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MENTAL CAPACITY AND THE CONTROL OF SEXUALITY OF PEOPLE WITH INTELLECTUAL DISABILITIES IN ENGLAND AND WALES

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In England and Wales, people with intellectual disabilities have sex in the shadow of two legal regimes. Under the Sexual Offences Act 2003 (SOA), it is a criminal offence to engage in sexual activity 'with a person with a mental disorder impeding choice', defined as lacking the 'capacity' to make a choice about consenting to sex (s30). This modernized older laws prohibiting a man from having extra-marital sex with 'a woman whom he knows to be an idiot or imbecile' (s7 SOA 1956). The intention behind this was to create a law which would permit people with intellectual disabilities to enjoy sexual relationships, whilst retaining a deterrent against sexual exploitation (Law Commission, 2000).

Meanwhile the Mental Capacity Act 2005 (MCA) governs when a person has the 'mental capacity' to give or refuse consent to their care arrangements, including restrictions on their liberty or intrusions into their privacy and bodily integrity. Because sex with a person who lacks 'mental capacity' is a crime, public authorities are required to 'undertake the very closest supervision of that individual to ensure, to such extent as is possible, that the opportunity for sexual relations is removed' (*IM v LM*, 2014: §1). Sometimes these steps amount to a deprivation of their liberty (*D Borough Council v AB*, 2011; *A Council v H*, 2012). The source of this legal obligation to control people has not been made explicit by the Court of Protection, which was established under the MCA. It may be an interpretation of the state's 'positive obligations' under the European Convention on Human Rights to prevent the exploitation of 'vulnerable persons' where it knows, or ought to know, that it might occur (e.g. *Đorđević v Croatia*, 2012: §138). The common law duty of care may place private caregivers under similar obligations (Bartlett, 2010).

The concept of 'mental incapacity' thus plays a twofold gatekeeping role in relation to sex: it invalidates a person's consent, rendering sexual activity with them a criminal act, and it *also* renders lawful restrictions on their liberty and invasions of their privacy to prevent them from engaging in sexual activity. This article asks, after Richardson (2013: 90), 'can mental capacity bear the burden placed on it here?'

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BACKGROUND

In the early 20th century, when eugenic discourses were in the ascendant, the Mental Deficiency Act 1913 introduced guardianship as a way to control people with intellectual disabilities who were living in the community, so that they did not 'procreate'; a policy adopted because of public opposition to sterilization (Fennell, 1992). Today, control over the sexuality of people with intellectual disabilities no longer has an explicitly eugenic basis, but is framed in terms of their vulnerability to sexual exploitation, or to harmful social and emotional consequences arising from relationships, pregnancy, or health risks connected with sex.

Many people involved in the lives of people with intellectual disabilities may regard their sexuality with some ambivalence (Aunos and Feldman, 2001). Their families may regard sexual relationships as unacceptably dangerous (Heyman and Huckle, 1995). They may seek their sterilization (Aunos and Feldman, 2002) or long term use of contraception (McCarthy, 2011). An implicit role of care and support services may be the regulation of sexuality (Brown, 1994). These concerns are not entirely without foundation (Heyman and Huckle, 1995). People with intellectual disabilities are more likely to experience sexual violence than non-disabled people (Hollomotz, 2011). Parents with intellectual disabilities experience an array of barriers to social justice (Jones, 2013). These risks have a complex etiology, arising from an interaction of social and environmental factors with a person's impairment (Hollomotz, 2011; Shakespeare, 2013). The critical question is: what kinds of measures are acceptable to protect people against these risks, and what criteria should we use to determine when they should be applied?

THE MENTAL CAPACITY ACT 2005

Guardianship legislation has undergone significant changes since the 20th century. The MCA was presented as a law that would 'empower' people, rather than control them (Lord Chancellor's Office, 2007). It is sometimes described as establishing 'rights' for people with disabilities to make their own decisions (e.g. Hollomotz, 2011: 42, 43, 49). Yet in strictly legal terms, the MCA simply sets out the circumstances where a person's ordinary legal rights to make decisions may be denied, on grounds connected with their disability. In contemporary disability rights parlance, this is a denial of 'legal capacity'. A new international treaty – the United Nations Convention on the Rights of Persons with Disabilities ('CRPD', 2006) – has critiqued such laws as a discriminatory denial of legal capacity for people with disablities (Dhanda, 2012; United Nations Committee on the Rights of Persons with Disabilities, 2014). Only a decade ago the MCA was considered a leading example of legal capacity

legislation which complied with contemporaneous international human rights norms. However today it is considered likely to violate them because it stands at odds with a 'new paradigm' of rights articulated in connection with Article 12 CRPD – the right to equal recognition before the law (Bartlett and Sandland, 2013; Richardson, 2013).

