of Difference: The Capability Approach to Disability and Special Educational Needs' (2005) 39 *J. of Philosophy of Education* 44.

[68] V. A. Entwistle and I. S. Watt, 'Treating Patients as Persons: A Capabilities Approach to Support Delivery of Person-Centered Care' (2013) 13 *Am. J. of Bioethics* 29.

desires in practice. It also requires that the practice of *consensual* sexual intimacy happens in an environment that supports bodily integrity and ensures that the person is free from sexual abuse.

4.2 | Capabilities, sexuality, and intimacy

Focusing on the internal ability to understand and communicate an understanding of the health risks of sex does not, in our view, properly capture the essence of the potential harms of sexual relationships. If the individual does not understand sexual activity as a mutual practice, then they are at risk of being either a victim or perpetrator of sexual assault when putting their desires for sexual intimacy into practice. Until recently, the approach to sexuality in the MCA appeared to require the possession of internal capabilities, with little regard to the external conditions (and support for those conditions) within which sexual expression develops. Yet in light of the CRPD and a greater attentiveness to the importance of targeted support,[69] there has been some movement towards combined capabilities in mental capacity law and practice.

The requirement to understand the risks of pregnancy and STIs does provide some protection for the central combined capability of bodily health. Yet if a person is unable to describe the health risks associated with sexual relations, then they may be denied the opportunity to engage in intimacy unless or until they develop the required understanding. The result of doing so could then be restrictive of other capabilities, like emotion or affiliation. Consequentially, a lack in one capability is used as a justification for restricting access to other central capabilities, instead of facilitating the development of better understanding of the health risks of sexual intimacy so that the person can achieve the necessary understanding. The capabilities approach, therefore, offers a set of persuasive social justice arguments to establish a moral duty on the state to provide the resources necessary to enable this support to be realized in practice.

An example of this can be seen in the reported case of *Re CH*.[70] In that case, a 38-year-old man with Down's syndrome was awarded damages for the breach of his Article 8 rights under the European Convention on Human Rights (ECHR) as protected by section 6(1) of the Human Rights Act 1998. Damages were awarded for the delay of more than 12 months in the provision of a sexual education programme, during which time CH was prevented from having sexual relations with his wife, who also withdrew 'to another bedroom and withheld much physical affection', so as 'not to lead him on' – actions that were described as having a 'profound' impact on CH.[71] The award of damages in this case serves as a useful reminder to local authorities that they must meet their obligations to support and facilitate capacity (and capabilities) as required by the CRPD.

Capabilities theory requires that opportunities are not *denied* on the basis of a lack of the necessary internal (or combined) capabilities – in fact, quite the opposite; a person should be *given* the opportunity to develop such capabilities on the basis of a human entitlement to having that capability. Lacking the capability to understand or maintain one's own reproductive health or bodily integrity does not provide a justification for preventing a person from engaging in activities that might put those things at risk. Rather, the capabilities approach provides a justification for an *entitlement to develop* the necessary capabilities and a related moral obligation on the state to provide her with the support that she requires to do so. The capabilities approach therefore provides

[69] The need for person-centred support and/or care is a central part of the capabilities approach to these issues; see id.

[70] *Re CH (by his Litigation Friend, the Official Solicitor)* v. *A Metropolitan Council* [2017] EWCOP 12.

[71] Id., 19.

a way of refocusing the legal issue of capacity to consent to sex on the ways in which a person can be supported to reach certain *minimum* capabilities before they are denied the chance to pursue intimate relationships.

Our approach, which grounds sexuality in consensual, mutual, and positive relationships that engage multiple capabilities, would additionally focus the minds of professionals working with disabled adults to encourage, educate, and support them in making informed decisions about intimacy. Our aim is not to leave disabled adults unprotected. Rather, reframing the capacity threshold in the way in which we suggest would remind those working with disabled adults that developing the capability (and capacity) for sexual intimacy goes beyond universal understanding of the health risks such as STIs or pregnancy to include understanding the consensual nature of such relationships.

