

Consenting adults?

**Guidance for
professionals and
carers when considering
rights and risks in
sexual relationships
involving people with
a mental disorder**

Who we are

The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have a background in healthcare, social work or the law. Some of us are carers or have used services ourselves.

We believe everyone with a mental illness, learning disability or other mental disorder should:

- Be treated with dignity and respect;
- Have the right to treatment that is allowed by law and fully meets professional standards;
- Have the right to live free from abuse, neglect or discrimination;
- Get the care and treatment that best suits his or her needs; and
- Be enabled to lead as fulfilling a life as possible.

What we do

- We find out whether individual treatment is in line with the law and practices that we know work well.
- We challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice, information and guidance to people who use or provide mental health and learning disability services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

Why did we produce this guidance?

Sexual expression, sexual relationships, marriage and children are a natural and expected part of a person's life experience. People with a mental illness, learning disability or other mental disorder, have the same personal and sexual needs and rights as anyone else. At the same time people with a mental disorder can be at particular risk of abuse or exploitation. Balancing those rights and risks raises a host of legal and moral dilemmas to which there are no easy solutions. Whilst the motivation may be to protect, professionals and carers need to consider carefully whether any interference with an individual's rights is ethical, lawful, necessary and in proportion to the risks.

This guidance has been produced in response to a number of legal, ethical and practical issues concerning sexual relationships that have been raised with us through our work with people with mental disorder and those involved in their care. It is intended to provide a framework for discussion of the general issues that need to be considered when assessing risk and considering the need for intervention in a person's sexual life.

Fundamental principles of this guidance

- People have a right to sexual relationships, to marry and to form a family.
- Any interference with a person's rights must be necessary and lawful.
- Proper assessments of capacity and vulnerability are essential where the person may be at risk as a result of their own, or other people's, sexual behaviour.

- Any intervention must be proportionate, having carefully weighed up both the risks and benefits to the individual. The principles of the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007 provide a framework for decisions.
- Care professionals have a duty to protect people from abuse or exploitation. They also have a duty to assist people's sexual expression through education, counselling and support.
- Resolving legal, ethical and practical dilemmas requires discussion between professionals, carers and the person themselves. Appropriate information sharing is essential.
- Staff must consider the person's individuality, background and culture and must take care not to impose their own values when considering sexual activity and expression.

Legal framework

The European Convention on Human Rights (ECHR) affords all individuals the right to marry and found a family (Article 12) and the right to respect for private and family life (Article 8)¹. These rights are not, however, absolute and the state may in certain circumstances intervene to prevent disorder, the commission of crime, the protection of health or morals, or the protection of the rights and freedoms of others.

The law in Scotland relating to the sexual relationships of people with mental disorder is designed to strike a balance in protecting those people who do not have the capacity to

consent to sexual relations or are vulnerable to harm, whilst upholding and preserving the rights of those people who do have the necessary capacity to consent. The principles set out in the Adults with Incapacity (Scotland) Act 2000², the Mental Health (Care and Treatment) (Scotland) Act 2003³ and the Adult Support and Protection (Scotland) Act 2007⁴ provide a framework for considering this balance. These principles include the need to consider whether intervention:

- is necessary;
- has maximum benefit for the person;
- restricts the person's freedom as little as possible;
- takes into account the person's past and present wishes;
- has regard to the views of others;
- ensures the person's abilities are maximised; and
- takes into account the person's background and personal characteristics.

These principles must be taken into account by professionals and carers when considering a range of issues for some people with a mental disorder in relation to sexual health and well being.

People who may be thought to lack capacity or are vulnerable do enter into sexual relationships. Where these do not raise concerns about an imbalance of power, exploitation, coercion or abuse of any kind, there may be no need for intervention. In assessing and deciding on the need for intervention, this guidance looks at a number of significant questions for practitioners.

These include:

- assessment of capacity;
- issues of consent;
- knowledge of the person's background and past and present wishes;
- the nature of the mental disorder;
- different forms of sexual expression;
- potential risks as against benefits;
- staff attitudes, knowledge and training;
- assistance given by staff;
- family attitudes;
- cultural and religious beliefs;
- the person's living situation;
- statutory duties and professional and organisational responsibilities to investigate, including issues of confidentiality and disclosure; and
- intervention that may be required.

The guidance discusses these issues with reference, where appropriate, to the legal framework, UK case law and case examples. It looks at the need for intervention and a range of statutory measures that may be required. It relates solely to adults (persons aged 16 and over) with a mental disorder.

¹ www.hri.org/docs/ECHR50.html

² www.opsi.gov.uk/legislation/scotland/acts2000/asp_20000004_en_1

³ www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_1

⁴ www.opsi.gov.uk/legislation/scotland/acts2007/asp_20070010_en_1

The term 'mental disorder' used here is in line with the definition in Scottish legislation and includes mental illness including dementia, learning disability and personality disorder.

Has the person the capacity to consent?

The law starts from the assumption that all individuals have the capacity to consent to sexual relations. If a person has a mental disorder this does not mean that they necessarily lack the capacity to consent. Some people with a learning disability for instance may have capacity to make decisions on sexual activity, but others will lack that capacity. Similarly, someone with an intermittent mental illness may lose the capacity to consent to sexual relations when unwell and become more vulnerable to abuse or exploitation at this time, but have the capacity to make such decisions when relatively well.

Capacity is a legal test and is directly related to the specific task or decision the person is required to make. A definition of "incapacity" is provided by the Adults with Incapacity (Scotland) Act 2000. It describes a person as incapable of taking a decision if he or she cannot act, make a decision, communicate a decision, understand a decision or remember a decision made because of mental disorder, or cannot communicate because of physical disability. A person who can communicate with help or assistance is not regarded as incapable under the Act. Whilst it does not specifically deal with capacity to decide on sexual relationships, the Act defines decision-making capacity in general terms to then be applied to specific tasks or decisions. A person may be able to consent to sexual relations, but be unable to make decisions about medical treatment.

The definition of capacity in criminal law, with regard to sexual offences, fits with civil law. The Sexual Offences (Scotland) Act 2009 defines a person as incapable where due to mental disorder they are unable to understand what a sexual act is, to decide whether to take part in the sexual act, or communicate such a decision.

Capacity and sexual relations

The person needs to understand that the relationship is sexual as distinct from other types of relationship such as friendships, familial or work relationships. To have capacity to make decisions in this regard, they need to understand the nature of the sexual act (at least in rudimentary terms) and the possible consequences of it. Further, the person must be able to communicate their decision to consent/dissent and be able to act on their decision to consent or not. It is not enough for the person to have an understanding of sexual relationships and sexual activity, if, they are unable to act on their decision not to engage in the sexual activity due to, for example, their suggestibility or desire to please.

Whilst there is no recent reported case law in Scotland in this area, it may be useful to consider UK case law. The case of *X City Council v MB, NB and MAB*⁵ concerned a young man with autism whose parents had planned an arranged marriage to his cousin in Pakistan. In his conclusions, the judge stated the capacity to marry must include the capacity to consent to sexual relations and the test of capacity to consent to sexual relations must be the same as that required by the criminal law. He concluded that the person needed to have 'sufficient knowledge and understanding of the sexual nature and

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character of the act of sexual intercourse or other sexual activity they are involved in and the foreseeable consequences of it, in order to choose whether to engage in it or not.' Foreseeable consequences were defined as an understanding that 'the sexual activity could have implications for his/her sexual health and in the case of a woman pregnancy'. The key areas here are therefore an **understanding of the nature of the sexual act, its voluntariness and some understanding of the consequences.**

Some useful guidance on assessing the capacity of adults with regard to sexual relationships, can be found in Murphy and O'Callaghan.(2004)⁶. They have developed a functional approach to defining capacity to consent to sexual relationships in people with intellectual disabilities which may be relevant in relation to other groups with a mental disorder. They consider the following areas to be important when evaluating capacity:

- (1) basic sexual knowledge (e.g. of body parts, sexual relations, and sexual acts);
- (2) knowledge of the consequences of sexual relations, including sexually transmitted diseases and pregnancy;
- (3) an understanding of appropriate sexual behaviour and the context for this;
- (4) an understanding that sexual contact should always be a matter of choice;
- (5) the ability to recognize potentially abusive situations; and
- (6) the ability to show skills of assertion in social and personal situations and to thereby reject any unwanted advances at a given time.

Murphy and O'Callaghan used a number of tools, some specifically developed for the study, which included a sexual knowledge inventory, measures of understanding of abuse, the person's social network, their vulnerability in social situations and their understanding of the law around sexual offences. The contribution of clinical psychology, in addition to other disciplines, may therefore be crucial in very difficult situations where more formal assessment of sexual knowledge, understanding of abusive situations and suggestibility is required.

Although the decision on whether a person has capacity in relation to sexual relationships is made by a medical practitioner, there should always be full consultation with those who are involved with the person in a professional or a caring role. This is particularly important where the person has communication difficulties. Those who are familiar with the person and their means of communication can contribute substantially to this assessment, both from their previous knowledge and discussion with the person and by facilitating communication. Input from a speech and language therapist may also be useful in advising on effective communication. Where the person's capacity is being assessed, consideration must therefore be given to the most appropriate facilitator, the person's

⁵ [2006] EWHC 168 (Fam), www.bailii.org/ew/cases/EWHC/Fam/2006/168.html

⁶ O'Callaghan A: Murphy G (2004) Capacity of adults with intellectual disabilities to consent to sexual relationships *Psychological Medicine*: 34(7) Oct 2004, pp1347-1357, ISSN 0033-2917

communication needs, the environment where this should take place, and the sensitivity of the subject.

Access to appropriate information and education to promote the person's sexual knowledge, understanding, choice and ability to consent is crucial. For example, a number of studies have shown that people with a learning disability and those with Autistic Spectrum Disorder are significantly less knowledgeable about all aspects of sex and significantly more at risk of abuse, because they find it more difficult to distinguish between abusive and consenting relationships. Their capacity to understand the nature of sexual relationships, however, can be enhanced by information and education and this is most effective if reinforced on a regular basis (Murphy and O'Callaghan 2004). There are a number of educational programmes on sexual relationships, covering a wide range of topics at various levels. These need to be tailored to the individual – for instance, someone with Autistic Spectrum Disorder may need greater emphasis on aspects of social interaction in relationships and less on factual information to minimise the risks of exploitation. Incapacity should therefore not be assumed, without ensuring the person has had the opportunity to access appropriate information and education and assistance in understanding this information and its relevance to them. They may have previously been denied this due to age or cultural background, or the failure of professionals to recognise and respond to this need. Some measures of protection may be necessary in the short term but it may be that with education, experience, or maturity the person becomes capable of making decisions. This is particularly

important for young people with any sort of mental disorder as they make the transition to adulthood.

Capacity, however, is not the only test. A person's mental disorder may affect their judgement or ability to properly assess the risk and consequences inherent in certain actions or decisions. In these circumstances, measures may need to be taken under the Mental Health (Care and Treatment) (Scotland) Act 2003 to safeguard the person. Where the criteria are met, this might lead to detention in hospital. Where a person has capacity to consent to sexual relations but is unable to safeguard themselves and is likely to come to serious harm, the local authority may have responsibilities under the Adult Support and Protection (Scotland) Act 2007.