This article considers critiques of the MCA's empowering credentials by looking at case law concerning the capacity to consent to sex. This is one of the best developed areas of law on mental capacity as it has been the subject of extensive litigation. These cases offer a stark illustration of the issues and tensions in using 'mental capacity' as a gatekeeper to paternalistic interventions.

The MCA's main claim to being progressive and empowering is its 'decision specific' and 'functional' approach to capacity. A person is presumed to have 'mental capacity' until it is demonstrated otherwise (s1(2), see also s2(3)). However, the mental capacity of people with disabilities is more likely to be called into question than for others, so this presumption may subtly shift for them. Unlike earlier 'status' approaches to legal capacity, which would have denied some people with disabilities legal capacity in all areas of their life, the MCA is 'decision specific' and so a person might have legal capacity to make some decisions but not others. Whilst this may afford some people greater autonomy than status-based approaches to capacity, it also means that people's mental capacity to make decisions could be called into question in any area of their decision making, and repeatedly over time. The Official Solicitor – who typically represents the 'best interests' of people 'who lack the capacity to litigate' in the Court of Protection - has argued that this can be burdensome on public authorities and 'will encourage paternalistic attempts to deprive the disabled with capacity of their autonomy' (Pitblado, 2013).

The MCA uses a 'functional test', which defines a person as unable to make a decision if they are unable:

(a) to understand the information relevant to the decision,
(b) to retain that information,
(c) to use or weigh that information as part of the process of making the decision, or
(d) to communicate his decision (whether by talking, using sign language or any other means) (s3(1))

This 'functional' approach to mental capacity purports to focus on the *process* by which a person made a decision, not the outcome of that decision – and thus to avoid being hostage to the subjective values of those assessing capacity (Law Commission, 1991). The Act specifies that 'A person is not to be treated as unable to make a decision merely because he makes an unwise decision' (s1(4)). Yet scholars have questioned the MCA's 'value neutrality'. Freyenhagen and

O'Shea (2013: 67) argue that the MCA may inevitably 'smuggle in contentious evaluative commitments without discussion'. Veitch (2006) argues that the supposedly objective test of 'mental capacity' is attractive because it allows us to disavow the value judgments at work in these cases. Unsurprisingly, capacity assessors describe experiencing difficulty disentangling 'unwise' from 'incapacitous' decisions (Williams et al., 2012), and express concern that 'On the same set of facts, two practitioners could come to a completely different view' (evidence of the Royal College of Psychiatrists to the House of Lords Select Committee on the MCA, 2013: 29).

The MCA contains a 'diagnostic threshold', which requires that any failure of the functional test must be caused by 'an impairment of, or a disturbance in the functioning of, the mind or brain' (s2(1)) to constitute 'mental incapacity'. This requirement appears facially discriminatory as it means adults without disabilities could fail the functional test and yet retain their legal capacity (Bartlett and Sandland, 2013: 198; Dhanda, 2012). Paradoxically though, in some cases it has served to make it *harder* to demonstrate that a person with disabilities 'lacks mental capacity' because although they failed the functional test causation could not be shown (*CYC v PC*, 2013).

Some have questioned how far the functional test does assess an internal 'cognitive' process of deliberation by drawing attention to relational elements and power dynamics of capacity assessments. Stefan (1992-3: 766-7) observes that:

> '...the whole focus of a competence inquiry centers on the alleged incompetent person to the exclusion of the powerful side of the dialogue. Therefore, incompetence is seen as the attribute of the less powerful person and all failures of communication are attributed to her'

Morgan and Veitch (2004) argue that capacity assessments do not so much assess how a person makes a decision, but 'whether the person making that decision can construct a convincing case why he or she reaches the standard of the 'ability' that law expects in such circumstances'. This is an important distinction, and it suggests that capacity assessments may often depend upon a person's ability to persuade and articulate, rather than to *decide*.