5 | CAPABILITIES IN PRACTICE: FROM MEDICALIZATION AND CONTROL TO CONSENT AND SUPPORT

Our observation and analysis of CoP cases show that, in practice, the test for capacity to consent to sex has focused on P's understanding of pregnancy and STIs, rather than on consent. This represents a medicalized approach to the risks of sexual relations, perhaps influenced by the weight placed on medical evidence in CoP proceedings.[72] Medicalization is not always problematic as it can lead to the development of new technologies and treatments to alleviate disease and suffering. Similarly, it can help to minimize the disappointments of 'natural' inequalities, such as through the provision of assisted reproductive technologies to the infertile.[73] Yet the normalization of medicalization can also create gaps in our understanding of practices that do not primarily require a medical response. Considering which practices and events are medicalized, and in what ways, can help to highlight the gaps in our understanding when we do resort to medicalization. In sexual relations, the potential for an STI or pregnancy to result means that the practice of sexual relations is medicalized.[74] In other words, intimacy is seen as requiring a medical intervention such as contraception. While this is not necessarily a problem as many people would benefit from learning about contraception, the resort to medicalization simultaneously disregards other risks of sexual relations, such as non-consensual sex. The risks of sex that relate to the capability for bodily integrity, such as sexual assault, are sidelined by the medicalized, act-specific approach to sexual relations.[75] We are not suggesting that understanding the bodily health risks of sex is not important; rather, we argue that there has been a failure to focus on equally important issues of consent in these cases because the CoP takes a medicalized approach to capacity.

[72] P. Case, 'Dangerous Liaisons? Psychiatry and Law in the Court of Protection: Expert Discourses of "Insight" (and "Compliance")' (2016) 24 *Medical Law Rev*. 360; J. Lindsey, 'Competing Professional Knowledge Claims about Mental Capacity in the Court of Protection' (2020) 28 *Medical Law Rev. 1*.

[73] A. V. Bell, 'The Margins of Medicalization: Diversity and Context through the Case of Infertility' (2016) 156 *Social Science & Medicine* 39.

[74] See, for example, Bell's discussion of the medicalization of reproduction: id.

[75] For example, there are a number of reported cases where there were allegations of sexual violence that were not pursued: see *Derbyshire County Council* v. *AC*, op. cit., n. 43; *The London Borough of Tower Hamlets* v. *TB and SA*, op. cit., n. 7; *Birmingham City Council* v. *Riaz and others* [2014] EWHC 4247.

Expert witnesses in the CoP commonly use medicalized approaches to assess capacity.[76] This is arguably because capacity is often considered to be a clinical question, which can be assessed through cognitive tests or other quasi-objective measurements used by psychiatrists to aid diagnosis.[77] The emphasis on the medical (or health) risks of sexual relations is perhaps unsurprising given the weight attached to medical expertise in the CoP, something clear from this empirical research that has been published elsewhere.[78] The medicalization of capacity was also readily apparent from the CoP case files reviewed. For example, in *K County Council* v. *SL*, notes from the case file suggested that SL's understanding of infection was central to the issue of capacity. The expert stated that he thought SL lacked capacity to consent to sex but said:

> I would have to revise this opinion if a person [probably a woman speaking to her alone] was able to get her to describe the sexual act in simple terms and of the risks of infection. I do not think this is likely but am less certain in this case than I am in most cases.

In this case, following educative work, the expert changed his opinion, finding that SL had capacity to consent to sex, and proceedings were withdrawn. While this focus on support and education is to be commended, the primary focus on disease and mechanics remained, and was reinforced in another case, *K County Council* v. *MW*, where the expert clinical psychologist explained her approach to assessing MW's sexual capacity using a training pack from the British Institute of Learning Disability.

Here, the expert concluded that MW had capacity to consent to sexual relations, noting:

> MW demonstrated understanding of the male and female body parts and of sexual behaviour (with the exception of anal sex, which she showed recognition for when told). She also demonstrated an understanding of the mechanics of the act and that a consequence of sex was 'disease … get sick afterwards', and that condoms could prevent this. She also knew that condoms could be used to prevent pregnancy. She lacked awareness of alternative forms of contraception.

