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Assessing Capacity to Consent to Sexual Activity: Legal Considerations

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Determining whether psychiatric facilities with long-term inpatients should develop policies to address consensual sexual activity between inpatients, or between inpatients and their non-admitted significant others, remains, and likely will remain, a controversial issue. In one British hospital, the policy has focussed on how to respond, after the fact, to reports of sexual activity between patients in the context of allegations of sexual assault.[1] While it is obviously important to ensure a sensitive and timely response to what may prove to be criminal conduct, some health care providers would argue that consideration should also be given to appropriately addressing, in a pro-active manner, the sexual needs of long-stay, admitted inpatients.

Studies have shown that inpatients on acute psychiatric wards are engaging in sexual activity during their inpatient admission.[2] Given that this is happening, what is the right response? Is it better to look the other way or, should health care providers attempt to address the complex issues that attach to supporting the sexual needs of the mentally ill patient and provide privacy rooms where patients may do so?

Articles elsewhere in this issue of JEMH address the underlying assumptions that have contributed to a reluctance to address the sexuality and sexual education needs of inpatients suffering from mental illness. Increasingly, a viewpoint is emerging that "(e)thical, moral, and holistic mental health practice must take greater steps to ensure that sexuality, as a normative part of life, is addressed in treatment"[3] While there may be greater willingness to consider that inpatients should be able to express their sexuality during a lengthy hospital stay, support for such sexual expression must take into account the reason for the admission: an episode of acute mental illness that has given rise to the need for care and treatment in a psychiatric facility. Just as a psychiatrist turns his or her mind to whether the patients for whom they are proposing treatment are capable of consenting to or refusing that treatment, physicians who would support a patient's right to sexual expression while in hospital must also consider the patient's capacity to consent to or refuse sexual activity and also, whether any proposed sexual activity would be detrimental or beneficial to the patient's recovery.

Whether the assessment of sexual capacity happens prospectively, in light of a patient's report that he or she plans to engage in sexual activity, or retrospectively, following a patient's report of having done so, the legal principles that govern the right to consent to or refuse treatment, as well as the law relating to consent as a defence to a criminal charge of sexual assault, may provide some guidance to physicians evaluating sexual capacity.

Applying treatment capacity principles to sexual capacity assessment: useful analogy?

Assessing a patient's capacity to consent to sexual activity may be similar to assessing the patient's capacity to consent to treatment. Ontario's *Health Care Consent Act* sets out a two pronged test for capacity to consent to treatment:

> A person is capable with respect to a treatment ... if the person is able to understand the information that is relevant to making a decision about the treatment ... and able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision.[4]

Similar to the assessment of treatment capacity, the assessment of capacity to consent to sexual activity should "avoid the error of equating the presence of a mental disorder with incapacity."[5] A person is presumed to be capable with respect to treatment, and healthcare providers proposing treatment are entitled to rely on that presumption, unless there are reasonable grounds to believe that the person is incapable of consenting to the proposed treatment.[6] Similarly, should physicians assessing capacity to consent to sexual activity be entitled to rely on a presumption of capacity, unless there are reasonable grounds to believe otherwise? What are reasonable grounds that might trigger an obligation to assess capacity to consent to sexual activity?

Arguably, "reasonable grounds" could be the same conditions considered during treatment capacity assessments; for example, the presence of cognitive disorders or psychotic symptoms that interfere with the person's ability to process information relevant to making a decision. The Supreme Court of Canada, in *Starson v. Swayze*, considered the two branches of the legal test for capacity to consent to treatment and found that the first branch involves the person's "cognitive ability to process, retain and understand the relevant information".[7]

Analogizing this branch of the test to an evaluation of capacity to consent to sexual activity raises some interesting questions. What will the healthcare provider consider to be the relevant information that the person needs to understand? Is it the biomechanics of sexual activity, how such activity could lead to pregnancy or sexually transmissible diseases and what steps can be taken to minimize those risks? Will it also include information about consent itself, i.e., that each person has an obligation to obtain the other person's consent to the activity in question, and to know that the other person may withdraw his or her consent at any time during the sexual activity? Is the person able to process, retain and understand these concepts?