Article 12(3) CRPD obliges states to give people with disabilities the support they may require in exercising their legal capacity. The MCA takes some steps in this direction, but in contrast with the absolute duty to provide support under the CRPD its requirements are heavily qualified. It merely states that people should not be treated as lacking capacity unless 'all practicable steps' have been taken to help them to make a decision (s1(3), see also s3(2)). It does not specify who should provide this support, nor does it give any legal recognition to the kinds of supports which a person might use in exercising legal capacity, in contrast with other jurisdictions (Then, 2013). In some cases people

have been held to 'lack capacity' *because of* their reliance on others for assistance with decision making (*Verlander v Rahman,* 2012). As Bartlett and Sandland (2013: 180) observe, the Court of Protection sometimes imposes measures on a person against their will on the grounds that it will enhance their mental capacity. This stands at odds with the consensual model of support for the exercise of legal capacity, including supported decision making, proposed in connection with the CRPD (UN Committee on the Rights of Persons with Disabilities, 2014). Bartlett and Sandland also comment that it is a 'rare case' where the Court of Protection does consider whether all steps to support a person to make a decision have been exhausted (p198).

When people 'lack capacity', third parties may make decisions on their behalf in their 'best interests' (s1(5)). Best interests decision makers must consider the person's past and present wishes, feelings, values and beliefs. They must help the person to participate in the decision 'so far as reasonably practicable', and consult with others engaged in caring for them or with an interest in their welfare (s4). The aim of this approach is 'to consider matters from the patient's point of view', however these subjective factors are not binding on substitute decision makers (*Aintree University Hospitals NHS Foundation Trust v James,* 2013). Where best interests decisions depart from a person's subjective will and preferences they will constitute 'substitute decisions', which the Committee on the Rights of Persons with Disabilities' (2014) maintains are prohibited by Article 12.

Under the MCA, decision makers must consider the least restrictive course of action (s1(6)), but are not obliged to adopt this course. Neither does the MCA create any pressure to *make available* less restrictive options. Where restraint is used or threatened, or a person's liberty is restricted, it must be a proportionate response to the likelihood of the person suffering harm, and the seriousness of that harm (s6). The MCA also contains a framework for detention in care homes and hospitals – known as the deprivation of liberty safeguards.

The imposition of substitute decisions which conflict with a person's own will and preferences on disability-related grounds is considered by many to be a form of disability discrimination which violates Article 12 CRPD (Dhanda, 2012). The UN Committee on the Rights of Persons with Disabilities (2014) has stated that the CRPD requires states to offer support and to abolish regimes of substitute decision making. This was a highly contentious issue during the negotiations of Article 12 CRPD (Dhanda, 2012). The claim that imposing measures on people with disabilities against their will on disability-related grounds is discriminatory also arises in connection with Article 14 CRPD (the right to liberty), Article 17 CRPD (respect for physical and mental integrity), and other elements of the CRPD. In addition, Article 23 CRPD prohibits discrimination against people with disabilities in matters connected with marriage, family life and relationships. This article does not aim to provide a

legally 'correct' interpretation of the CRPD, nor offer any alternative legal framework which might satisfy the CRPD, but it does offer some examples of how 'mental capacity' approaches can indeed operate in the discriminatory and oppressive ways that critics maintain.

CASE LAW: ISSUES AND TENSIONS

The court cases discussed here bring to the surface tensions between a desire to adopt a low threshold for capacity, in order to safeguard rights to liberty and privacy, and the pull of a higher threshold which would permit a more protective approach.