Capacity to consent to marriage/ civil partnership

Decisions, such as consent or refusal of marriage/civil partnership, cannot be taken by anyone else on behalf of the adult. The General Register Office for Scotland which deals with registration of births, deaths and marriages is the sole determinant of whether someone is capable of entering into the marriage contract or a civil partnership.

Registrars endeavour to satisfy themselves that individuals are free to marry each other/ enter into a civil partnership by reference to the information given in the notices and in documents the parties are required to submit, and by making any necessary enquiries. Registrars will also often meet with the couple beforehand. If registrars have concerns, they normally get in touch with the General Register Office, who would usually suggest that they contact the relevant social work department

to see if there has been any social work involvement with individuals concerned.

Couples in Scotland must submit marriage/partnership notices to the registrar for the area where the marriage/partnership is taking place, no earlier than three months and no later than 15 days before the date of the ceremony. The individuals' names must be displayed at the registrar's office for a minimum of 14 clear days. This is to allow time for any objections to be submitted and considered. It is the Registrar General's decision as to whether an objection can be upheld or rejected. An objection can only be upheld if there is an impediment to the marriage/partnership and evidence to prove this is required.

There is a legal impediment where one or both of the parties is incapable of understanding the nature of a marriage/partnership ceremony or of consenting to marriage/civil partnership (Marriage (Scotland) Act 1977 s5(4)(d); Civil Partnership Act 2004 s92(2))⁷. Therefore, if there is an objection which brings into doubt a person's capacity to enter into marriage/civil partnership, medical evidence would be required in order for the objection to be upheld.

There are a number of limited civil remedies to protect individuals who may have entered into a marriage or a civil partnership but lacked the capacity to do so. Section 20A Marriage (Scotland) Act 1977 provides for two situations where lack of consent may result in a marriage being void: first, if at the time of the ceremony a party who consented did so by reason of threats, force or fear; and second, if at the time of the ceremony one of the parties was incapable of understanding

the nature of the marriage and consenting to the marriage. In terms of section 123 of the Civil Partnership Act 2004 a partnership may be void if one of the parties did not validly consent to its formation⁸.

The onus is on the party seeking to prevent or dissolve the union to prove that this incapacity exists or existed. It is also worth noting that if such a party were incapable of raising the relevant proceedings, then an intervener or guardian could be appointed under the 2000 Act to initiate the relevant proceedings. Section 64(1) (c) of the Act may confer the power on a guardian to 'pursue or defend an action of declarator of nullity of marriage, or of divorce or separation in the name of the adult'.

We are aware of a number of cases in Scotland where there have been concerns around the capacity of a person to consent to marriage/civil partnership. One case related to a woman with learning disabilities, who was planning to marry a much more able man who had a history of domestic violence with previous partners. The medical practitioner, following consultation with all parties, provided evidence of incapacity to

⁷ www.opsi.gov.uk/RevisedStatutes/Acts/ukpga/1977/cukpga_19770015_en_1
www.opsi.gov.uk/acts/acts2004/ukpga_20040033_en_6#pt3-ch2-l1g92

⁸ www.statutelaw.gov.uk/legResults.aspx?Le gType=All+Legislation&title=civil+partnership+act&searchEnacted=0&extentMatchOnly=0&confersPower=0&blanketAmendment=0&TYPE=QS&NavFrom=0&activeTextDocId=975804&PageNumber=1&SortAlpha=0

the Registrar and the marriage did not go ahead. Another case related to a man with dementia who planned to marry a much younger woman where there were suspicions of financial exploitation. He was assessed as having capacity and appeared able to weigh up the risks versus the benefits of entering a marriage contract. He decided against any financial prenuptial agreement and the marriage went ahead.

In the absence of reported case law in Scotland, there have been several cases in England where a local authority has challenged family plans for arranged marriages in court. These cases provide helpful comments on the assessment of capacity and attempt to strike the balance between the autonomy of the individual with the need to protect them in certain circumstances. For example, the case of *London Borough Council v KS and LU*⁹ concerned a woman from an Afghan refugee family who suffered from a schizoaffective disorder and a learning disability. She had been married three times, possibly to secure entry to the UK for the men concerned. She had been pregnant on a number of occasions, though had only once given birth. This had caused a relapse of her illness for an extended period and the child had died. The local authority were seeking authority for her to remain in local authority accommodation and an injunction to prevent her family encouraging her to leave, removing her, or arranging any form of marriage for her. It was held that she did not have the capacity to marry, which the judge defined as being unable to understand the nature of the marriage contract or understand the duties normally associated with marriage.

(He expanded on his view of the marriage contract as ‘a contract formally entered into, conferring status of man and wife, agreement to live together, love one another to the exclusion of others, a relationship of mutual and reciprocal obligations typically involving sharing a common home, a common domestic life and right to enjoy each other’s society, comfort and assistance.’) The court also looked at her capacity to consent to sexual intercourse (‘having sufficient knowledge and understanding of the act of sexual intercourse and of its reasonably foreseeable consequences to have the capacity to choose whether or not to engage in it’). The woman was held to have a fluctuating capacity in this regard but the Court felt that protective measures in this area would be a disproportionate interference with her rights. Decisions of English courts are not binding on Scottish courts but are regarded as of persuasive authority. However, where a decision relates to the meaning of a statute, common to both England and Scotland, or which adopts identical wording, it would be unusual for a Scottish court not to follow an English authority (and vice versa). However, since each decision is “fact sensitive” these decisions should be treated as providing helpful guidance rather than laying down rigid rules.

What is consent?

This right to sexual expression assumes that the individual consents to the sexual activity.

⁹ [2008] EWHC 636(Fam). www.bailii.org/ew/cases/EWHC/Fam/2008/636.html

Consent, however, is not given where the person:

- has capacity and does not give consent;
- lacks capacity to consent to sexual activity and is therefore unable to give it; or
- has capacity but feels coerced into sexual activity because the other person is in a position of trust, power and authority.

Where consent is not given, the situation may be deemed abusive or exploitative, or the person may be at risk of abuse or exploitation. Such abuse or exploitation can involve:

- contact abuse (penetration or attempted penetration of vagina, anus, mouth by penis, fingers or objects, masturbation of either or both persons or touching of genitals, anus or breasts);
- non-contact abuse (being forced or encouraged to look at/download pornographic materials, obscene phone calls, indecent exposure, indecent photography, serious teasing or innuendo);
- other physical, emotional, psychological or sexual abuse resulting from a power imbalance between two people.

Any concerns of this nature involving an ‘adult at risk’ as defined by the Adult Support and Protection (Scotland) Act 2007 should be reported to the local authority, which has the lead role in adult protection and has a duty to investigate such situations.

The Sexual Offences (Scotland) Act 2009¹⁰ creates a number of statutory offences, previously common law offences, such as rape, sexual assault and sexual coercion.

It defines consent as ‘free agreement to conduct’ and that consent can be withdrawn at any point before or during the conduct. It details additional circumstances in which consent would seem to be absent e.g. where someone is incapable due to alcohol or other substances, where there is threat or coercion, or the victim is asleep or unconscious. Consent is also not given where the person is incapable of giving consent, as with children or people incapable due to mental disorder.

The Sexual Offences (Scotland) Act 2009 clarifies that a person is incapable of consenting if they are unable to understand what a sexual act is, to decide whether to take part in the sexual act, or communicate such a decision, as discussed in the previous section. This definition corresponds with the definition of incapacity in the Adults with Incapacity Act 2000. In addition, there is further deemed to be no consent when such consent is obtained as a result of being placed in a state of fear or being subjected to threats, intimidation, deceit or persuasion (2009 Act s13).

There were a number of statutory sexual offences specifically relating to mentally disordered persons in the 2003 Act (s311-313), which have been repealed and replaced by the Sexual Offences (Scotland) Act 2009 (s17 and s46)¹¹. We are aware of very few prosecutions under these provisions.

¹⁰ www.opsi.gov.uk/legislation/scotland/acts2009/pdf/asp_20090009_en.pdf

¹¹ www.opsi.gov.uk/legislation/scotland/acts2009/pdf/asp_20090009_en.pdf

Our investigation into the care and treatment of Ms A – ‘Justice Denied?’ – highlights some of the issues for the police and courts in bringing cases for prosecution where the victim has a mental disorder¹². Miss A was a woman with a learning disability who had been raped and sexually exploited over a period of years with no charges ever being brought against the known perpetrators. This was largely due to concerns that she would not be a ‘reliable witness’. The Scottish Government’s Justice Department has since worked to address some of these issues, such as ensuring that the support measures available in the Vulnerable Witnesses (Scotland) Act 2004 are considered when assessing a person’s ability to give evidence¹³.

Section 17 of the Sexual Offences Act 2009 (which replaced s311 of the 2003 Act) creates an offence when there is a non consensual sexual act with a person with mental disorder, when the person does not consent or is incapable of consenting. This applies to vaginal and anal intercourse and to any other sexual act which a reasonable person would regard as sexual in nature, and applies to both heterosexual and homosexual acts. There are a number of penalties upon conviction, including a maximum of life when conviction is on indictment.

Section 46 of the Sexual Offences Act 2009 (which replaced s313 of the 2003 Act) creates an offence of engaging in a sexual act with a mentally disordered person when the offender provides care services, or is employed in a hospital providing medical treatment to the victim. This applies whether the victim has capacity to consent or not. There are certain defences such as where the offender could not reasonably have been expected to know that

the person had a mental disorder, where there was a pre-existing relationship between the two people, or where they are spouses.

What is known about the person’s background and past or present wishes?

If there are any concerns about a person’s sexual behaviour, it may be important to establish the nature of previous sexual behaviour to know whether there has been a change. A person may, for instance, be sexually disinhibited because of a bipolar affective illness, or this may be their normal pattern of sexual engagement. Where there has been a change, this may indicate that protective measures may need to be considered. Similarly where someone with dementia for example, is behaving aggressively towards their partner, this may or may not be a change in behaviour. Someone with Autistic Spectrum Disorder, who may be exposing themselves on the way to the toilet, may simply be wrongly sequencing events rather than being sexually disinhibited. Understanding the person’s background may reveal the reasons for this and affect the way such behaviours are managed.

Past lifestyle and wishes can also help determine longer term decisions on sexual relationships. For example, where someone with an acquired brain injury has had a same-sex relationship without their family’s

¹² www.mwscot.org.uk/web/FILES/Publications/Justice_Denied_Summary_FINAL.pdf

¹³ www.opsi.gov.uk/legislation/scotland/acts2004/asp_20040003_en_1

knowledge and the family are now denying that this was their sexual orientation, it may be very important that the person’s past wishes and past sexual behaviour are understood when considering current sexual relationships. On the other hand, there are rare occasions when frontal lobe damage can cause a change in sexual orientation, which can be extremely distressing and difficult for the person and their family to come to terms with.

Whilst staff need to have an understanding of the significant relationships in the person’s life, they do not need to know about their sexual history unless this is an issue. If there are serious concerns, past records or relatives may provide some of this information, though practitioners should approach others only if necessary and respect the individual’s privacy as far as possible. For instance, a man who had committed a Schedule 1 offence against a child subsequently suffered a traumatic brain injury leaving him severely physically and cognitively impaired. The level of risk in the care setting where he now resided was substantially reduced. While it was considered necessary to inform the manager of the home, it was not necessary or proper to inform other care staff.