The second prong of the test for capacity to consent to treatment is the ability to understand the reasonably foreseeable consequences of a decision or lack of decision. In *Starson v. Swayze*, the Court interpreted this part of the test to mean that the person must be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof.[8] Again, by way of analogy, if this test were to apply to capacity to consent to sexual activity, health care providers will have to assess whether the person is able to apply the relevant information to him or herself and to weigh the risks and benefits of the activity – including how engaging in sexual activity may affect recovery from the acute episode of the mental illness that has resulted in the admission to hospital.

There is no doubt that similarities exist between the capacity to consent to treatment and capacity to consent to sexual activity: consent to either may be withdrawn at any time; further, in order to be valid, consent must be voluntary and informed. One significant difference arises in the treatment context: when a patient is found incapable of giving or refusing consent to treatment, the law requires the health care provider to obtain consent from a substitute decision maker. In contrast, the criminal law makes clear that consent to engage in sexual activity cannot be given on another person's behalf.

How does the criminal law consider capacity to consent to sex?

Under the *Criminal Code*, the sexual activity that forms the basis for a sexual offence may be quite broad. For example, the offence of sexual interference includes:

> ...any touching of the body of a person, directly or indirectly, without that person's consent, with a body part of another person, or with an object, for a sexual purpose.[9]

The *Criminal Code* sets out several other sexual offences, including invitation to sexual touching (s. 152), sexual exploitation (s. 153), sexual exploitation of a person with a disability (s. 153.1), indecent exposure (s. 173), sexual assault (s. 271), and sexual assault (s. 272). Underlying the sexual assault charge is the charge of assault, which is defined to include the intentional application of force to another person (s. 265).

How does the issue of capacity to consent to sexual activity relate to these sexual offences? In general, consent is a defence to a sexual assault charge, since if consent exists, there can be no application of force in the sexual activity. In this context, consent is defined as "the voluntary agreement of the complainant to engage in the sexual activity in question."[10] Further, the law provides that there can be no consent to a sexual activity where any one of the following circumstances exists:

(a) the agreement is expressed by the words or conduct of a person other than the complainant;

(b) the complainant is incapable of consenting to the activity;

(c) the accused induces the complainant to engage in the activity by abusing a position of trust, power or authority;

(d) the complainant expresses, by words or conduct, a lack of agreement to engage in the activity; or

(e) the complainant, having consented to engage in sexual activity, expresses, by words or conduct, a lack of agreement to continue to engage in the activity.[11]

The conditions which negate consent are interesting to consider in the context of a physician assessing a patient's capacity to consent to sexual activity. First, these conditions make clear that there are many circumstances under which sexual activity becomes criminal conduct. Secondly, they underscore the importance of ensuring that a patient who wishes to engage in consensual sex has the capacity to do so, including, *inter alia*, the ability to communicate his or her consent and to appreciate that he or she may withdraw his or her consent at any time during sexual activity. Further, courts have found that the presence or absence of consent to the sexual activity is subjective, and "determined by reference to the complainant's subjective, internal state of mind towards the touching, at the time it occurred"[12] This begs the question of how far in advance of sexual activity capacity should be assessed, with regard to the fluctuating nature of capacity and mental illness.

In one case, *R. v. R.R.*, the Ontario Court of Appeal considered the defence of consent where the complainant was a 21-year-old, developmentally delayed woman whose cognitive functioning was described by a medical expert at the trial to be on par with a 4 to 6-year-old child.[13] The 57-year-old male accused was the complainant's neighbour, who had known the complainant and her family for over 10 years. The accused knew that "despite the complainant's chronological age and physical maturity, she was developmentally disabled."[14] The accused had engaged in digital penetration of the complainant, along with fondling and oral-genital contact. The accused alleged that the complainant had consented to the activity, in part because she demonstrated what he characterized as an apparent willingness to reciprocate the touching and oral-genital contact.