Minimalist approach

Early cases adopted a low threshold for the capacity to consent to sex, requiring only a 'rudimentary knowledge of what the act comprises and of its sexual character to enable her to decide whether to give or withhold consent' (*X City Council v MB, NB and MAB*, 2006: §74). In *D Borough Council v AB* (2012) Mostyn J[1] commented that 'the Court must tread especially carefully where an organ of the state proposes that a citizen's ability to perform, in a non-abusive way, the sex function should be abrogated or curtailed. It involves very profound aspects of civil liberties and personal autonomy' (§11). Accordingly, Mostyn J took a minimalist approach to the capacity to consent to sex, a requiring only understanding of the following (§42):

1) The mechanics of the act
2) That there are health risks involved, particularly the acquisition of sexually transmitted and sexually transmissible infections
3) That sex between a man and a woman may result in the woman becoming pregnant

Where homosexual sexual activity was concerned, the third requirement was discounted. In this case, 'Alan'[2] did not attain this low threshold of capacity because his knowledge of the health risks of sex was limited: 'he thought that sex could give you spots or measles' (§44). Mostyn J ordered the council to 'provide Alan with sex education in the hope that he thereby gains that capacity' (§52), so that the restrictions could be lifted.

[1] By convention, High Court judges are referred to by their surname, followed by a 'J', and the surnames of Court of Appeal Judges – Lord or Lady Justices – are followed by 'LJ'.

[2] Not his real name, but a name chosen by Mostyn J for the anonymised judgment.

Alan's case highlights difficulties with even this 'minimalist' approach. Alan failed the test because of his limited understanding of sexual health matters, consequently he was deprived of his liberty until he could demonstrate a better understanding. Yet a legal system that results in deprivation of liberty because a person believes that sex might give you spots or measles, then releases them from detention when they have corrected this false belief, seems arbitrary and absurd. The courts have not spelled out precisely what knowledge a person must demonstrate to pass this element of the test. It is hard to see how they could do so in a way that does not either collapse into vagueness ("there are some health risks"), or place expectations of knowledge on people with disabilities which other members of the population are not required to demonstrate. Many people without disabilities have poor knowledge of sexually transmitted infections (Samkange-Zeeb et al, 2011), but there is no question of this meaning they cannot give a legally valid consent to sex. The suggestion that those people should be closely supervised and their liberty restricted until they can demonstrate this knowledge would be unthinkable. In this element of the test, there is a clear danger that – despite the expressed desire of some judges to avoid this – the 'mental capacity' approach can discriminate against people with disabilities.

In Alan's case, it is also pertinent to ask whether his lack of understanding was caused by a mental impairment – as required by s2(1) MCA – or by inadequate sex education. It is unclear from the judgment whether those assessing Alan's mental capacity took any steps at the time to help correct his false belief that sex could give you spots or measles, as would be required by s1(3) MCA. There is a danger that this element of the test may be neglected by assessors who would prefer an outcome which restricts a person's opportunities to engage in sexual activity.

Mostyn J's minimalist approach makes demands on abilities to articulate knowledge of pregnancy and health risks connected with sexual activity. This will almost inevitably mean that people with serious communication impairments will be found to lack capacity in this regard. Yet it is not inevitable that these people are being sexually exploited if they enjoy sexual relationships where they are able to demonstrate an ability to choose or refuse sexual activity, and benefit from sexual and personal intimacy.

The 'management of monsters'

Sandland (2013) draws on historical case law on sexuality and intellectual disabilities, to argue that beneath the surface of claims to intercede on behalf of the 'vulnerable', one can often discern a deeper concern with managing deviant or 'monstrous' sexuality. Sandland sees Alan's case as a modern example of this preoccupation with dangerousness and monstrosity. It appears that the question of Alan's capacity to consent to sex arose not because there were concerns about potential

harm to him – indeed, possible harms to Alan are not discussed anywhere in the judgment – but because of suspicions that he may have behaved sexually inappropriately in front of children when unsupervised in the community.