Where there is a potential risk to the person or others, information must be passed on to future carers. Our investigation into the care and treatment of Miss A criticised the lack of transfer of significant information from one agency to another¹⁴. Ms A, a 67 year old woman with a learning disability, had been in care since she was eight. She had reported to the staff of her housing association that she had been raped. When staff contacted

the police, they found there had been previous allegations of similar assaults. The housing association had not been informed by the social work department of the history of assaults and her related vulnerability. Had they been aware of this, they could have increased their vigilance and perhaps highlighted the need for a more intensive package of support for Ms A.

Whilst previous lifestyle and past wishes must be taken into account, this does not mean, where capacity is fluctuating or diminishing, that all previous patterns of sexual behaviour are acceptable. For instance, where the person may have previously been in the habit of having unprotected sex, loss of capacity and increased vulnerability may justify the need for some intervention in this regard. Similarly, where an older woman has been subject to domestic abuse all her life but has now lost capacity due to dementia, intervention may be necessary to protect her against further abuse.

Involvement of independent advocacy may help the person express their current wishes on a wide range of issues, including aspects of their sexuality. Where the mental disorder fluctuates and sexual behaviour has been an issue in previous episodes of illness, statements made in advance may also be useful in determining the person’s views on how they wish to be treated when ill or incapacitated.

In summary, where sexual issues arise, it is important to be aware of the person’s past

¹⁴ www.mwscot.org.uk/web/FILES/Publications/Justice_Denied_Summary_FINAL.pdf

sexual orientation, significant relationships and previous sexual behaviour as well as present wishes. This can help put their current behaviour and wishes into context and ensure, if necessary, that they are adequately protected.

What is the significance of the person's diagnosis?

It is important to consider the signs and symptoms of the person's mental disorder, how these affect sexual behaviour and the capacity to make decisions about sexual relationships. Where someone has a progressive condition, such as Huntington's or dementia, or a fluctuating disorder, such as a bipolar affective disorder, their capacity may diminish or vary from time to time. Alternatively, the onset may be more abrupt, as in acquired brain injury, causing a loss of capacity in decision-making which may then improve over time. Conditions where there may be a more gradual decline can also improve where circumstances change e.g. alcohol-related brain damage. Complex disorders, where there may be multiple diagnoses, or which may be complicated by alcohol or substance abuse, can also lead to fluctuations in sexual behaviour and risks. Changes in the risks posed by sexual behaviour may therefore necessitate assessment and reassessment of the person's care plan and their capacity.

Where the mental disorder is fluctuating, as with bipolar affective disorder, the person's judgement can be temporarily impaired. Sexual disinhibition can be a symptom of the illness and can make the person open to exploitation and abuse in the

community as well as in a hospital setting. Such allegations of abuse need to be taken seriously. In December 2009, a woman with a bipolar affective illness who reported being raped when unwell was given an out-of-court settlement when it was found that police failed to begin an investigation of her allegation until two months after she had reported the incident. The victim reported the incident from a psychiatric unit where she had been admitted and she believed her illness contributed to the way the police handled the case. Changes in sexual behaviour can also result from psychotic episodes where the person's perception of themselves and others may be distorted by delusional ideas. It is important to understand these symptoms in order to assess the degree of risk and to keep this under review.

Where a person's mental disorder is chronic or progressive this can result in ongoing changes in personality, presentation and behaviour, including sexual behaviour. This can range from rejection or disinterest in a previous sexual partner to disinhibited sexual behaviour, such as public masturbation or inappropriate touching of others. Partners of people with a progressive mental disorder may also find their own feelings change with the increased dependency of the relationship. Considerable support may be required in redefining the intimacy of the relationship. If the person is unresponsive and passive to their partner's sexual approaches, their ability to consent needs to be questioned. Most partners will feel that, if someone is not able to signal enjoyment or consent, it is an abuse of the relationship. Members of staff may need to balance the right to privacy and respect for a long term relationship with

It is important to be aware of the person's past sexual orientation, significant relationships and previous sexual behaviour.

concerns they may have about the benefits to the individual. They need to closely monitor verbal and non-verbal signs of distress, anxiety or fear. When there is any suspicion of a potentially abusive situation, there needs to be discussion with the professionals involved. Resolution of such situations could range from increasing a partner's understanding of the condition and issues of capacity to give consent, to instigating adult protection procedures.

Changes in behaviour might include an excessive interest in sex, or sexual aggression with demands for repeated sex from partners, attempts to have sex with people other than a partner, public masturbation etc. It is important for partners to understand that this is the result of the deteriorating condition but it is also useful to consider whether, for instance, the person is signalling a need for closeness or perhaps anger, or that it may possibly be a side effect of medication. Again a care plan should be in place for managing the behaviour and risks, where it is evident that the person does not have capacity. The assessment of capacity is crucial to considering the appropriate intervention and to assessing risk. A recent case reported to us involved a man with dementia in a care home who was having a sexual relationship with another resident without the knowledge of his wife. Staff were concerned about both capacity issues and confidentiality. Following assessment it was concluded that both parties had capacity to enter into the relationship and that the gentleman's right to confidentiality in keeping this from his wife had to be observed. Another instance involved a man whose sexual advances towards his wife, who had severe

dementia, were causing her considerable distress as indicated by her behaviour. As he refused to modify his behaviour in any way, this eventually required a guardianship order under the Adults with Incapacity (Scotland) Act 2000 to enable supervision of his visits to the care home.

Other couples, however, despite one having a progressive neurological condition, may continue a sexual relationship in the context of a contented long-term relationship and it may be overly intrusive to be proactive in every situation.

Where a person has a stable mental disorder, as with some people with a learning disability, concerns can arise where there are increased opportunities to develop a sexual relationship as the person matures, or when his or her social circumstances change. For all of us sexual relationships are part of maturing into adulthood and of developing a fuller life. We all learn from our good and bad judgements. Where someone with a mental disorder is engaging in risky sexual behaviour or is being exploited, there should be some discussion as to whether they have capacity and are simply making a bad choice, or whether their capacity is impaired. In most cases, carers would be trying to inform and support individuals in developing fulfilling relationships before considering further interventions.

For someone with a developmental disorder such as autism or Asperger's Syndrome, understanding the significance of the triad of impairments (social communication, social interaction and social imagination) as well as possibly sensory difficulties (e.g. tactile sensitivity) on sexual behaviour and relationships may be crucial. Whilst sexual

knowledge and sexual intercourse may not pose a problem for some, the social skills to establish and maintain a relationship may be lacking to various degrees. This can include, for instance, difficulties with eye contact, turn-taking in conversation, reading facial expressions and body language, having obsessive interests which do not interest others, lack of comprehension of the rituals of relationships, difficulties in responding to the emotional needs of a partner with spontaneity and flexibility, anxiety at changes in routine etc. These difficulties may result in unintended but inappropriate sexual or social behaviours, or may leave individuals at high risk of sexual exploitation by others. An individual may need very specific help to understand the social expectations of relationships and to learn how to practice appropriate behaviour to cope with these. Like others, they may need protection as well as support where they are deemed to be an 'adult at risk' in terms of the Adult Support and Protection Act.

Are there problems that arise from the form of the person's sexual expression?

There are sexual activities that are statutory offences under criminal law. These include rape, sexual assault, coercing someone to be present during sexual activity or to look at sexual images, communicating indecently, sexual exposure, voyeurism, administering substances for sexual purposes and so on. There are also specific offences related to sexual activity with children and with someone with a mental disorder by a member of staff involved in his or her care, as detailed earlier.

Beyond these there is a wide range of sexual behaviours that will be regarded by some as deviant and by others as normal. It is important that moral judgements of individual behaviour do not cloud the assessment of capacity or risk. Such behaviours may not be illegal when carried out in privacy and with the consent of the adult/s concerned, if they have the capacity to consent. Some people may need advice and counselling by staff or carers to understand sexual boundaries and the need to confine these activities to private places.

Where there are concerns about a potential risk of offending, the appropriate expertise, such as psychiatry/clinical psychology/ forensic psychiatry/forensic clinical psychology, should be sought and a risk assessment and management plan instigated. For example, where someone with a foot fetish is getting sexual gratification by initiating conversation on feet or shoes or by going into shoe shops, it is important to ensure there are clear boundaries established so that staff know how to manage this behaviour. This plan must respect the individual's right to a sexual life, whilst minimising the risk to him and to others. The level of risk posed, or the level of restrictions imposed, for instance, where it amounts to a deprivation of liberty¹⁵, will determine whether any legislative framework is required to support the care plan.

What are the specific sexual risks arising from the person's mental disorder or social situation?

It is necessary to identify the risks or potential risks in detail, as well as those who pose the risk, in order to consider how these should be managed. Clear, factual information from

It is important that moral judgements of individual behaviour do not cloud the assessment of capacity or risk.

first hand sources can be important. Information, particularly on sexual matters, can quickly be distorted by interpretation and reinterpretation of events in the light of staff, family and cultural attitudes. Therefore, as with any risk assessment, past incidents/history need to be as accurately recorded as possible.

There may be a risk or potential risk of:

- denial of the right to have a sexual relationship despite capacity to consent – this may be at any age, with a variety of diagnoses and in a range of care settings;
- sexually transmitted diseases/HIV/Aids;
- unwanted pregnancy;
- forced marriage;
- being a victim of a sexual offence as set out in the Sexual Offences Act (Scotland) 2009 and other legislation e.g. Criminal Law (Consolidation) Act 1995;
- other sexual harassment/manipulation/exploitation;
- physical, emotional, psychological or financial abuse; or
- sexual offending – details of both convictions and incidents that have not led to charges being brought (e.g. due to lack of fitness to plead, Procurator Fiscal's decision not to take matters forward, matters unreported to police etc) need to be examined from original sources as far as possible. Where someone has been convicted of sexual offences, violent offences or offences where they are believed to pose significant risk of harm, they may be subject to MAPPA (Multi-Agency Public Protection Arrangements)¹⁶ and have a risk assessment and management plan

in place. For these and others who may not have convictions, there are a variety of tools for assessing the risk of violence and sexual behaviour. Many of these are more appropriate for use with people with mental illness or personality disorder than for people with learning disabilities¹⁷.

Risks may be from the person's own behaviour, from a partner or relative or from a wider group of people.

The most difficult dilemmas in risk assessment are where there are very obvious benefits as well as risks to the person, whether they have capacity or not. The benefits of being in a relationship in terms of self-esteem, self-confidence, fulfilment, happiness and perceived social acceptance must be weighed against possible financial, physical or sexual exploitation, once all means of minimising those risks have been taken. Any intervention must consider the proportionality of the response to the risks in light of the risks/benefits assessment. It is hard to be prescriptive on the balance between rights and protection in cases where someone is engaging in sexual behaviour which is perceived by staff as being potentially damaging, but is actively sought by the service user. Adult protection procedures do provide an essential framework in such situations for

¹⁵ www.mwscot.org.uk/web/FILES/Publications/Autonomy%2C_benefit_and_protection_FULL.pdf

¹⁶ openscotland.net/Publications/2006/12/mappa15-2006

¹⁷ See Risk Management Authority Risk Assessment Tools Directory www.rmascotland.gov.uk/ViewFile.aspx?id=280

multi-disciplinary discussion and decision-making on the management of risk and for regular review. Advocacy also plays an important role in ensuring the service user's views are heard by the professionals in drawing up any risk management plan.