The consequences of sex are very narrowly defined here and have, like many other areas of CoP practice, become medicalized. This is despite the fact that most sexual intimacy results in neither pregnancy nor infection and research evidence demonstrates that low awareness of the medical risks of sex is not limited to disabled people. For example, evidence from Public Health England shows that in 2015 there were approximately 435,000 diagnoses of STIs in England and cases most commonly related to young heterosexuals under the age of 25 years and men who have sex with men.[79] Evidence from research with young people suggests that many 'felt that that they ought to

[76] See the guidance produced by the British Medical Association and Law Society and by the British Psychological Society: A. Ruck Keene (ed.) *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (2015); C. Herbert et al., *Capacity to Consent to Sexual Relations* (2019) at<https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Capacity%20to%20consent%20to%20sexual%20relations.pdf>.

[77] See further Lindsey, op. cit., n. 72.

[78] Id. See also Case, op. cit., n. 72.

[79] Public Health England, *Health Protection Report: Sexually Transmitted Infections and Chlamydia Screening in England, 2015* (2016) Vol. 10, No. 22, at <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/559993/hpr2216_stis_CRRCTD4.pdf>.

have known more when they first felt ready to have some sexual experience'.[80] Women in particular were 'more likely to report having wanted to know more about "contraception/birth control" (27.5% … vs 19.3% …) and "how to say no" (16.6% … vs 10.7% …) than men'.[81] Similar educational and social barriers to understanding sex have been found for adults with disabilities.[82] There is, therefore, a widespread misunderstanding about the risks of sexual relations across a range of age groups, socio-economic categories, and intellectual abilities. Developing the capability of *all* individuals to better understand the multiple risks of sexual relations, including the social challenges of consent, should be a key aim of sex and relationships education, whether in schools, in the home, or through community services. This would allow everyone to understand the ways in which sex and sexuality impact on bodily health as well as the importance of emotion, affiliation, and the tools required to protect bodily integrity.

A capabilities analysis encourages us to look at an individual's functioning and decide what skills *that individual* needs to be capable of intimacy in the context of their own lives. In some instances, this will be understanding of pregnancy and STIs; in others, consent will be the central issue. A more careful analysis of these issues is required, alongside a legal test that is sufficiently flexible to respond to the individuals before the court. Understanding decisions to consent to sexual relationships through the interlinked capabilities of bodily health, bodily integrity, emotion, and affiliation would allow more nuanced engagement with the specificities of the relationship in question, while remaining attentive to the importance of the multiple risks of sexual relations.

Another observed case, *Y County Council* v. *LC*, provides a useful case study for exploration of these issues in more detail. This case, observed in 2016, concerned LC's capacity to marry and to consent to sexual relations. LC was in her early twenties and was described in the case as having autism and a mild learning disability. She had been in a relationship with GK for more than three years when the proceedings commenced in 2015. The trigger for the proceedings was when others became aware of her secret marriage to GK. As a result of this marriage, SC, LC's mother, informed social services about the relationship because she was concerned that GK was motivated to marry LC to obtain a spousal visa to remain in the United Kingdom (UK).

A detailed judgment was handed down which, to date, has not been published. Two experts provided evidence on capacity to consent to sex. Dr T, a clinical psychologist, provided the original capacity assessment for the application to the CoP. Dr Y, a forensic psychiatrist, was instructed during CoP proceedings to provide an independent expert report on LC's capacity. Dr T's evidence focused on LC's understanding of STIs, explaining that she could name 'AIDS' but could not understand that a person could have it without symptoms. Similarly, when Dr Y was questioned by Counsel for GK, she said that LC told her she 'didn't like condoms' and was 'on the Depo injection'[83] and that in her view LC 'didn't understand it didn't stop sexual diseases'. When further questioned about what LC did know about diseases, Dr Y said that she could name 'AIDS' but did not 'understand what other diseases you could get' and that she believed 'as long as it looked normal' then there was no problem and no risk of disease. Importantly, evidence suggests that many non-disabled adults are also more familiar with AIDS than other STIs given its higher

[80] C. Tanton et al., 'Patterns and Trends in Sources of Information about Sex among Young People in Britain: Evidence from Three National Surveys of Sexual Attitudes and Lifestyles' (2015) 5 *BMJ Open* 1, at 3.