Unlike the Mental Health Act 1983 (MHA), the MCA only purports to protect the interests of the individual, not the public. Yet there are signs that the MCA is being used to manage 'dangerousness' to others. ZZ had mild intellectual disabilities, and was sexually attracted to children (*Y County Council & ZZ*). 'George' had a string of psychiatric diagnoses, including 'childhood autism, obsessive-compulsive disorder, dissocial personality disorder, mixed anxiety disorder and paedophilia' (*J Council v GU & Ors*, 2012: §5). The MCA was used to deprive them of their liberty on grounds that they lacked the capacity to consent to their care arrangements. In neither case are the findings of incapacity reasoned, as they were not contested. This can occur in Court of Protection cases where 'litigation friends' may conduct litigation in a person's 'best interests', not according to their will (Series, forthcoming). The strip searches, room searches and surveillance to which George was subject were so invasive that Mostyn J queried whether they might not violate his rights to private life, as there was no guidance on using the MCA in this way and the monitoring mechanisms were so weak. Lawyers practicing in this area observed 'It is no doubt in the 'best interests' (broadly defined) of any potential sex offender to be kept under such close supervision that no opportunities for offending behaviour arise, but that is not how society functions in respect of those without learning disabilities' (39 Essex St Court of Protection Team, 2013). These cases show how under the MCA a person's disability can form the basis of a regime of preventive detention, which could not be applied to potential sex offenders without disabilities without any criminal conviction, to stop them from committing offences.

Understanding the nature of consent itself

Most researchers writing about sexuality and intellectual disabilities agree that a component of a valid consent to sex is understanding that it is a choice which a person can refuse (McCarthy and Thompson, 2004; Hollomotz, 2011; Centre for Disability Law & Policy, 2012). Yet in Alan's case, Mostyn J had deliberately excluded an understanding of consent from the test of capacity to consent to sex, on the (somewhat bizarre) basis that paedophiles and rapists are regarded as having the capacity to consent to sex despite not – in Mostyn's view – understanding the nature of consent (§39). However, in *A Council v H* (2012), Hedley J held that it was important that a 'highly sexualised' young woman with intellectual disabilities understood 'that they do have a choice and that they can refuse' (§25).

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Understanding the consequences?

The MCA requires a person to be able to understand the 'reasonably foreseeable consequences' of making a decision either way (s3(4)); this has given rise to debate over precisely what consequences a person must understand in order to consent to sex. The Court of Protection has generally been reluctant to expand this information beyond a bare minimum.

In *A Council v H*, H's carers were 'perplexed' by her sexuality – she described a history of 'willingness to have sex with anyone who asked her including strangers', sex with groups of much older men, of having had oral and anal sex and 'that she had attempted to have sex with dog' (§9). The council argued that mental capacity required an understanding of the emotional and moral issues pertaining to sexuality. Hedley J declined to adopt this approach, questioning whether such a test could be 'workable' (§24-25), as did Mostyn J in Alan's case.

In *London Borough of Ealing v KS* (2008), a council argued that the capacity to consent to sex must include an understanding of specific risks to a person's mental health of a pregnancy or failed relationship. They maintained that KS lacked capacity because she held false beliefs about the likelihood that any man who had sex with her would marry her, and thought she would be able to keep her child if she became pregnant. Roderic Wood J considered that this blurred the distinction between capacity and best interests (§142), and observed that similar 'false beliefs' might be held by many women in society, which went to the *wisdom* of sexual relations rather than the validity of consent (§144).

In *Re A (Capacity: Refusal of Contraception)* (2010) a council sought a declaration permitting contraceptives to be administered to a woman against her will, arguing that she needed to understand the long-range consequences of a pregnancy to refuse consent to contraception. Bodey J rejected this argument, saying that this set the bar too high and had shades of social engineering.

Ability to 'use or weigh' the information'

The Court of Protection has generally downplayed the MCA's requirement to 'use and weigh' information in relation to sex. Early case law distinguished between the 'refined analysis' required to consent to medical treatment, and the test of capacity to consent to sex (*Council X v MM & Anor (No. 1),* 2007). In *A Council v TZ* (2013) an expert psychiatrist argued that the capacity to consent to sex required an ability to evaluate 'a complex analysis of risks and benefits often in the abstract and hypothetical' (2013: §42). Baker J emphasized that for most people in society, choices about sexual relations were often emotional, instinctive and impulsive than rational: 'Human society would be very different if such choices were made the morning after rather than the night before' (§53). He

warned of 'a danger that the imposition of a higher standard for capacity may discriminate against people with a mental impairment' (§55).

In *IM v LM* (2014) the Court of Appeal acknowledged that whilst *some* ability to use and weigh information in order to give a valid consent to sex was required by the MCA, this was 'unlikely to loom large in the evaluation of capacity to consent to sexual relations' (§81). Sir Brian Levenson held that tests of capacity to consent to sex 'should not become divorced from the actual decision-making process carried out in that regard on a daily basis by persons of full capacity' (§80).