The case of a local authority in *X v MM*¹⁸ highlighted some of the issues that may be useful for local authorities and others to consider. MM had a moderate learning disability and a paranoid schizophrenic illness. She was from a chaotic and emotionally deprived background and was taken into care aged 13 having been sexually abused by her brother. She had been in a relationship with her partner for around 15 years, after meeting him in a homeless hostel. He had been diagnosed in the past with a psychopathic personality disorder and abused alcohol. He was abusive towards professionals, had been violent towards her, used her benefits for alcohol and encouraged her to leave her accommodation and disengage with psychiatric services, leading to deterioration in her mental health. In 2006 she was living in supported accommodation with an agreement that her partner would not come to the unit and that she would let staff know when she was going out and be back by 8.30pm. However, encouraged by her partner, she stayed away from the unit for extended periods on a number of occasions, apparently sleeping rough and without medication. The local authority asserted she did not have capacity to determine where she should live or with whom she should have contact. They wanted her to remain in her supported accommodation, as this protected her from abuse and exploitation and prevented relapse in her

mental illness. The Court agreed that she did not have capacity in this regard. The local authority also wanted to restrict her contact with her partner to supervised access for two hours once a month. The Court ruled that MM had capacity to consent to sexual relations and felt that determining that she lived in a place where her partner could not visit was disproportionate interference with their family and private lives. This denied her an ongoing sexual relationship and was contrary to Article 8 of the European Convention on Human Rights. In light of the Strasbourg principles of necessity and proportionality, the Court ruled that due to the longevity of the relationship and the balance between her safety and her happiness, the local authority's response was disproportionate. There was therefore agreement that the couple could have unsupervised contact weekly for four hours and that the local authority should enable her to continue her sexual relationship in an appropriate and dignified way.

How do the knowledge, values and attitudes of staff impact on the care provided?

It is important that staff providing care in a variety of settings have training to provide appropriate support and protection. They need to be able to positively support individuals where that person wishes to develop personal relationships. Staff should not allow their personal prejudices, judgements or sexual preferences to affect their work. It is accepted they will hold their own religious, cultural and moral views and they will not

¹⁸ (2007) EWHC 2003(Fam). www.bailii.org/ew/cases/EWHC/Fam/2007/2003.html

The most difficult dilemmas in risk assessment are where there are obvious benefits as well as risks to the person.

be expected to alter their personal beliefs. However, they cannot impose their own values and beliefs on service users and should support the implementation of agreed programmes of education, counselling or other interventions. People may identify themselves as lesbian, gay, heterosexual, bisexual, transsexual or transvestite. Staff must accept the person's identity and their choice of partner, provided the relationship is a mutual one and not abusive or coercive in any way. Staff training should raise awareness of service users' rights in this regard. Where in-depth work is required with a service user, consideration may need to be given to the most appropriate member of staff to take this forward; strongly held beliefs by a team member may be one of the factors taken into account in deciding this. Again, the person may benefit from the support of an independent advocacy worker to help them assert their choices and preferences. Staff should ensure that people know how to access advocacy services and, where necessary, support them to access these.

In addition to their organisation's policy on confidentiality, staff must be aware of adult protection requirements and their organisation's adult protection policies which can override duties of confidentiality. Where there are concerns about safeguarding the person or other people, these should be shared and discussed with their line manager in the first instance. Staff need to be clear on issues of capacity, consent and protection and when to involve others. They need regular supervision and support by their line manager so they can discuss issues that arise in their day to day work with people. This is particularly important as work increasingly takes place

on a 1:1 basis, often in relative isolation from colleagues and with considerable individual responsibility. Similarly, service users should be made aware of the organisation's policy on confidentiality and the boundaries of this.

An increasing number of people are opting for self directed support and employ their own personal assistants, who may not have the same supervision, support and training available to agency workers. The service user or their proxy has a responsibility to ensure safe recruitment procedures are in place, to be clear about the services they are purchasing and to provide appropriate information and training to workers. The local authority must ensure they have arrangements in place for both financial monitoring and to monitor that the care and support is meeting the person's needs. Where the local authority has concerns about a personal assistant and the risk to the welfare of an individual, they can ultimately discontinue self directed support¹⁹.

How should staff respond to requests for assistance in sexual matters?

Education and counselling

Education and counselling should be provided when individuals express a wish for this or display a need for such assistance, or may be considered when families and/or professionals request it. Where relatives object to education and advice being given on sexual matters, the question of the capacity of the adult needs to be assessed. Where the adult has capacity, his or her wishes should be adhered to. Where

¹⁹ <http://www.scotland.gov.uk/Publications/2007/07/04093127/3>

the adult does not have capacity to decide on these matters, there may still be a need for this and it may be necessary for the local authority to act under their “duty of care” or to consider guardianship. Guardianship with powers to determine some of these matters (such as education) may already have been granted to a family member. Where there are concerns about the use of the powers not being in line with the principles of the 2000 Act, and where other means of resolving disagreement have been exhausted, the local authority can consider taking this back to Court to ask the Sheriff for direction on the use of powers under Section 3.

Contraception

Staff may be asked to assist someone with accessing contraception from a chemist, family planning clinic or GP. Ideally an adult should choose the method of contraception that suits them best and should be supported in accessing primary care resources and specialist agencies as appropriate. Staff and carers can support adults in understanding the information given about choices and use as far as possible. Contraception should be seen in terms of the needs of the individual rather than as a means of relieving the anxiety of staff and relatives. Where someone has capacity to give consent, staff do not have the right to make decisions about contraception for them nor the right to inform their partner or relative about contraceptive choices without the person’s permission.

Where an adult lacks capacity to understand the purpose or effects of contraception, this may be prescribed by a medical practitioner under section 47 of the 2000 Act. The medical practitioner’s decision on whether or not to

prescribe must be based on the principles of the Act. This includes consultation with relevant people such as family members. The views of family members may, however need to be balanced with principles such as benefit to the adult and least restriction. If there is a welfare guardian or welfare attorney in place, with power to consent or refuse medical treatment, they will need to be consulted. Where there is disagreement between the guardian and the prescribing doctor, there are processes in Part 5 the Act for resolving these.

Promoting Sexual Health

Individuals may also need staff assistance with organising or attending regular checkups or treatment for sexually transmitted diseases. Again staff, who are familiar with the person’s communication, may have a role in enhancing the person’s understanding of sexual health issues such as sexually transmitted infections, HIV and AIDS, and accessing appropriate resources. Similarly issues around capacity to consent to treatment and confidentiality need to be considered.

Medicines for the purpose of reducing sex drive are subject to special safeguards under Part 16 of the 2003 Act and Part 5 of the 2000 Act.

Pornography

Requests for other kinds of assistance can raise issues for carers. Staff should be aware that activities such as accessing pornography, prostitution, stripping, lap dancing, peep shows, phone sex lines etc are forms of commercial sexual exploitation, mainly of women, and can be harmful to the emotional, psychological, sexual and physical mental wellbeing of the individuals involved in these sex industries. Sexual activity becomes sexual exploitation

if it breaches a person’s right to dignity, equality, respect and wellbeing. (Safer Lives: Changed Lives COSLA/SG 2009)²⁰

Service users might request assistance to access legal pornographic material for the purposes of sexual arousal or entertainment.

Whilst this is part of sexual activity for many adults, staff should never introduce such materials to service users or encourage their use. It may be appropriate to explain to the person the exploitative nature of such materials and that they do not represent a true picture of sexuality. This being said, staff do not have the right to be judgemental, deny access to legal pornography to an individual who is able to make the choice, nor impose their own views on other people.

Legal pornography includes any materials that may be legally sold in the UK in a newsagent, a licensed sex shop, DVDs certificated by the British Board of Film Censors (BBFC), or material legally downloaded from the internet. Illegal pornography includes indecent photographs of children (s52 Civic Government (Scotland) Act 1982) and possession of ‘extreme pornographic images’ (Criminal Justice and Licensing (Scotland) Act 2010). Extreme images are those depicting rape or non consensual penetrative activity or act likely to result in a person’s severe injury (s42) Information is also available on the BBFC website.²¹ Where materials are being accessed that are believed to be illegal, staff should immediately seek advice from

²⁰ <http://www.scotland.gov.uk/Resource/Doc/274212/0082013.pdf>

²¹ <http://www.bbfc.co.uk>

their line manager, who may report the matter to the police.

In secure hospitals, residential or independent living settings people may be entirely dependent on staff support if they want to access pornographic material. Staff must never help people access illegal material. We think there may be occasions when institutions or organisations have to decide on the balance between supporting a disabled person to access legal materials which are available to others against concerns about the exploitative nature of the sex industry. Where an organisation sanctions the purchase of legal material for an individual, such decisions should be clearly recorded and where a staff member has personal views against this, they should not have to be involved in this. A member of staff should never be taking such decisions without the full knowledge of their organisation. As previously stated, directly employed personal assistants may not have the support, supervision, training or the forum to discuss such moral and ethical issues and where dilemmas arise, they should contact the local authority who funds the care.

It should be made clear that where service users have pornographic materials, however acquired, these should be used in private, should not be shared with other people and should not be displayed when staff are with the person. The storage and the visibility of such material may need to be discussed depending on the person’s living situation, where the rights of co-residents may also need to be considered.

For some individuals there may be concerns about pornography leading to unhealthy sexual

expression or increasing the potential for sexual offending. Staff may need to discuss this in the wider multidisciplinary team, in order to decide on access to or possession of such materials. Others will have restrictions imposed on them because they are in hospital settings where hospital policies, individual care plans and legislative restrictions may apply, or they may be in a community setting but still subject to legislative restrictions.

In residential settings access to legal pornography on the internet will not be permissible on the organisation's computers and this will be covered by organisational policy. However, many service users will have their own computers, or other technologies which give internet access, with no filtering or blocking. There would be considerable risks to staff and potentially the service user in assisting someone to access internet pornography. Furthermore the speed and ease of access increases the risk of service users entering sites with more hard core or potentially illegal material without necessarily understanding the consequences.

Social Networking

Staff may also be asked to assist people in accessing social networking sites or chat rooms and increasingly people are forming relationships online. Whilst the use of such sites can have positive benefits for people, staff need to be aware of the risks to adults, as well as children, of internet grooming. Groomers may try to establish relationships and gather more information on their potential victims and their vulnerability, assess the risk of going further with their plans, try to isolate victims from those around them (e.g. sabotaging relationships with family/

friends/carers) and may use threats and blackmail to achieve compliance and control. Some are interested in the victim's social networks, targeting an index victim in order to access other people who may be vulnerable. They may expose victims to inappropriate and illegal sexual material, or material that is offensive and traumatising for some, or subject victims to cyber sexual abuse on line e.g. using webcam/audio technology to observe or exhibit sexual behaviours. Where staff are suspicious or concerned about such activity, they should discuss it in the first instance with their line manager, who may consider involving the police and notifying the local authority under adult protection procedures. Education on the risks of social networking may increase service users awareness of the potential dangers. Both the Child Exploitation Online Protection Centre thinkUknow and the Childnet International Know IT All websites have materials for young people, which may be useful in this regard.