[81] Id., p. 4.

[82] A. Hollomotz, *Learning Difficulties and Sexual Vulnerability: A Social Approach* (2011) 52.

[83] Depo-Provera is one of a number of contraceptive injections provided to women to protect against pregnancy. It is administered every 12 weeks and is believed to be at least 99 per cent effective if used correctly. See NHS, 'The Contraceptive Injection' (2018) at <http://www.nhs.uk/Conditions/contraception-guide/Pages/contraceptive-injection.aspx>.

public profile.[84] Dr Y was also asked what understanding LC had of pregnancy and explained that she 'understands by having sex you can get pregnant'. This focus on STIs and pregnancy was despite the fact that LC had not, as far as the available evidence suggested, contracted an STI in her four-year relationship, nor had she become pregnant.

In stark contrast, LC had clearly been in an abusive relationship. LC's social workers explained that she had expressed unhappiness with elements of her relationship with GK, particularly anal sex, from which she sustained an anal fissure, and a criminal investigation into the possibility that GK had raped LC during their relationship was ongoing. GK was transported to and from prison to attend the final hearing. Yet the CoP focused heavily on the medical aspects of the test rather than the issues around consent.

The judge in LC's case held that she lacked capacity to consent to sexual relations and this meant that she would be prohibited from having any intimate relationship. The judge explained that LC 'does have sufficient understanding of the mechanics of the act', but he appeared unconvinced that she had capacity to understand pregnancy and risk of disease. The approach to capacity was highly medicalized, with the court placing significant focus on scientific and expert opinion on how the individual understood sex. However, there was very little focus on consent, despite it clearly being the primary reason that the case was before the court. The judge briefly considered LC's ability to say no, marking an important recognition of the relevance of this aspect of the test:

> 69. The experts were of the view that she had no real understanding of her ability to say no. This was particularly so within marriage. While she told her solicitor (in response to information given by the representative) that she understood that *'rape can happen within marriage*', she had previously told [Dr Y] that if a person is married then they have to want to have sexual relations whenever their husband wants this, and that if you were married and did not want sex then you had to split up.
>
> 70. … [Dr T] stated that [LC] would find it difficult to translate 'no' into reality. [Dr Y] stated that [LC] '*does not understand forced sex*'.

Despite this recognition, there was only limited discussion of consent within the expert evidence or presentation of the case.[85] However, LC's case was precisely the type of case where consent should have been at the very core: it was entirely about sexual exploitation of a mentally disabled woman by her partner.[86]

Applying a capabilities analysis, LC would have benefitted from the opportunity to develop her capabilities in relation to health and intimacy, and to put that newly acquired knowledge and understanding into practice before a capacity determination. Taken to its logical conclusion, the capabilities approach would have imposed a normative moral duty on the state to provide her with the support and resources that she required to gain the appropriate level of understanding, rather than allowing the state to prevent her from engaging in sexual intimacy as a result of her limited

[84] J. Dalrymple et al., 'Socio-Cultural Influences upon Knowledge of Sexually Transmitted Infections: A Qualitative Study with Heterosexual Middle-Aged Adults in Scotland' (2016) 24 *Reproductive Health Matters* 34, at 39.

[85] There were two brief references by Counsel for GK and two very brief references to the issue from the Official Solicitor.

[86] For a discussion of the meaning of vulnerability in this context and the need to move away from stigmatizing vulnerability discourse, see V. E. Munro and J. Scoular, 'Abusing Vulnerability? Contemporary Law and Policy Responses to Sex Work in the UK' (2012) 20 *Feminist Legal Studies* 189; J. Lindsey, 'Developing Vulnerability: A Situational Response to the Abuse of Women with Mental Disabilities' (2016) 24 *Feminist Legal Studies* 295.