The influence of person and situation specific factors

One issue has dominated the case law on the capacity to consent to sex: to what extent might a person's ability to make a decision regarding sex be affected by who their sexual partner is, or the situation in which the decision is made? Until *IM v LM* the MCA case law was very unsettled on this point. Public authorities – concerned that a person may be in an abusive or harmful relationship – have persisted in arguing that a person who could pass a minimalist test of the capacity to consent to sex might yet lack mental capacity when it came to sex with a specific person. This approach was rejected in a number of cases. In *Council X v MM & Anor (No. 1)* Munby J questioned whether 'it can sensibly be said that she has capacity to consent to a particular sexual act with Y whilst at the same time lacking capacity to consent to precisely the same sexual act with Z' (§87). In Alan's case, Mostyn J asked 'Is the council supposed to vet every proposed sexual partner of Alan to gauge if Alan has the capacity to consent to sex with him or her?' (§35). In *TZ*, Baker J observed that 'To require the issue of capacity to be considered in respect of every person with whom TZ contemplated sexual relations would not only be impracticable but would also constitute a great intrusion into his private life' (§23).

However, in *R v C* (2009) the House of Lords endorsed a more situational and person-specific analysis for the purposes of the SOA 2003. The victim was a 28 year old woman 'with an established diagnosis of schizo-affective disorder, an emotionally unstable personality disorder, an IQ of less than 75, and a history of harmful use of alcohol' (§17). She met C shortly after her doctor had recommended her compulsory re-admission to hospital under the MHA, but before it had been carried out. She told him that she had recently been discharged from detention under the MHA and that people were after her. He offered to help her, so she went to his friend's house:

> He sold her mobile telephone and bicycle and gave her crack. She went to the bathroom but the defendant came in and asked her to give him a "blow job". Her evidence was that she was really panicky and afraid and wanted to get out of there.

> She was saying to herself "these crack heads . . . they do worse to you". She did not want to die so she just stayed there and just took it all. (§18)

The complainant knew what a blow job was (§26), but Lady Hale held that there was more to the capacity to consent to sex than simple understanding of the act *in general*, one must demonstrate *situational* understanding: 'it is difficult to think of an activity which is more person and situation specific than sexual relations' (§27).

It is easy to see why Lady Hale favoured a more situational understanding in this case. Feminist and disability rights scholars have argued that the validity of consent to sex must take into account wider situational and relational factors (Centre for Disability Law & Policy, 2012; Herring, 2012; McCarthy and Thompson, 2004). This situational approach was taken up only once by the Court of Protection, in *D County Council v LS* (2010). Yet the consequences of adopting this test in a civil law context are very different to the criminal law situation: rather than resulting in the punishment of sex offenders, the result may be the expansion of control and supervision over the potential victims, with far reaching consequences for their rights to privacy, relationships and – ultimately – liberty.

In *IM v LM* the Court of Appeal concluded that the invasion of privacy and the practical burden on public authorities of adopting a person- and situation-specific approach to capacity for the purposes of the MCA was too great, and endorsed the 'minimalist' approach. However, they maintained that the situational and person-specific analysis should be retained for criminal cases, where the focus was inevitably on the specific incident, with a specific person. This decision may yet be appealed to the Supreme Court.

DISCUSSION

These cases illustrate many of the concerns of critics of the MCA. As Veitch, Freyenhagen and O'Shea predicted, the cases described here show that public authorities have indeed tried to 'smuggle in' evaluative commitments into the test of capacity to consent to sex, particularly around understanding the moral, emotional and social dimensions of sexual activity, although the Court of Protection has generally resisted these efforts. Far from being a neutral affair, the test of capacity itself has become a secondary battleground where lawyers and caregivers attempt to draw lines in the sand demarcating the boundaries of what sexual touching is permissible, and when others may lawfully intercede to prevent it. Meanwhile the requirement for understanding the health risks of sex looks likely to collapse into redundancy or have serious discriminatory and absurd effects.