Sex Aids

Requests with assistance to purchase sex aids should be considered in the same way as pornography – there should be discussion with the line manager or, where there are more serious concerns, the wider multidisciplinary team. Decisions should be recorded and staff should only assist if they are willing to do so. Again the use of such aids needs to be in a private setting, staff should not be involved in this and the storage and visibility of such items needs to be considered. Service users and staff also need to be aware that buying such items via the internet or by mail order may lead to a lot of unsolicited correspondence from companies selling similar products.

Family may need support in accepting their relative's sexuality, while the person may need help in asserting their rights and relationship choices.

The exception to the above is the use of sex aids for educational or counselling purposes, rather than for sexual stimulation and pleasure. In such instances, staff would be using aids with service users as part of their care plan, for example, to enhance sexual understanding or assist with correct use of contraception.

Masturbation

Masturbation is an acceptable and natural part of an individual's sexual behaviour. Some individuals due to their mental disorder may not understand where and when it is appropriate to masturbate. Staff may need to assist in redirecting people in terms of the time and place as to when and where this sexual behaviour is acceptable. Staff may also have an educative role, either in explaining how to masturbate or to prevent someone hurting themselves when masturbating. This may be carried out using diagrams, and visual aids, as long as this is agreed as part of their care plan. Staff should never physically assist a client to masturbate. Where individuals have other sexual difficulties, such as erectile dysfunction or ejaculation problems, specialist advice and support should be sought.

Prostitution

A service user may choose to seek the services of a sex worker. Where the person's disability makes it difficult for him or her to do so, they may request help from staff. Staff should NOT get involved in making arrangements with a sex worker or agency. In addition to the moral and ethical issues, this could leave staff open to a variety of allegations and potential criminal charges.

Other Guidance

A number of health boards and local authorities have produced policies and practice guidance for staff working with people with learning disabilities on these issues, which may be helpful e.g. Highland Learning Disability and Relationship Group (Draft Guidance for Staff on Relationships and Sexuality 2006), Fife Social Work Service (Practice Guidelines of Sexual Issues), NHS Lothian with West Lothian, East Lothian, Midlothian and City of Edinburgh Councils (Making Choices Keeping Safe 2004).

Do family attitudes and views need to be taken into account?

It is important to recognise that family members and carers have no legal powers to intervene in the life of an adult they care for, unless they have proxy powers such as welfare power of attorney or welfare guardianship under the Adults with Incapacity Act. However, many people live with family members, are dependent on them for support and their families may strongly influence their values, attitudes and decisions. With a few exceptions, family members and carers generally act with the best interest and autonomy of the person in mind, often at the expense of their own health and well-being, but they may also have great difficulty in coming to terms with the adult's sexuality or sexual behaviour and fear the consequences. Family may need support in accepting their relative's sexuality, while the person may need help in asserting their rights and relationship choices.

It is important when families and professionals are planning for the transition of young people with a mental disorder to adulthood that sexual matters are taken into account. Where relevant and with respect for the young person's privacy, this may be part of the planning discussions prior to leaving school and beyond. Young people will be making new friends and new relationships, some of which may develop into sexual relationships. They need ongoing help and support to cope with both the physical and emotional aspects of these relationships. They may need support to assert their rights and wishes to have a sexual relationship and well as awareness of how to protect themselves from exploitation. Parents too need to recognise that adulthood brings change in terms of their children's expectations, as well as their legal rights and they too need support in finding the balance between protection and positive risk-taking.

Families may have strong views on many aspects of sexual relationships, contraception, sex outwith marriage etc. It may be important, particularly where guardianship with considerable powers has been granted indefinitely when the adult was 16-18 and is now in their 20s, to reassess their capacity or the appropriateness of some of the powers. We have some concerns about the increase in indefinite guardianship orders for relatively able young people with a learning disability in transition to adulthood and the scrutiny of the use of the powers granted. Where a guardian has decision-making powers, they should consider on the basis of every decision whether it is appropriate for them to apply those powers and to what extent they should be applied. For example, they may be able to

make decisions about who the adult spends time with and how they spend their time. In exercising such powers, the guardian may feel the adult does not have the capacity to have a sexual relationship, but it may be overly restrictive and not in the adult's best interests to prevent them having a relationship where they may simply want to hold hands or kiss. Reference to the principles of the 2000 Act must always be evident when considering how powers are being exercised.

Where the adult has sexual relations but lacks capacity to consent or is being coerced into sexual activity, adult protection measures may need to be considered to implement certain aspects of a care plan. Where informal measures fail powers under the Adults with Incapacity Act to provide support, to determine who has access to the adult, to determine with whom they consort/associate or to consent or refuse medical treatment may be sought by a private guardian or the local authority. However, the 'workability' of such measures, particularly if the adult is unlikely to be compliant with the powers, may present a challenge to staff and families. This does not mean that legal measures should not be tried where informal measures have failed. It may be that certain individuals will defer to the authority of the court and the powers granted to a proxy.

Not infrequently there are cases of adults with a mild learning disability and a personality disorder or challenging behaviour, who repeatedly put themselves sexually at risk with a variety of partners and ignore all legal measures and support, short of hospital admission. These situations need ongoing

multi-disciplinary risk assessment. There may be a point at which the risk is such that hospital admission under the 2003 Mental Health Act, or use of the power to determine the individuals' residence to remove them from a harmful environment, may be more beneficial in breaking a cycle of behaviour than remaining where they are.

Does consideration need to be given to cultural or religious values?

Across and within cultural, ethnic and religious groupings there are huge variations in values, attitudes and practices in sex education, sexual activity, contraception, gender roles, marriage and parenting. For instance, in some families sex may not be openly discussed and the adult may need instruction in basic anatomy and human reproduction.

Some people from Islamic, Sikh or Hindu backgrounds hold to traditions of arranged marriage, forbidden premarital sex and desire for children, particularly sons, soon after marriage. There are frequently different attitudes to these issues between generations, which can lead to considerable conflict. It may be more difficult still for someone with a mental disorder to assert their independence and values without the support of others. Staff should be aware of these differences and deal with this sensitively in discussion with others. They need to bear in mind that, in some cultures, the individual's rights may not be as important as family or community cohesion. Some decisions may require careful consideration of the balance between risks and benefits. Where advocacy services are involved, they also need to be aware of the significance of cultural and religious values in the situation.

Where there is concern about capacity, staff may come into conflict with family. Whilst there have been no relevant reported cases in Scotland, there have been several where an English local authority has challenged family plans for arranged marriages. The case previously mentioned of X City Council v MB, NB and MAB concerned B, a 25 year old man with autism, whose parents were devoted to him and were making arrangements for his marriage to his cousin in Pakistan²². The local authority had sought various injunctions, including a confiscation of his passport and an all ports alert order to prevent him being taken abroad to be married. They argued that he did not have the capacity to consent to marriage and if he sought to return to the UK with his new wife, she would be denied entry, as the marriage would be invalid due to his lack of capacity. He would then remain in Pakistan and be denied access to the support he needed in the UK. The Court concluded he did not have the capacity to marry and even if the marriage were recognised as valid in Pakistani law, it would not be valid in English law. The court accepted his parents' undertakings that they would not take him out of the jurisdiction or arrange any sort of marriage for him.

Is the person's living situation significant in terms of support and protection?

Every individual should have an equal opportunity to have a fulfilling personal relationship whatever their living situation. Provided the person has the capacity to consent and wishes to engage in sexual activity, care homes and supported

²² [2006] EWHC 168 (Fam), www.bailii.org/ew/cases/EWHC/Fam/2006/168.html

accommodation should provide the person with the privacy and support to develop sexual relationships. Where there are concerns about the level of understanding of either or both the individuals, further assessment may be useful. Staff should also consider the education, advice and support that may enhance the person's understanding of sexual activities and relationships. It is also necessary to remember that individuals may not want a full sexual relationship, but may be looking for the comfort of a lesser degree of physical intimacy in a relationship. Where this is appropriate, care providers should be providing the opportunities for this in terms of private time and space. Independent advocacy have an important role in helping the service user express their wishes and in having their views listened to. Where a guardian or welfare proxy has powers in relation to whom the adult consorts or associates with, it is necessary that staff make them aware of any developing relationships.

Similarly, people with a mental disorder in different settings should be equally protected. Where protection is required, it is important that this is provided in the least restrictive manner and in a way that is of maximum benefit to the person concerned. For instance, where it may be necessary to move someone to an environment where closer supervision can be provided, it may be easier to provide this in a core and cluster model of care rather than in an individual supported tenancy where they may feel "under guard".

People with mental disorder are more often subject to sexual harassment and exploitation than the population as a whole. This is particularly evidenced in hospital settings. In acute wards and Intensive Psychiatric

Care Units the intake is very varied with both sexes, ages ranging from 16 to 65, a variety of diagnoses, acutely disturbed and extremely vulnerable patients on the same ward, and occasionally forensic and non-forensic patients together. Risks must be individually assessed and care plans put in place to deal with possible adverse interactions between patients, both on the ward and when on leave from the ward. Careful consideration should be given of safety and privacy in bathroom and sleeping arrangements and the risks posed by a difficult patient mix.

In adult secure units the emphasis is on observation and security rather than privacy. Wards may be single sex and individuals may be there for longer periods of time without access to sexual relationships, often when they are young adults at the peak of their sexual interest. Some individuals may be sexual offenders; others may have a history of being sexually abused. Again this must be addressed in patients' care plans to balance protection with the opportunity for some sexual expression. In addition, unit policies in relation to accessing, for example, legal pornography or sexual aids will need to be carefully thought through in order to provide this balance.

Older patients with mental and often physical disabilities are the most likely group to be subject to abuse which, due to their circumstances, is frequently under reported. Older people, along with those with learning disabilities, are easily targeted due to their language and cognitive problems and/or their dependence on help with personal care. They will have greater difficulty relating back events in sequential order. Allegations should not

be dismissed as evidence of confusion or symptoms of mental illness but should always be taken seriously and investigated. The Kerr/Haslam enquiry²³ highlighted the issue of patients making allegations and these being "routinely disbelieved".

Many people are cared for in community settings in care homes, small group facilities or single tenancies with support. These can be quite isolated with limited oversight by managers, social workers or inspection agencies. Service users, relatives and members of staff in these settings can be afraid to report suspicions for fear of reprisal. In addition there have been cases of networks of abusers working together in certain areas and targeting vulnerable individuals. There are a number of common indicators of situations where abuse is more likely to occur which should be borne in mind²⁴.

These include:

- one dominant (usually male) member of staff who is older and longer serving than the rest of the staff;
- sexual harassment of female staff;
- misuse of alcohol by staff;
- isolation from other services;
- lack of monitoring procedures e.g. bathing and toileting;
- financial irregularities;

²³ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4115349

²⁴ www.rcpsych.ac.uk/files/pdfversion/cr145.pdf

- low staff morale;
- poor record keeping;
- feelings of powerlessness in staff; and
- lack of respect for service users.

A range of measures can minimise the opportunities of such abuse. These include the availability of independent advocacy, layout of wards, staff recruitment practices, staff team meetings, staff training, staff supervision, good management and leadership, protocols relating to personal care, staff/patient relationships, registration and inspection agencies, whistle blowing policies, and policies and procedures for investigating allegations of sexual harassment and abuse.