Ultimately, the trial judge accepted the Crown's expert evidence that the complainant did not have the ability to consent to sexual activity. Although the expert had stated that there was no specific test for capacity to consent to sexual activity, he testified that consent "requires some knowledge of what the act will lead to, both in the short and the long term" and in this case, the expert did not believe that the complainant had the "cognitive abilities to fully comprehend the consequences of the outcome of the sexual liaison."[15]

The Court of Appeal confirmed the trial judge's conclusion that there was no consent because the complainant lacked capacity to consent and commented on the importance of determining consent where one of the participants is vulnerable due to his or her mental condition:

> Under any circumstances, there is a responsibility, prior to engaging in sexual activity, to take reasonable steps to ascertain consent: *Criminal Code*, s. 273.2(b). But in circumstances such as these, where one of the participants has demonstrable mental limitations, the threshold of responsibility escalates exponentially. This is not to suggest that persons who are developmentally disabled cannot consent; rather it requires that prior caution be exercised to avoid the exploitation of an exceptionally vulnerable individual. The issue in any event was not the capacity of persons with developmental disabilities to consent to sexual activity, rather, the issue was the capacity of this particular complainant to consent to sexual activity with the appellant[16] (emphasis added).

This excerpt from the decision will no doubt resonate with physicians who may be called on to assess capacity to consent to sexual activity in persons suffering from mental illness or developmental or cognitive disorders. Similar to the assessment of capacity to consent to treatment, there should be no global assessment that individuals suffering from an acute episode of a major mental illness or a developmental or cognitive delay are presumptively incapable of consent to sexual activity. However, healthcare providers should be alive to the implications of a finding that a patient is capable with respect to consensual sexual activity and also to their obligation to consider whether the patient's circumstances make him or her vulnerable to exploitation; for example, not only the patient's mental condition but also the effects of long term hospitalization which may give rise to loneliness and institutionalization.

It is fair to assume that courts, when scrutinizing an alleged sexual assault, will likely consider patients who require care and treatment in a psychiatric facility as a vulnerable population. For all people, generally, the risk of sexual activity goes beyond the risk of sexually transmitted diseases and unwanted pregnancies to include the unwitting re-enactment of sexual abuse or trauma, engaging with persons who may have paraphilias or antisocial personalities, as well as the moral and emotional discomfort of family and significant others. Arguably, that risk escalates in the members of vulnerable populations, particularly those who have been admitted to hospital at a time of acute illness and possibly, impaired judgment.[17]

Conclusions or further questions?

Hospitals providing long-stay capable patients with access to privacy rooms for the purpose of expressing their sexuality should take steps to ensure that the patients' capacity to engage in consensual sex has been thoroughly assessed and that the risks of such behaviour for the particular patient thoroughly explored. Most psychiatrists are familiar with the legal framework for assessing capacity to consent to treatment. Arguably, much of that framework is analogous to capacity to consent to sexual activity. For example, the law on consent to treatment is clear that capacity to consent to treatment may fluctuate over time; that is, a patient may be capable with respect to a treatment at one time but not at another, and capable with respect to some treatments and incapable with respect to others.[18] These concepts seem relatively applicable to consent to sexual activity, as is the test for capacity to consent to treatment: "the person is able to understand the information that is relevant to making a decision about the treatment ... and able to appreciate the reasonably foreseeable consequences of a decision or lack of a decision."[19]

However, the risks associated with sexual activity suggest that applying treatment capacity principles are not enough. In particular, the fact that sexual activity without consent is criminal conduct raises the bar, as does the potential vulnerability of the mentally ill inpatient. In that context, it seems prudent to incorporate the principles set out in the criminal law to determining capacity to consent to sexual activity. Incorporating legal principles from both treatment capacity law and criminal law, the test for capacity to consent to sexual activity could involve, for example, determining whether the person has:

