



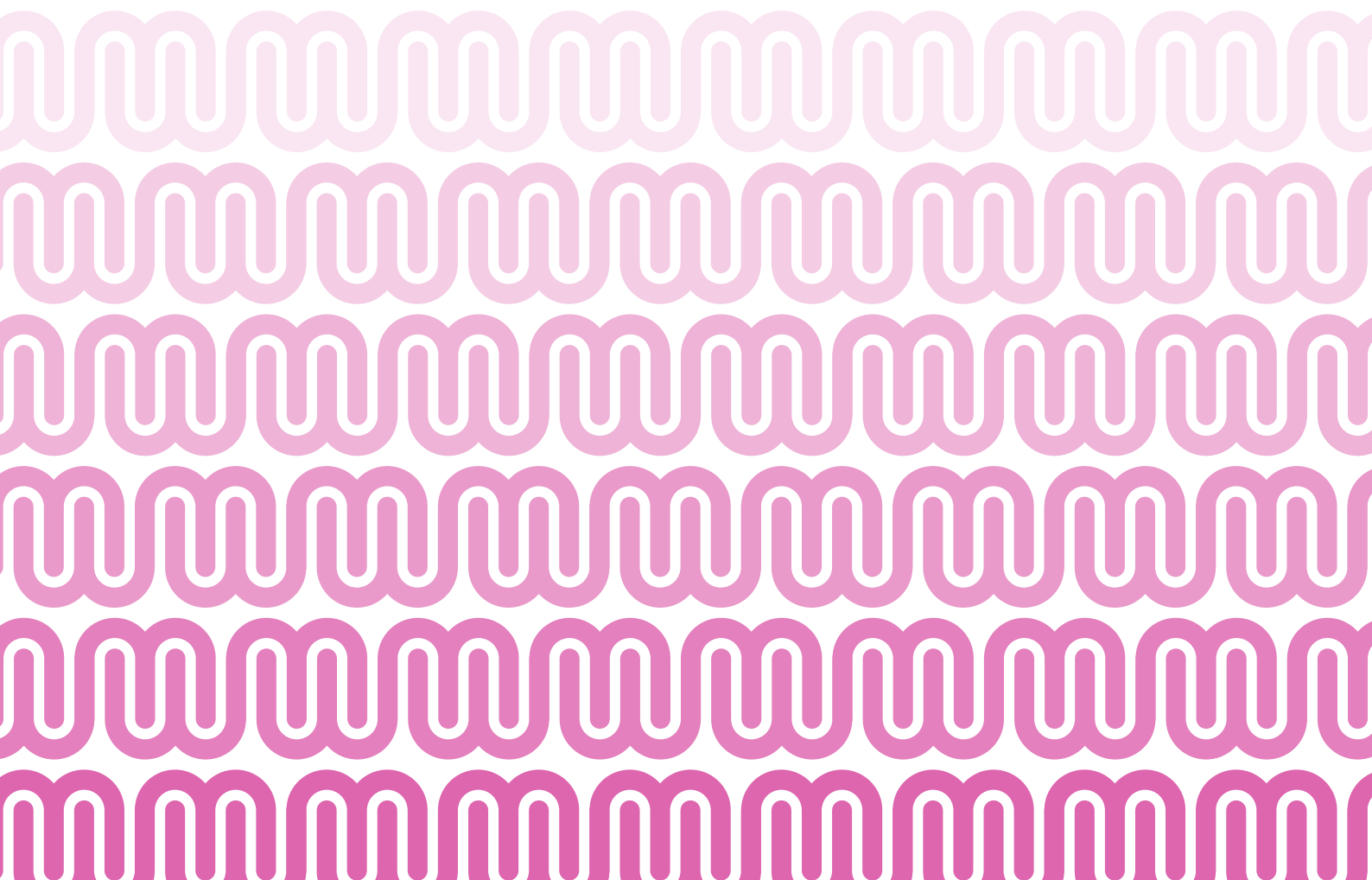
**mental welfare**  
commission for scotland

# **Consenting adults: capacity, rights and sexual relationships**

Good practice guide

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April 2021



# Our mission and purpose

## Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

## Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

## Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

## Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

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This good practice guide was previously published in 2012. It has been comprehensively updated in 2021. Significant changes include content on social media and internet use and updates to case law.