What are the duties of statutory bodies and professional and organisational responsibilities, in the investigation of adult protection concerns, including issues of confidentiality and disclosure?

Local authorities have a number of duties and powers to investigate situations where a person may be at risk of harm. These arise under different pieces of legislation, such as the Adults with Incapacity (Scotland) Act 2000²⁵, Mental Health (Care and Treatment) (Scotland) Act 2003²⁶ and the Adult Support and Protection (Scotland) Act 2007²⁷. These acts have slightly different emphases but overlap in many of their provisions.

²⁵ *ibid*

²⁶ *ibid*

²⁷ *ibid*

The 2007 Act requires the local authority to make enquiries where an adult protected by the legislation is 'at risk'. An 'adult at risk' is defined as an adult (person aged 16 and over) who is unable to safeguard his or her own property, rights or other interests, is at risk of harm and because he/she is affected by disability, mental disorder, illness or physical or mental infirmity, is more vulnerable to being harmed than adults who are not so affected. An adult is at risk of harm if another person's conduct is causing or is likely to cause the adult to be harmed, or the adult is engaging or is likely to engage in conduct which causes or is likely to cause self-harm.

Where the adult or another person obstructs this investigation, the local authority can apply to the court for a warrant:

- to gain entry to premises;
- an order authorising an assessment of the adult; or
- an order to remove him to a place where he can be examined or assessed.

These powers are only used where other means have failed. Most initial investigations will be relatively informal and, where necessary, it is hoped that the adult will accept the help that is on offer. Local authorities have general duties under Section 12 of the Social Work (Scotland) Act 1968²⁸ to promote social welfare in their area by providing advice, guidance, assistance and such facilities as they consider suitable and adequate. They must assess the person's needs for community care support and may provide services directly or contract with another organisation to provide these.

The local authority will therefore generally be the first point of contact where there is

any suspicion of harm or abuse. Although the 2007 Act does not place a strict legal duty on voluntary or independent organisations to report harm or abuse, they have obligations under their general duty of care to discuss concerns about adults at risk with the statutory agencies. This is reinforced in the code of practice²⁹, contractual agreements with local authorities and in adult protection policies required by the Care Commission. Informal carers, relatives and friends have no legal responsibility to report concerns about abuse or harm but they do have a duty of care to the adult to do so.

In carrying out their investigation, the local authority can require other public bodies to cooperate with them and with one another by sharing information or working with them. It can be an offence to prevent or obstruct anyone carrying out the various functions set out in Part 1 of the Act (s49-50). Those required to cooperate are:

- all local authorities;
- NHS boards;
- Chief Constables of police forces;
- the Scottish Commission for the Regulation of Care;
- the Mental Welfare Commission; and
- the Office of the Public Guardian.

²⁸ www.opsi.gov.uk/RevisedStatutes/Acts/ukpga/1968/cukpga_19680049_en_1

²⁹ www.scotland.gov.uk/Publications/2009/01/30112831/4 Chapter 2 para 13

The 2007 Act also gives a council officer the power to require any person holding health, financial or other records relating to the adult, to grant access to those records by handing them over or providing copies. This includes records held by voluntary organisations, health or social care providers, banks or building societies or records such as bank books held by relatives.

Under the 2000 Act, where a person with a mental disorder is unable to protect their welfare, finances or property, the local authority has a duty to investigate. It will look into the welfare concerns but may pass any serious financial concerns to the Office of the Public Guardian to pursue³⁰. It must also investigate complaints about welfare attorneys and welfare guardians/interveners. Where medical examination or treatment is required and the adult lacks capacity to consent, this can be carried out under Part 5 of the Act. If the adult has capacity to consent, a medical examination can only be undertaken with their agreement.

Under the 2003 Act the local authority has a duty to inquire where someone with a mental disorder in its area is at risk of self harm, abuse or neglect in terms of their welfare, property or finances. If necessary the local authority can obtain a warrant to:

- enter the premises;
- authorise a medical examination; or
- gain access to medical records.

Where the person is a risk to themselves or at risk from others, the local authority can also apply for a removal order under section 293 to remove them to a place of safety for up to seven days. Unlike a removal order

under the 2007 Act, the person can be detained for up to seven days under a 2003 Act removal order.

There are a variety of statutory measures by which the local authority can investigate situations of risk, harm or abuse. In deciding which is the most appropriate, consideration should be given to the powers required, the capacity of the individual, the nature of the abuse, the urgency of the situation and what is the least restrictive option. Although the local authority may investigate under one piece of legislation, they may decide that an intervention under other legislation is more appropriate to the person's circumstances.

The police also have powers to enter and take action where they suspect a crime has taken place. A perpetrator may be removed to custody or bail conditions can be set to prevent them returning home or approaching the adult. It may then not be necessary to apply for removal or banning orders. Where the person with a mental disorder is the alleged offender, or the police are interviewing a potential witness, the police should involve an appropriate adult in this process³¹. If matters are taken to court, measures under the Vulnerable Witnesses (Scotland) Act 2004 can assist both witnesses and the accused when giving evidence³².

³⁰ www.publicguardian-scotland.gov.uk/

³¹ www.scotland.gov.uk/Topics/Justice/law/victims-witnesses/Appropriate-Adult/Guidance

³² www.opsi.gov.uk/legislation/scotland/acts2004/asp_20040003_en_1

What intervention may be required following investigation?

Usually any interventions to minimise the risk of potential sexual offending or the risk to sexual health and wellbeing, are undertaken with the person's agreement and as part of their care plan. However, where the person is non-compliant or reluctant to accept support, statutory intervention may be required under the Adults with Incapacity Act (Scotland) 2000, Mental Health (Care and Treatment) (Scotland) Act 2003 or the Adult Support and Protection Act 2007. The response must be proportional to the risk and the principles of the legislation borne in mind when deciding on what intervention, if any, is required. This is illustrated by the case of a middle-aged man living in supported accommodation, who had been repeatedly stealing women's underwear from washing lines and had been cautioned by the police. At a multi-disciplinary team meeting it was decided to assist him to purchase underwear, which was to be kept in a box and used in the privacy of his bedroom. This was detailed in his care plan with a designated member of staff to deal with him on this matter. Although there were some concerns about his capacity to understand the potential repercussions of his behaviour, he indicated compliance with the plan and it was seen as the least restrictive option by staff. However, some time later he resumed these thefts, staying out late at night and returning with unexplained injuries. Due to concerns about offending behaviour and that he was being sexually exploited, an assessment of capacity was carried out and welfare guardianship applied for. The powers granted allowed an increase in the support and supervision he received, particularly

when he was out of his house. It provided support for the continuation of the care plan with regard to his sexual activity, whilst minimising the risk of his offending or being offended against.

If someone is reluctant to accept support and supervision, or where the care plan is quite restrictive, consideration should be given to the use of legislation to protect the person's rights. Someone with dementia who is sexually disinhibited and living in a care home may be able to be supervised and diverted from inappropriate sexual activity. However, where they are persistently aggressive with staff and resistant to being guided to their room or to a quiet area, welfare guardianship may be required to provide a legal framework for a care plan. Someone who is sexually disinhibited due to a bipolar illness and is living at home may need detained in hospital under the 2003 Act, with close supervision on the ward and escorted for when off the ward until risks have subsided.

Interventions under Adults with Incapacity (Scotland) Act 2000

Medical Treatment – Part 5

Where an adult (person aged 16 or over) lacks the capacity to understand the purpose of treatment e.g. the nature of contraceptive methods or treatment of sexually transmitted diseases, a medical practitioner may prescribe contraception (where this requires prescription) or treatment under section 47 (Part 5) of the 2000 Act. Treatment cannot be given by force, unless it is immediately necessary and then, only for as long as is necessary. Obviously, careful consideration needs to be given as to the appropriate form of

contraception following discussion with carers. There may already be a guardian or power of attorney in place who has powers to consent or refuse medical treatment. In such cases, this person needs to be consulted about proposed treatment to which the adult cannot consent. A section 47 certificate of incapacity is required, even where a guardian or welfare attorney agrees. Where the proxy does not agree, Part 5 of the 2000 Act requires the Mental Welfare Commission to appoint a designated medical practitioner who can give an independent opinion on whether the treatment is appropriate. There are further legal measures in Part 5 if disagreement continues.

Certain types of treatment for those who lack capacity to consent cannot be given with the sole authority of a certificate of incapacity under section 47. They require specific approvals detailed in the regulations and in Part 5 of the Code of Practice³³. These treatments include sterilisation, where there is no serious malfunction or disease in the reproductive organs, abortion, surgical implant of hormones for the purpose of reducing sex drive and drug treatment for reducing sex drive. Similarly, there are specific safeguards for someone subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003, who is to receive drug treatment to reduce sex drive.

Protection under Part 6 of the 2000 Act

The 2000 Act does not specifically deal with decision-making in relation to sexual relationships and sexual behaviour. Where capacity of an adult is an issue and there are concerns about protection against sexual exploitation and manipulation in

relationships, access to sex education/counselling or medication including contraception, a variety of powers under a welfare guardianship order may be sought. These would allow for a care plan designed to address the sexual risks to be put in place. These powers require careful consideration as to their relevance, practicality and likely effectiveness.

These include the power to:

- determine residence and convey or return the person there;
- determine the level of the support package in accordance with the care plan;
- determine escort arrangements;
- consent or refuse medical treatment or assist the person with attendance at medical appointments or other appointments e.g. family planning, sexual counselling;
- determine education/training; and
- determine with whom the person associates/consorts or who has access to the person or to take necessary steps to remove any persons considered unsuitable from the adult's residence.

The local authority has a duty to take forward applications for welfare guardianship and intervention orders where necessary and where no one else is doing so. Where the person who is subject to the order refuses to comply with the welfare powers, the guardian may apply to the Sheriff under section 70 of the 2000 Act for an order to compel the adult

³³ www.sehd.scot.nhs.uk/mels/HDL2002_50.pdf

to comply with the decisions of the guardian. Whilst the guardian must consider whether the section 70 warrant/order is likely to make a difference to compliance with the powers, the Sheriff will then need to be satisfied of the positive benefit to the adult and that this is the only reasonable way of achieving that benefit. Where the adult still does not comply, it may then be appropriate to consider revoking the order or whether any other legislation may provide better protection for the individual.

Some decisions, such as consent or refusal of marriage, cannot be taken by anyone else on behalf of the adult.

Interventions under Adult Support and Protection (Scotland) Act 2007

The 2007 Act provides powers to protect an 'adult at risk'. Intervention has to be **with the person's agreement, unless they are thought to be under undue pressure from someone else**.

The 2007 Act allows the local authority to make inquiries where there may be risk of harm or allows a Sheriff to authorise an assessment order (lasts seven days), a banning order (lasts up to six months) or a temporary banning order, or a removal order (expires seven days after the person is moved). Any intervention should be guided by the principles, which include benefit to the adult, the least restrictive measure, having regard to past and present wishes of the adult and relevant others, and participation of the adult.