The requirement to understand the nature of consent introduced by Hedley J is closely aligned with suggestions in the literature on sexuality and disability (Centre for Disability Law and Policy, 2012; Hollomotz, 2011; McCarthy and Thompson, 2004). It is unclear as yet precisely how a person must demonstrate this understanding. Must they be able to verbally articulate the principles of consent, or might it suffice – as Hollomotz (2011: 49) has suggested - 'that two individuals are content in each other's company, that they are able to communicate displeasure or alert a member of staff to help them in the event of an unwanted sexual approach and that they understand the sexual behaviour they are about to engage in'?

IM v LM leaves undisturbed the legal requirement to prevent sexual activity where a person is considered to lack the mental capacity to consent to it (§1). However, by endorsing a 'minimalist' conception of capacity to consent to sex, the Court of Appeal limited the circumstances in which public authorities and care providers can – and must - intercede to prevent sexual activity altogether. Because it is possible that a person might be found to have the capacity to consent to sex on the civil law test, yet lack the capacity to consent to sex with a particular individual or in particular circumstances under the SOA, this means that in theory public bodies and care providers may not be able to intercede to prevent sexual activity which could constitute a criminal offence. Yet the MCA offers other tools to control the sexuality of people with disabilities, even if they cannot be used to prevent sex altogether. For example, by contending that a person lacks the capacity to make decisions about contact with specific individuals, contact with those individuals might be restricted or supervised. Where there are concerns that a person cannot appraise the risks of new sexual partners, care plans may be devised to manage risks – including through careful monitoring of new partners by support staff (*A Local Authority v TZ (No. 2),* 2014). However, where a person does have the capacity to consent to sex, public bodies may still be required to facilitate opportunities for sexual intimacy even within these restrictions (*Council X v MM*, 2007).

The SOA 2003 could still be used to intercede *after the event* where a person's consent to sex was invalid because of situational or relational factors. Yet the criminal justice system might tolerate some instances of sex which the MCA would not. The Crown Prosecution Service (2012) regards relationships of 'genuine affection' as a mitigating factor, and the Law Commission (2000: [4.74]) recommended that sexual activity between two people who *both* lacked capacity should not constitute an offence 'unless there is oppression or exploitation'. However, as Bartlett (2010: 141) comments, mitigation is not a defence: an offence would still be committed even if it were not prosecuted.

These cases reveal a deep and difficult tension between instincts to protect people who may be vulnerable to sexual exploitation, for whom the risks of emotional, social and health related harms arising from sexual activity may be greater, and a desire to respect their autonomy. They illustrate the stark reality that in striving to protect people from sexual offences, we have arrived at a position where the liberty of victims, not merely offenders, is at risk.

In the literature on disability and sexuality, there have been various attempts to frame what a valid consent to sex should look like. In contrast with the Court of Protection's minimalist approach, and more in accordance with the approach taken by Lady Hale in *R v C,* almost all of these have recommended taking into account situational and relational factors, although some have eschewed capacity based approaches. McCarthy and Thompson (2004) are sceptical about the value of tests of capacity to consent to sex, but do say that 'there needs to be reasonable degree of equality between the parties, so that both parties have sufficient power to make the choice to engage or not engage in sex, without fear of adverse consequences' (p234). Herring (2012: 477) states 'There is no getting away from an assessment of the relationship the person is in and whether it is marked by the kind of values which enable sexual autonomy to be enjoyed'. The Centre for Disability Law and Policy (2012) endorsed McCarthy and Thompson's approach, but argued that the test for a legally valid consent in the context of sexual offences should be 'disability neutral', on the basis that to define an offence in terms of mental disorder or mental incapacity would be discriminatory and contrary to the CRPD. They suggest that one possible offence might be 'abuse of a position of power', and that consent should be given the same definition for everyone, as 'a consent freely and voluntarily given... a consent is not freely and voluntarily given if it is obtained by force, threat, intimidation, deception or fraudulent means'. They do not discount the possibility that 'mental incapacity' might be a factor that would need to be taken into account in some cases, but their proposals would mean that where a person lacked mental capacity they would not *necessarily* be treated as incapable of giving a valid consent to sex. Palmer (2013) has argued the meaning of consent in general is contested and uncertain, and that a better concept than for defining sexual offences might be 'freedom to negotiate', an approach which would not assume 'that a person who is in some way 'vulnerable' or dependent on others is never capable of actively choosing or negotiating their sexual encounters.'