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## Quick guide

1. People with mental illness, dementia, learning disability or related conditions have the same human rights as anyone else to sexual expression, sexual relationships marriage and children. These are an important part of life.
2. But some may lack capacity or judgement to make informed decisions. They may therefore be vulnerable and at greater risk of abuse, exploitation or other serious consequences. Professionals need to balance rights and risks, recognising that there is always some risk, and that it is important not to be over-protective.
3. There may be no need to intervene if there are no concerns about exploitation, coercion or abuse. Unnecessary intervention will limit someone's rights and could be unlawful. Legal advice may be needed.
4. Scottish law around capacity, mental health and adult protection is based on principles, including supporting people to make their own choices. There is more about the law in section 3.

### Principles (section 2)

1. The guidance is based on principles, including:
  - Any interference with rights must be necessary and lawful.
  - Proper assessments of capacity and vulnerability are essential.
  - Capacity assessment must be based on the activity, rather than any partner or proposed partner.
  - Any intervention must be proportionate and based on the risks and benefits to the individual and the principles set out in law.
  - 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.
  - Decisions should be based on a multi-disciplinary approach and involve the person and their carers.
  - Staff must consider the person's individuality, background and culture and must not impose their own values.
  - Formal legal measures may be necessary where someone lacks capacity, and may be the best way of protecting their rights.

### Legal framework (section 3)

2. A summary of relevant national and international law.

### **Assessing capacity (section 4)**

3. Incapacity is defined in the Adults with Incapacity (Scotland) Act 2000 as where a person cannot act, make, communicate or understand a decision, or remember it, because of mental disorder. A person will also lack capacity if they cannot communicate because of physical disability; and there is no human or mechanical aid that can overcome this.
4. Assessment should be of the person's capacity to consent to and engage in sexual relations generally.
5. Any concerns around the risks that a particular partner might present should be addressed through the Adult Support and Protection (Scotland) Act 2007.
6. An English Court of Appeal case (section 4.4) provides a useful framework for what someone needs to understand to have capacity to consent to a sexual relationship:
  - the nature, character and mechanics of sexual intercourse;
  - the fact that the adult can give or withhold consent;
  - that a woman could become pregnant;
  - that there are health risks, which can be reduced by taking precautions; and
  - that the other person must have capacity and must consent before and throughout the sexual activity.

### **Risk assessment and other factors (sections 5,6 and 7)**

7. Other factors to consider, include:
  - the person's background and previous sexual behaviour;
  - their past or present wishes, and advocacy to support these;
  - the impact of their diagnosis, including possible changes or fluctuations in capacity or judgement;
  - managing risks to the person and/or others, including denial of the right to have a sexual relationship despite capacity to consent, sexually transmitted disease, pregnancy, forced marriage, sexual offending or being the victim of an offence or abuse;
  - family attitudes, including possible difficulty in coming to terms with the adult's sexuality or sexual behaviour, which may be a particular issue for lesbian, gay, bisexual or trans individuals;
  - culture and religion;
  - sexual orientation and the importance of staff not making assumptions and ensuring support does not discriminate;
  - impact of living situation or care setting, such as privacy and safety;
  - the importance of being alert to possible abuse, and taking seriously allegations made by adults with learning disability or dementia.

### **Marriage/civil partnership (section 8)**

8. The decision to marry or enter into a civil partnership can only be made by an adult with capacity and cannot be taken by anyone else.
9. Where there are concerns, registrars can make enquiries, such as contacting the social work department.

10. The General Register Office for Scotland decides whether someone is capable of entering into the marriage or civil partnership.
11. If there are concerns that a marriage may be forced, there should be an urgent adult support and protection case conference. The Forced Marriage (Scotland) Act 2011 has a range of protection measures.