The 2007 Act may be useful where there is a need for speedier intervention than the 2000 allows, or where the person has

capacity but is vulnerable. For example, a young man living in his own tenancy, who was regarded as having capacity, reported sexual abuse by his parents. This took place during weekends and evenings when support staff were not around and involved both physical and sexual abuse. The young man was afraid of objecting and it was some time before he reported this to his GP who had been prescribing him antidepressants. Due to his concern his GP detained him under the mental health law on an emergency detention certificate. This was revoked after a few hours by the psychiatrist as the individual did not meet the grounds for detention. He agreed on discharge he would stay with a friend for a few days, but was not agreeable to moving from his flat and was responding to text messages from his mother enquiring where he was. An adult protection case conference was called by the social work department and it was decided to apply for a removal order under section 14 of the 2007 Act, as he appeared to be dissenting from a move due to fear of his parents. It was hoped the removal order, which gave authority to remove the person to other accommodation for seven days, would give time for professionals to establish some sort of relationship with him in order to make further plans with his agreement.

Where the measures under the 2007 Act cannot provide longer term protection, other civil or criminal legislation may need to be considered.

Interventions under the Mental Health (Care and Treatment) (Scotland) Act 2003

There are situations where compulsory measures such as detention in hospital and compulsory treatment are required for a period of time. The 2003 Act covers persons of any age and is not restricted to adults. Compulsory measures may be for a short period of time when someone is acutely ill, or for a longer period where there are ongoing risks and a less restrictive measure is unsuitable. Compulsion may be under an emergency detention certificate, a short term detention certificate or a compulsory treatment order (CTO). CTOs can be hospital or community-based. Where an individual is at risk due to their non-compliance with treatment for mental illness but does not need detention in hospital, a community CTO may be considered to ensure they remain well and risks are minimised. In addition to providing for medical treatment, community CTOs can also specify a range of other conditions. These can include a residence requirement, attendance at certain places and times for medical treatment, receipt of community care services, access for certain people involved in the adult's care and treatment, and requirement to get approval or notify a change of address. The use of the 2003 Act may be appropriate where there is a likelihood of non-compliance with medication which cannot be enforced under the 2000 Act, or where a person is assessed as having capacity but their judgement about the need for treatment is significantly impaired.

There are cases where individuals have been subject to both a community CTO, due to the need for medication, and a welfare

guardianship order, due to the need for other powers which cannot be specified as part of a community CTO, such as determining who the person associates with or who has access to the person.

When there is no issue about compliance with medication, there has been debate as to whether, in certain situations, a community CTO or a welfare guardianship order is more appropriate. Much will depend on the assessment of the powers required, as guardianship may provide more specific powers to address a situation of risk. Where all things are equal, it may be that the individual's perception of the legislation is significant. For example, there have been occasions when non-compliance with welfare guardianship has led to the individual being detained in hospital and it may appear to professionals that the person is more likely to comply with the requirements of a community CTO rather than being discharged again on guardianship. Alternatively, where a person has been detained in hospital on a number of occasions under the 2003 Act, they may feel more resentful of a community CTO, more oppositional to their care plan, and guardianship may present a more 'acceptable' option.

Interventions under the Criminal Procedures (Scotland) Act 1995

There are a number of mental health options available to the court under this Act, in addition to the full range of criminal justice disposals. These include Compulsion Orders (hospital or community based s57a), Compulsion Orders with a Restriction Order (s57a and s59), Guardianship Orders (s58

(1A)), Hospital Directions (s59a), Probation Orders with a condition of treatment. Depending on the type of order in place, specific conditions may be attached to an order. For instance, someone conditionally discharged from a compulsion order and restriction order with a conviction for indecent assault of a child may have specific restrictions relating to approaching children, being in the vicinity of children, or being out of the house at particular times of the day.

Interventions under other legislation

Antisocial Behaviour etc (Scotland) Act 2004

ASBOs are civil orders that exist to protect the public from behaviour that causes or is likely to cause alarm or distress. An order contains conditions prohibiting the person named in it from doing anything specified in the order, such as verbally abusing named persons or entering defined areas. The minimum age at which a person may be subject to an ASBO in Scotland is 12 years of age. ASBOs for adults are intended to tackle both behaviour likely to escalate to the criminal level, and patterns of behaviour which cumulatively cause considerable alarm or distress to the community. ASBOs are not criminal penalties and are not intended to punish the offender, nor are they a substitute for criminal proceedings where these are appropriate. They may however be complementary to other civil procedures.

It would not be appropriate to use an ASBO where an individual cannot understand the consequences of their actions. For example, it is highly unlikely that an ASBO would be the most appropriate means to address the behaviour of an

individual with autistic spectrum disorder or any disability, developmental or medical condition which is considered to cause their behaviour. It may, however, provide some measure of protection to such people where they are being subjected to sexually abusive language, to intimidating behaviour, sexual or otherwise, or to other anti-social behaviour.

Marriage (Scotland) Act 1977/ Civil Partnership Act 2004

Where it has been assessed that an adult is not capable of understanding the marriage contract, the Registrar of Births, Deaths and Marriages can refuse to marry a couple or conduct a civil partnership, or declare it void, where they are provided with the relevant evidence of incapacity. (See section on Capacity to consent to marriage/civil partnership.)

Conclusion

Balancing a person's rights to a fulfilling sexual life and meaningful sexual relationships against the risks that may arise from these requires careful assessment, reassessment and management. There are no easy, definitive answers to the complex situations that face professionals and carers in day to day practice. Any intervention must be necessary, lawful and proportionate to the risks and must be in line with the principles of the legislation. There are likely to be a number of different views regarding the need for intervention and what intervention is most consistent with the principles. This guidance hopefully provides a useful framework for discussion of the issues and guidance on appropriate interventions.

There are no easy definitive answers to the complex situations that face professionals and carers in day to day practice.

Appendix 1

Glossary of Terms

advocate – an independent person who provides support to another individual in order that their voice can be heard in decision-making processes.

adult – a person who is 16 years of age or over.

advance statement – written and witnessed document drawn up in accordance with s275-6 of the Mental Health Act, made when person is well, which sets out how they would prefer to be treated if they were to become ill in the future.

appropriate adult – someone with experience in the field of mental disorder who facilitates communication between a person with a mental disorder and the police and, as far as possible, ensures understanding by both parties.

common law offence – an offence under the law developed by judges through decisions of the courts rather than through legislative statutes.

mental disorder – the overarching term used in legislation which includes mental illness, learning disability, personality disorder, however caused or manifested.

proxy – person acting for an adult who has lost decision-making capacity such as a guardian or power of attorney under the Adults with Incapacity (Scotland) Act 2000.

Schedule 1 offence – an offence covered in Schedule 1 of the Criminal Procedures (Scotland) Act 1995/Sexual Offences (Scotland) Act 2009, which relates to sexual offences against children and sexual offences by care workers against adults with a mental disorder.

statutory offence – an offence which is defined by statute.

welfare attorney – individual specified in Power of Attorney document to take on welfare decision-making powers on behalf of another adult, when that adult has lost capacity to make such decisions – appointed by an individual while they still have decision-making capacity.

welfare guardian – individual appointed by the courts to make specific welfare decisions on behalf of another adult who does not have the capacity to make such decisions themselves.

Appendix 2

Useful links

Acts including amendments

www.opsi.gov.uk/legislation/revised

Codes of Practice

The Mental Health (Care and Treatment) (Scotland) Act 2003

Volume 1 of the Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003 deals with a range of issues relating to the general framework within which the Act operates. www.scotland.gov.uk/Publications/2005/08/29100428/04289

Volume 2 of the Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003 (“the Act”) deals with a range of issues relating to what can be termed “civil compulsory powers”. www.scotland.gov.uk/Publications/2005/08/30105347/53499

Volume 3 of the Code of Practice for the Mental Health (Care and Treatment)

(Scotland) Act 2003 covers a range of issues relating to mentally disordered offenders. www.scotland.gov.uk/Publications/2005/09/16121646/16474

Adults with Incapacity (Scotland) Act 2000: Code of Practice: For persons authorised under intervention orders and guardians www.scotland.gov.uk/Publications/2008/03/18094148/0

Adults with Incapacity (Scotland) Act 2000: Code of Practice: For Supervisory Bodies Under Part 4 of the Act. Part 5 Code for Supervisory Bodies

Adult Support and Protection (Scotland) Act 2007: Code of Practice. www.scotland.gov.uk/Publications/2009/01/30112831/18

Links to other organisations

Alcohol-related brain damage – Wernicke’s encephalopathy and Korsakoff’s psychosis www.alzscot.org/pages/info/alcohol.htm

Alzheimer’s Scotland www.alzscot.org

Bipolar Scotland www.bipolarscotland.org.uk/

British Institute of Learning Disabilities www.bild.org.uk/

Dementia Services Development Centre (DSDC), Stirling University dementia.stir.ac.uk/

Enable (Scotland) www.enable.org.uk/

Forensic Network Scotland www.forensicnetwork.scot.nhs.uk/

Family Planning Association www.fpa.org.uk/Shop/
Peoplewithlearningdisabilities

Headway – the brain injury association www.headway.org.uk/home.aspx

The Mental Welfare Commission for Scotland www.mwscot.org.uk

The National Autistic Society Scotland www.nas.org.uk/nas

NSF Scotland – National Schizophrenia Society www.nsfscot.org.uk/

SAMH – The Scottish Association for Mental Health www.samh.org.uk/

SCLD – The Scottish Consortium of Learning Disabilities www.sclد.org.uk/

The Scottish Huntington’s Association Website www.hdscotland.org/

Sexuality and dementia www.alzscot.org/pages/info/sexuality.htm

Links to some publications from the Mental Welfare Commission for Scotland

Autonomy, benefit and protection; how human rights can protect people with mental health conditions or learning disabilities from unlawful deprivation of liberty

Discussion paper prepared by Hilary Patrick, Mental Health Law and Practice

Consent to treatment: a guide for mental health practitioners. 2006

Rights, risks and limits to freedom: principles and good practice guidance for practitioners considering restraint in residential care settings. 2006

Justice denied: a summary of our investigation into the care and treatment of Ms A. 2008

Other Mental Welfare Commission for Scotland publications are available from <http://reports.mwscot.org.uk>

Miscellaneous useful links

What’s next for people with learning disabilities in Lothian? 2009-2013

Making choices, keeping safe

This policy and its associated guidelines have been produced as a response to the sexual health needs of people with learning disabilities. It has been written in wide consultation with, and with input from, people with learning disabilities, their parents and carers. It is a supporting document for the Edinburgh & Lothian’s sexual health strategy

Caledonia Youth provides support for young people covering sexual health and wellbeing, personal relationships and emotional issues, by offering a range of services – information, advice and education, plus clinics and counselling

Child Exploitation Online Protection Centre’s thinkUknow website provides material for young people on safe use of the internet <http://www.thinkuknow.co.uk/>

Childnet International’s Know IT All website also has material for young people on safe use of the internet <http://www.childnet-int.org/kia>

Young Scot – Scottish Youth Information (the website has a section on relationships and on sexual health available at www.youngscot.org/channels/feelinggood/?ss=157&s=44&sr=66&ID=19015)

Human Rights and Equalities Commission (Scotland)

Tony Attwood – Asperger’s Syndrome www.tonyattwood.com.au/

Appendix 3

Case Study 1

John a 17 year old, who has a psychotic illness, has been placed in an adult ward, and is awaiting a supported accommodation place. He is a voluntary patient. He is immature and vulnerable, particularly in relation to drug/ alcohol use. He has no real friends and in the past has been on the fringes of a group who largely bully him.