- the cognitive ability to understand the sexual nature of the act;[20]
- the cognitive ability to understand information relevant to making a decision to engage in sexual activity, such as how to mitigate risks associated with the sexual act, such as safe sex practices and contraception;[21]
- the ability to appreciate that the person, and his or her partner, may chose to decline to participate at any time before or during the sexual activity in question;[22] and
- the ability to appreciate both the short and long term consequences associated with the activity that she or he is engaged in.[23]

By focussing on the Ontario and Canadian legal framework for assessing capacity to consent to sexual activity, it is my hope that this article will encourage debate on how to best address the fact that psychiatric inpatients are engaging in sexual activity with others during their inpatient admissions, at a time when they may be acutely ill and vulnerable to exploitation. Acknowledging this fact and addressing the question of capacity to consent to sexual activity amongst hospitalized mentally ill patients, should engage health care providers in assessing the "threshold of responsibility." Implicit in any discussion of capacity to consent to sexual activity is the likelihood that health care providers have some degree of responsibility for protecting incapable patients from sexual exploitation, and arguably, for providing safe opportunities for capable long-term patients to engage in consensual sexual activity.

Footnotes

1. Lawn, T. and McDonald, E., (2009) *Developing a Policy to Deal with Sexual Assault on Psychiatric Inpatient Wards*, The Psychiatrist 33:108-11, at p. 1; accessed on-line at http://pb.rcpsych.org/cgi/content/full/33/3/108 (last accessed October 2012).

2. *Ibid*., citing Warner et al., (2004) *Sexual activity among patients in psychiatric hospital wards*, Journal of the Royal Society of Medicine, 97, 477-479; and Welch et al., (1996), *Development of a policy on sexuality for hospital chronic psychiatric patients*, Canadian Journal of Psychiatry, 41, 273-279.

3. See for example, ''Where is the Sex in Mental Health Practice? A discussion of sexuality care needs of mental health clients" (McClure, this issue).

4. *Health Care Consent Act*, S.O. 1996, c. 2, Sch. A. ("HCCA"), s. 4(1).

5. *Starson v. Swayze*, [2003] 1 S.C.R. 722, at para. 77.

6. HCCA, *supra* note 4, ss. 4(2) and 4(3).

7. *Starson v. Swayze, supra* note 5, at para. 78

8. *Ibid*., at para. 78.

9. *Criminal Code of Canada*, R.S.C. 1985, c. C-46, s. 151.

10. *Ibid*.,s. 273.1(1)

11. *Ibid*., s. 273.1(2).

12. *R. v. Ewanchuk*, (1999) 131 C.C.C. (3d) 481 (SCC), at 494.

13. *R. v. R.R.*, 2001 CanLII 27934 (On. C.A.); appealed to the Supreme Court of Canada on other grounds; [2003] 1 SCR 37; appeal dismissed.

14. *Ibid*., para. 4.

15. *Ibid*, paras. 46 and 50.

16. *Ibid*, para. 57.

17. J. Maher, M.D., "Should the Hospital Provide a Safe and Accessible Environment for Clients who Choose to Engage in Consensual Sex?", Presentation, Ontario Shores Centre for Mental Health, Feb 13, 2006.

18. HCCA, *supra* note 4, sections 15(1) and 15 (2).

19. HCCA, *supra* note 4, section 4(1).

20. R. v. *Patriquin* (M.A.), (2004) 221 NSR (2d) 370 at 374 (NSCA).; see also HCCA, supra note 4, s. 4(1).

21. HCCA, *supra* note 4, section 4(1).

22. *Ibid*.

23. *R. v. J.R.*, 2006 CanLII 22658 (On.S.C.), at para 42-43.

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