### **Social media and internet use (section 9)**

12. Social media and the internet can help people socialise and engage with others, but also present risks of abuse or exploitation due to impaired judgement or lack of understanding.
13. Any restrictions must be very carefully considered and appropriately risk appraised and balanced and should not necessarily seek to minimise every risk.
14. English court decisions have said that use of the internet and of social media should be treated as the same thing for the purposes of assessing a person's capacity, but differently from other forms of social or physical contact. To have capacity the adult would need to understand:
  - Things could be shared with people they don't know without them knowing or being able to stop it.
  - Sharing can be limited by using privacy and location settings (but not necessarily how to do this without support).
  - What might be rude or offensive material, and that this can upset or offend others and might lead to police involvement.
  - Some people they 'talk to' online may not be who they say they are and may pose a risk to them.
15. If someone lacks capacity to use social media and internet following assessment, the risks should be considered.
16. Education, informal supervision and support or monitoring might enhance a person's capacity or minimise risk.
17. If they are unable or unwilling to consent to any restrictions, appropriate powers under a welfare guardianship may be needed.
18. People with capacity may also be at risk using social media and the internet. Education and support may help; but when someone is at risk the Adult Support and Protection (Scotland) Act 2007 may be needed.

### **Capacity, consent and the criminal law (section 10)**

19. The right to sexual expression assumes that the individual consents. Consent is not given where the person does not or cannot consent, or is coerced.
20. If there are concerns about abuse or exploitation, which includes not only direct physical acts but also non-contact abuse such as being forced or encouraged to look at pornographic materials, obscene phone calls, indecent exposure, indecent photography, serious teasing or innuendo, or other physical, emotional, psychological or sexual abuse, the local authority has a duty to investigate under the Adult Support and Protection (Scotland) Act 2007.



### **Staff knowledge, values, attitudes and practice (sections 11 and 12)**

21. Staff need training and support to ensure that they can positively support individuals to develop personal relationships.
22. Staff should not allow personal values, beliefs, prejudices, judgements or sexual preferences to affect their work.
23. Staff must accept the person's own sexual identity and choice of partner, provided the relationship is mutual and not abusive or coercive.
24. Staff must be aware of adult protection requirements, which can override duties of confidentiality.
25. Where the adult has capacity, his or her wishes should be adhered to. Where they lack capacity, guardianship should be considered.
26. Staff may need to support the adult to get contraception and sexual health checkups.
27. There are issues around how staff might approach requests for access to pornography or sex aids, but they do not have the right to be judgemental, deny access to legal material to an individual who is able to make the choice, or impose their own views. The use of sex aids must always be in private without staff involvement (other than for educational purposes).
28. Staff may need to provide education about masturbation and support to ensure it is in private.
29. Staff should not get involved in making arrangements with a sex worker or agency.

### **Adult protection duties and interventions (section 13)**

30. This section sets out in detail the possible range of legal interventions under the Adults with Incapacity (Scotland) Act 2000, Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adult Support and Protection (Scotland) Act 2007 and other legislation.
31. The local authority may investigate under one piece of legislation, but decide that an intervention under other legislation is more appropriate.
32. The police also have powers to enter and take action where they suspect a crime has taken place.
33. Usually any interventions to minimise risk to sexual health and wellbeing or the risk of sexual offending are with the person's agreement and as part of their care plan.
34. If the person does not have the capacity to consent, formal interventions may be more appropriate and may better protect the person's rights.

# 1. Why did we produce this guidance?

Practitioners will be familiar with the tension between balancing a person's right to make their own decisions and choices against the risks that this can sometimes present. The principle of autonomy, and the right of all to enjoy life's experiences to the full are fundamental. Sexual expression, sexual relationships, marriage and children are an important and natural part of a person's life experience.

People with a mental illness, learning disability, dementia or related condition have the same personal and sexual needs and rights as anyone else. At the same time, impaired capacity or judgement can sometimes place people at greater risk of abuse or exploitation and can also impact on a person's capacity to engage in or consent to sexual relations. Balancing those rights and risks raises a host of legal and moral dilemmas to which there are no easy solutions.

In some situations, there may be serious consequences for both the individual or possibly others if intervention does not take place; but unnecessary intervention will not only limit a person's ability and right to enjoy sexual relations with others but may constitute a potentially unlawful intrusion into their private life.