understanding of consent. The capabilities lens can therefore help us to understand how the individual might be better supported to achieve capacity, rather than considering capacity a binary yes/no question. It can also provide a more honest appraisal of the issues at the heart of the case. Here, the case was primarily about abuse, rather than capacity. If LC had been in a fully consensual relationship, we think it unlikely that this case would have reached the CoP, given her ability to express an understanding of the first three elements of the test for capacity to consent to sexual relations. Yet because English law allows intervention under the MCA to protect people who are assessed as lacking capacity to make a decision, capacity has become the key legal mechanism for intervening in intellectually disabled people's lives. Troublingly, the approach taken by the CoP identifies the cause of the abuse as the victim's impairment (LC's lack of capacity to describe the medical risks of sex, or to understand the concept of forced sex), rather than as the actions of her abuser. As consent becomes a more significant element of the capacity test in sexual relations in light of *JB*, it is important that, as with all capacity law, we do not place higher burdens on disabled people to rationalize their actions than on non-disabled people.

Our CoP empirical data also provides an insight into situations where sexual capacity is raised in relation to potential perpetrators of abuse. Four of the 20 cases in our sample involved intellectually disabled people who were considered at risk of perpetrating abuse: *N County Council* v. *CA*, *YS* v. *E District Council*, *OD* v. *R City Council* and *P CCG* v. *QB* (see Table 1). Our analysis of these cases suggests that an approach focused on consent would provide greater honesty about the reason for intervention. Taking one case as an example, *OD* v. *R City Council*, we show how capacity is used to regulate potential non-consensual sexual conduct.

OD concerned a 46-year-old male, OD, described as having mild learning disability and schizophrenia. His case centred on a challenge to his deprivation of liberty (DOL) in a care home brought by his relevant person's representative. OD had been physically and sexually abused as a child and at 19 he was convicted for the rape of his younger brother. He had further convictions for gross indecency in a public place and indecent assault and indecent exposure. More recently, it had been reported that OD had worked as a prostitute and had been financially exploited by pimps. OD's wishes and feelings were that he wished to live independently. He accepted that he would need carers but wanted a lower level of supervision. The case file noted that, as a result of his DOL, he was also in effect being treated as if he lacked capacity to consent to sex and to make decisions about contact with others.

One of the authors attended court for the final hearing of this case, which was vacated at the last minute as the parties had agreed a way forward based on the expert evidence. However, she spoke with the judge and viewed the court records, including all of the evidence filed for the hearing, such as witness statements and expert reports. The independent expert report of Dr L, Consultant Psychiatrist, concluded that OD lacked capacity to make decisions about residence, care, finances, contact, and litigation, but had capacity to make decisions about sex. This assessment was reflected in the agreed final order. In light of the expert report, the local authority's position statement explained:

> As P has capacity to engage in sexual relations, a further statement from the care manager has been provided setting out the likely steps to be taken should P identify a person with whom he would wish to have sex. As each person would need to be considered afresh, no specific plan can be formulated, save for that a risk assessment in respect of P's contact with that person would have to be initially undertaken first.

The medicalized approach to 'risk management' prevalent in psychiatric discourse[87] was very clear from both the expert report and the local authority's response to it. During their meeting, OD told Dr L that he did not like where he lived because of the 'staff and residents, mainly the staff'. He told Dr L that 'they don't treat me like a proper adult, they treat me like a kid'. OD also told Dr L that he was gay and that 'I used to sleep around and blokes … would pay me lots of money for sex'. He said that he would like to have a relationship with a man at the care home but could not because he did not know who was gay there. Concerns in this case were nothing to do with whether or not OD understood pregnancy, the risks of disease, or the mechanics of sex. The case was entirely about the risks of non-consensual sex and, ultimately, the findings of incapacity in respect of residence, care and contact justified controls placed on OD.

The *JB* decision may well have changed the outcome in this case if the independent expert had considered whether OD had capacity to *engage in sex*. We therefore acknowledge that this case may be decided differently if it were to reach the CoP again, and in a way that is likely to be, *prima facie*, more restrictive of a disabled person's freedoms. However, our approach, and the Court of Appeal's reframing of the test, better captures the serious risks involved in not understanding the mutual and consensual nature of sexual relations, rather than using contact or medical risks to control the person indirectly. Further, while we agree that a focus on consent may, in some cases such as this, lead to findings of incapacity to consent to sex, this approach more accurately reflects the reality of what is going on in practice in these CoP cases. It is better to be honest about what the law is being instrumentalized for here, even if we then need to have a debate about whether or not mental capacity law is the most appropriate vehicle for protecting others from the risk of abuse.[88] Rather than a medicalized, risk-focused analysis, an approach that prioritizes understanding of consent more honestly captures the essence of why we need a test for capacity in relation to sex at all.