Whilst in the adult ward John has started a relationship with a 35 year old woman, who was separated from her husband and has 4 children. She had been admitted for the first time with a bipolar affective disorder and is detained. Although her mental health has improved, there is uncertainty about her normal presentation. Despite guidance from nursing staff, the couple’s sexual behaviour on the ward was proving difficult for other patients – kissing and fondling in public areas etc. It was decided that John should be moved to another ward. He was moved and immediately ‘absconded’, as he was unhappy with the move. Due to concerns about his vulnerability and his drug affected state on return, he was detained.

The relationship has continued. Both have 4 hours ‘on pass’ from hospital daily and they spend this time together. John has now told his support worker that they have been to her flat to have sex. He claims she is on the pill and he used a condom. Ward staff are unsure whether they should be intervening.

- Consideration was given to whether both parties had capacity to consent. It was felt the young man had capacity to consent to a sexual relationship but

there were concerns around the woman's ability to understand the risks to her health and welfare.

- The psychiatrist required to get background information on the woman's past social and sexual behaviour from her family to assess the impact of her bipolar affective illness on her current sexual behaviour. This revealed that this behaviour was entirely out of character and that the risks she was exposing herself to were related to her mental state. It was felt she required some protection in this regard until her mental state improved.
- The decision was taken to continue to allow both patients some time off the ward but at different times of the day. They were able to visit each other in one ward or the other for 2 hours per day in the day room.
- Staff had separate discussion with both parties on contraception and sexual health, as well as appropriate sexual behaviour in communal areas of the wards. They provided educational material to the young man and ensured he had condoms. They offered the woman a pregnancy test.
- Efforts were made to expedite the young man's placement in supported accommodation.

Case Study 2

Margaret is a 40 year old woman who has cerebral palsy, a borderline learning disability and a bipolar affective disorder. She grew up in care and has had a series of abusive husbands and partners. She has had 5 children, all of whom have been taken into care and have been adopted.

Tom, the father of her youngest two children was physically, emotionally and financially abusive of her. He was eventually sentenced to 4 years imprisonment for seriously assaulting her and failing to get her medical help. He is now out of jail and has resumed his relationship with her. Margaret has always found it very difficult not to have a partner in her life. She becomes extremely unhappy, partly due to the perceived lack of social status, and it appears she often relapses into illness when on her own, requiring hospital admission. Whilst Tom was in prison, social work staff assisted Margaret to move to a new tenancy and furnish it, in an attempt to stop her house being used as a 'drinking den' by locals. The social work department became appointees for her benefits and helped her with budgeting. Every effort was made to provide a care package to engage her in other activities, but she was generally resistant to this. Her tendency to show interest in men who present risk to her reasserted itself. When Tom was in jail, she became involved with a Schedule 1 offender, who again sexually and physically exploited her.

Margaret is aware of the views of her brothers and professionals that Tom presents a risk to her. She therefore tries to conceal her growing relationship with him, though it is suspected he is living in her flat most of the time. She denies this. She is already presenting with unexplained injuries which she claims are due to falls but look more like non-accidental injuries. In addition she is about to receive Criminal Injuries Compensation Authority (CICA) money for the injuries inflicted by Tom. It is known that Tom feels that this should be his money as he has 'served his

time for it'. The money will not be paid if he is likely to benefit from it in any way. Tom is very aggressive towards social workers and social care staff and has had charges in the past for assault on them. Margaret's current package of care has been cut from four to two hours per day as workers have to 'double up', but on many occasions they do not get access. When they do get access, they are unable to stay in the house if Tom is there and Margaret can be loathe to go out with them.

- Attempts continued to persuade Margaret to cooperate with the support provided, either in her flat or using community facilities but her cooperation was very intermittent. Social work staff tried to link her in with Woman's Aid and the police domestic abuse liaison officer. This was partially successful though she continued to deny abuse by Tom. Bereavement counselling was accessed to try to help her deal with her grief over the loss of her children. Her social worker tried to identify, without success, accommodation which could deal with her physical disabilities, mental illness and learning disability and where staff and other residents might be able to cope with the likely intrusion of her violent partner.
- There was a careful review of all the files held by the social work department to collate all the significant concerns over the years relating to her physical and mental health and incidents of physical/sexual/financial/emotional abuse with the evidence associated with this. This highlighted the extent and range of risks she was subject to.

- Margaret agreed to cooperate with a psychological assessment of her capacity in various areas, after a series of adult protection case conferences concluded that the local authority should consider possible legal intervention under the Adults with Incapacity (Scotland) Act 2000 (welfare and financial guardianship) or the Adult Support and Protection (Scotland) Act 2007 (banning order) The assessment concluded that Margaret did not have capacity to determine where she resided, to consent or refuse medical treatment, to determine what support she received, to determine what professionals should have access and to deal with her finances. However it was assessed that she did have capacity to determine who she consorted with i.e. that she was able to balance the risks of an abusive relationship with the benefits to her.
- An application was submitted and granted limited welfare guardianship powers, excluding the power to determine who she associated/consorted with. It was recognised in any case that this power would have been very difficult to 'police' without Margaret's cooperation. It was considered whether a case could be made for a banning order under the 2007 Act, as it was felt she was under undue pressure from Tom. However, without Margaret being in 24 hour care this was thought to be unworkable, as she would constantly collude with Tom to undermine this. An application was granted for financial guardianship, to ensure Margaret benefited from the CICA money – it was felt that this had been an incentive in Tom renewing his relationship with Margaret.

- The guardianship order was used to support the continuation of one visit per day seven days per week with two workers. Margaret usually went out with workers for breakfast/shopping/paying bills etc. She also collected her DWP benefits from the social work office three times per week with the support workers and this encouraged her engagement with them. Staff also called at the door at teatime to ensure she was 'alive and well'. Where there was no answer, a protocol was in place for phone calls over the next two hours, contact with her social worker/out of hours social work service and then Police involvement. Margaret understood the protocol and, as she was aware Tom did not like any involvement with the police, she was largely cooperative with this. On a number of occasions Margaret did present with injuries and staff were able to ensure she got immediate medical attention. She also had several relapses in her mental health and staff again were able to deal with this promptly. It was thought that the knowledge of regular staff visits curtailed some of the excesses of Tom's temper.
- All attempts to engage with Tom failed.
- Although there remained considerable concerns about the risks to Margaret, the support package backed by the guardianship order offered a minimal safety net.

Case Study 3

Gordon is 28 years of age and lives in his own tenancy with support. When he was 25 he was involved in a serious road traffic accident. He is in a wheelchair. He has some cognitive impairment, is dysphasic and his moods can be quite unpredictable.

He has support four times per day from a support agency which is paid for through direct payments. He manages this himself with some help from the support agency. His parents visit four or five times per week and also provide him with practical and emotional support.

His parents have recently raised concerns about his money, as he now has a number of outstanding utility bills and appears to be always short of cash despite having a reasonable income. Gordon has been accessing the services of prostitutes who visit him approximately fortnightly. Some members of staff are aware of this because, due to his poor speech, Gordon has asked them to phone an escort agency to make these arrangements. He has also asked them to acquire sex toys and pornography for him. Because of the financial queries raised by his parents with the support staff, they are concerned about their role in procuring prostitutes and other items, the problems with his finances and the issue of confidentiality.

- A case discussion focussed initially on the issue of capacity. The wider team looked more closely at the extent of Gordon's capacity to deal with his finances – even with support. Staff had been providing only minimal assistance and it became clear

that they were unsure that Gordon's direct payments were being solely used for their intended purposes. He was unable to give a clear account of how much money he was spending on procuring prostitutes. There were fears that they may have been taking advantage of him. Some staff expressed concerns about the fact that some of the girls who showed up may be underage.

- Following discussion with Gordon, it was agreed that his use of prostitutes was a confidential matter and he did not wish to share this information with his parents. However reassurance was given to his parents that the issues around the management of his finances would be looked at and that he needed more support with this.
- It was known from Gordon's own accounts and from previous discussions with his family that he has had sexual relationships prior to his accident. His family believed that he had been aware of risks and had been sensible and practiced safe sex, but they have concerns that he might not exercise the same control or caution now and might be at risk of a sexually transmitted disease.
- Some of the female support staff felt very uneasy about his constant talk about and reference to his pornography and sex toys. He often displayed them in front of staff. They did not feel it was right that they should be expected to assist him in purchasing such items. They felt their right to dignity and privacy should also be respected. Other staff felt it was his right to have a sexual life but admitted feeling awkward and unsure about how they should respond when he requested their assistance in organising this. It was agreed that staff needed to be clear on the extent to which they should assist Gordon in these areas, if at all, and which staff would be agreeable to support him in some of these areas.
- The decision was taken to seek input from a psychologist about the level of Gordon's sexual knowledge and his ability to understand sexual risk. They felt that they had been open enough with Gordon that he would not object to speaking with a psychologist to help him and staff decide how they could best proceed in a way that safely and legally protected both Gordon's rights and respected the rights and responsibilities of staff.
- Staff were also to ask Gordon if he wanted to speak to an advocate about his wishes and how he wanted be treated and assisted.
- A referral was also made to a speech and language therapist to assist in maximising Gordon's ability to communicate his wishes, including advising over the use of assistive technologies.

Case Study 4

Jean is 68 and has a significant degree of dementia. She is in a care home and has become friendly with Alex. He has a mild degree of alcohol-related brain damage. Jean misidentifies Alex as her husband and gets a lot of pleasure from his company. Alex seems to be aware that she thinks he is her husband but is enjoying the attention.

Staff have become concerned that the relationship is becoming more sexual. They are often seen kissing and fondling. One day, staff find them in Alex's room in a state of undress. They intervene to separate them but Jean gets very distressed by this and wants to be with Alex. Jean's family are upset and want Jean to be kept away from Alex as they are clear she would never behave this way to anyone but her husband.

- Assessment of capacity for both Jean and Alex is essential. In this case, Jean did not have capacity to consent to a sexual relationship because she misidentified Alex as her husband.
- Alex has capacity and this leads to a power imbalance – he is in a position to knowingly take advantage of Jean's failure to identify him correctly.
- Staff must apply the principles of the 2000 Act when considering whether and how to intervene. This is not easy in this situation. Jean gets benefit from the security of the relationship, but may be harmed by having a sexual relationship where she is not giving capable consent. Also, her wish to have a relationship with Alex has to be taken into account, as do her family's wishes that there should be no relationship.
- There may be a welfare attorney or guardian with the authority to decide who Jean may or may not consort with. If so, the attorney or guardian must also act in accordance with the principles of the 2000 Act.
- Jean may benefit from independent advocacy to ensure that her views are represented when decisions are being made.
- The social work department convenes a case conference to allow all parties to express their views. This helps to achieve a consensus agreement that Jean is comforted by her relationship with Alex but that sexual contact is inappropriate.
- The relationship continues. Alex's key worker explains to him that Jean thinks he is her husband and that while this is comforting for her, it would be wrong for her and Alex to have a sexual relationship on this basis. Staff are vigilant and redirect them to public areas where they can be observed or to their individual rooms if there is a risk of sexual activity.