These approaches have in their sights *exploitation* or oppression within a particular relationship, or at a particular point in time. They are focussed on the power dynamics between the individuals in the particular sexual encounter, rather than the person's disability *per se*, although without discounting that disability and dependence may be factors which impinge upon those dynamics. There are attractions to these approaches. They could create more space for people with

intellectual and cognitive impairments to enjoy sexual relationships which are not oppressive or exploitative, whilst offering a flexible means of responding to those which are. But the very flexibility of these suggestions may be problematic: who is to decide what is exploitative, and what is oppressive?

Expanding the factors to be considered in connection with whether or not a sexual encounter was an offence, and framing them in a disability neutral way, might open up a broader discussion about vulnerability to sexual exploitation among disabled and non-disabled people alike. That could be a very important and worthwhile conversation. But it is not clear that these approaches are any less prone to subjective and arbitrary assessments than the test of 'mental capacity' was. Coming up with criteria which would 'permit the good sex, and outlaw the bad' is an extremely difficult enterprise (Bartlett, 2010). Might we have to concur with the Court of Appeal in *R v Bree* (2007), a case concerning whether a person could give a valid consent to sex when under the influence of alcohol, 'that there are some areas of human behaviour which are inapt for detailed legislative structures' (§35)?

Moreover, the recommendations from the literature on disability and sexuality do not clearly resolve the question of what should be done when a person is at risk of sexual exploitation – however it is defined. The criminal law's focus on perpetrators is clearly important, but what should public authorities and caregivers do when a person is actually known to be at a real risk of sexual exploitation? The approach under the MCA is to intervene in their 'best interests', in ways that potentially constitute enormous interferences with rights to liberty and private life. It is unlikely that this would be compatible with the CRPD, given its emphasis on autonomy and self-determination, but the CRPD also calls for people with disabilities to be given protection from violence, exploitation and abuse (Article 16).

One answer from the CRPD perspective might be that people should only receive protective measures that they consent to, or at least do not oppose, and that the consequences which may occur if those persons are then subject to exploitation are a fair price to be paid for ensuring that people with disabilities enjoy an equivalent 'dignity of risk' to others.[3] Another answer, suggested by Bartlett and Sandland (2013) is that we look at whether 'adult protection' legislation can itself be framed in a disability neutral way, to apply to disabled and non-disabled people who are at risk of exploitation and abuse. In fact, there are signs of a general adult protection jurisdiction emerging in England and Wales, which turns on situational vulnerability rather than 'capacity'. In a small number of cases, the High Court has claimed an 'inherent jurisdiction' to intervene where a person is

[3] For a discussion of the 'dignity of risk' in the CRPD literature, see Gooding (2012: 5).

considered to be at risk of abuse or neglect, and incapable of acting to protect themselves not because of 'mental incapacity' but because of the relationship of power between them and their abuser (for a review of the early case law, see Szerlectics, 2011). Interestingly, efforts to put these judge-made powers to intercede in 'vulnerable situations' on a statutory basis met with considerable public opposition. The government withdrew the proposals, noting 'We believe it is highly significant that members of the public were far more strongly against the proposal compared to health and social care professionals' (Department of Health, 2013). It seems that the general public might endorse paternalistic interferences in the lives of people with intellectual and cognitive disabilities, but not where others might be exposed to exploitation or abuse for other reasons.

Flynn and Arstein-Kerslake (2014: 100) suggest that the 'duty of care' or 'defence of necessity' may be used to permit certain interventions under the CRPD, but 'these exceptions and defences need to be extremely limited and carefully defined, to prevent any return to a more regressive system'. As yet, nobody has closely examined precisely when such interventions might be permissible within the 'new paradigm' of the CRPD. Suggestions that there might be some scope for intervention under the 'new paradigm' take us back to the beginning of our journey: where should the line be drawn, what non-consensual interventions might be permissible to protect people against situations of abuse and exploitation? The CRPD poses a challenge – to draw that line equally for all persons, with and without disabilities. The critiques of 'mental capacity' considered here suggest that it was only ever an illusion that we could draw the line in an objective way, free of our subjective desires to secure particular ends, and free of potentially arbitrary and absurd outcomes.

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