Overall, our approach would shift the focus in sexual capacity cases in two ways. First, and at the very least, adopting a capabilities analysis justifies the provision of support to achieve capacity before a case reaches a CoP determination. A capabilities approach provides a justice argument, rather than a legal obligation, that underpins a resources claim for the provision of support to improve a person's understanding. Second, it refocuses the issues to include concerns about bodily integrity and, therefore, consensual intimacy. The capabilities approach values supporting people to protect their bodily health and integrity and underpins the provision of support for disabled adults where they may 'not yet' have capacity to consent to sex.

6 | CONCLUSION

Our empirical research in the CoP highlighted that, in many cases, the approach to sexual capacity does not sufficiently focus on the central importance of consent in sexual relationships. The interpretation and application of the legal test for capacity to consent to sex unduly medicalizes the risks of sex and focuses on very narrow understandings of intimacy resulting in pregnancy and STIs. This approach sidelines the social risks of sexual activity, specifically the risks that arise from non-consensual sex as a result of not understanding that sexual intimacy is a choice, and one

[87] J. Fanning, 'Continuities of Risk in the Era of the Mental Capacity Act' (2016) 24 *Medical Law Rev*. 415; M. B. Simmons and P. M. Gooding, 'Spot the Difference: Shared Decision-Making and Supported Decision-Making in Mental Health' (2017) 34 *Irish J. of Psychological Medicine* 275; Case, op. cit., n. 72.

[88] For further discussion on this point, see Lindsey, op. cit., n. 44.

to which either party can say no, despite this being a significant concern in the majority of sexual relations cases that reach the CoP. Following the Court of Appeal decision in *A Local Authority* v. *JB*, the consent element of sexual relations is likely to have a greater role in CoP decisions. However, our analysis of CoP cases in practice from 2016 has shown that where this issue comes up in cases that are actually concerned with protection from abuse, the individual's lack of capacity is used as a justification for restricting her abilities to engage in any kinds of sexual activity, whether or not consensual.

Taking a capabilities approach to these issues, as we have done, offers a more holistic understanding of sexual intimacy, grounding decisions about capacity to consent to sex in their full range of individual and social contexts. The capabilities approach also offers a justification for why resources should be provided to help individuals gain the relevant capabilities before decisions are made about capacity. We recognize that developing a capability for intimacy requires much more than understanding that sexual intimacy is a choice. We also accept that society may have legitimate concerns about the spread of STIs or the cost of unintended pregnancies. However, protecting disabled people from sexual assault is a significant driver for these cases, given the prevalence of allegations of abuse in sexual consent cases at the CoP. Focusing on pregnancy and STIs therefore misses the point that the central practical function of the MCA in this context is to protect against abuse. Protection of intellectually disabled people from sexual assault and abuse can, we argue, be better achieved through supporting the individual to develop a capability for consensual intimacy, which values bodily integrity and emotional development. We accept that, in many CoP cases, the outcome on capacity may not be different if our approach were adopted. However, an approach that emphasizes the importance of understanding consent focuses the law on that issue, rather than medicalized risks of pregnancy and STIs, which in turn has an impact on the nature of the support provided to enable the individual to develop the capability for intimacy.

ACKNOWLEDGEMENTS

The authors would like to thank the anonymous reviewers for their feedback on this article as well as Donald Nicolson, Michael Thomson, Karen Yeung, and participants at the UK Mental Disability Law Conference 2018 for their comments on earlier versions of this article. Professor Harding is grateful for the support of the Leverhulme Trust through a Philip Leverhulme Prize.

How to cite this article: Lindsey J, Harding R. Capabilities, capacity, and consent: sexual intimacy in the Court of Protection. *J. Law Soc.* 2021;1–24.
https://doi.org/10.1111/jols.12278