Any intervention must recognise that people with impaired capacity or judgement are entitled to access the same life opportunities as anyone else. In taking this approach, there needs to be an understanding that exposure to life experiences, particularly engagement in sexual relations, will always present some level of risk. Care must be taken to avoid a heavy handed or overly-protective approach. Any intervention in this area should not seek to wrap adults we seek to protect in "forensic cotton wool"<sup>1</sup>

The law in Scotland is not designed to avoid and prevent all risks that an adult might face; it seeks to accord with a person's past and present wishes and assist them in the development of new skills and experiences.<sup>2</sup> Any approach should support people to make their own choices, with all reasonable and practical steps taken to support them to safely make their own decisions. Any intervention should allow mistakes to be made and lessons to be learned, when it is safe and appropriate to do so.

This guidance has been produced in response to these complex legal and ethical issues. We have included many of the practical issues concerning sexual relationships raised with us, in particular social media and internet use. 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 and relationships. It should be borne in mind that legal advice may be required whether an intervention is required or not.

This guidance recognises that people who may be thought to lack capacity or are vulnerable do enter into sexual relationships. There may be no need for any intervention if the circumstances do not raise concerns about exploitation, coercion or abuse. In assessing and deciding on the need for intervention, this guidance looks at a number of significant questions for practitioners.

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<sup>1</sup> Hedley J a paragraph 10 NHS Trust v P [2013] EWHC 50 (Fam) [10] and cited with approval in. [IM v LM & Ors \[2014\] EWCA Civ 37 \(23 January 2014\) \(bailii.org\)](#)

<sup>2</sup> See section 1 of the Adults with Incapacity (Scotland) Act 2000- general principles

These include:

- assessment of capacity;
- 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 and appropriate risk management and appraisal
- emotional wellbeing of the adult
- 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;
- intervention that may be required;
- support and education to maximise an adult's understanding and ability.

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.

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

## 2. 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.
- A person's capacity should always be considered in relation to the nature of the activity in which they wish to engage in. The focus should be on the adult's capacity and abilities to engage in a sexual relationship of itself. A person's capacity to engage in a sexual relationship should not be assessed in terms of the character of the person's partner/proposed partner or the benefits or disadvantages of the relationship itself.
- 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 basis upon which to make rights based decisions and adult focused approaches.
- Care professionals have a duty to protect people from abuse or exploitation. A range of options are open to professionals under the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007. For example a local authority could seek a banning order <sup>3</sup> if they considered it was necessary to protect a vulnerable adult from an abusive partner as an alternative to seeking a Guardianship order.
- Care professionals also have a duty to assist people's sexual expression through education, counselling and support. This support may require to be ongoing for the adult in order to safeguard the adult from harm and to allow the adult to maintain their skills and to develop new skills in regards relationships with others. It is good practice to support adults in promoting and maintaining the life choices they wish to make.
- A person's capacity to engage in sexual relations may be enhanced with the right support and education but equally be diminished by lack of such support or undue influence.
- Resolving legal, ethical and practical dilemmas requires discussion between professionals, carers and the person themselves. Appropriate information sharing is essential and should be encouraged through the use of multi-disciplinary team meetings.
- Staff must consider the person's individuality, background and culture and must take particular care not to impose their own values when considering sexual activity and expression. In cases where a person is considered to lack capacity to engage and consent to sexual relations, it may be that formal legal measures are necessary in order to protect that person and their rights.
- Some decisions require to go to court; others do not. This depends on the nature of each case. Whilst the evidence of professionals of a person's capacity to consent to and engage in sexual relations will be of importance to the court, it is the court that ultimately makes a decision on capacity.

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<sup>3</sup> Section 20 Adult Support and Protection (Scotland) Act 2007

## 3. Legal framework

### 3.1. The European Convention on Human Rights (ECHR) <sup>4</sup>

The 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). 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 to protect the rights and freedoms of others. The law in Scotland relating to the sexual relationships of people with mental disorder has been developed to attempt to strike this balance between affording legal protections for people who do not have capacity to consent to sexual relations (or who are vulnerable to harm) and protecting autonomy, and the right of all to enjoy a family and private life.

### 3.2. United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) <sup>5</sup>

The UNCRPD recognises that persons with mental disabilities are entitled to enjoy the exercise of rights on an equal and non-discriminatory basis with others.- This includes the limitation of such rights. - UNCRPD rights are not enforceable in the same way as ECHR rights; however, the UK, as a state party to the UNCRPD, is bound under international law to comply with it. The UNCRPD provides a useful framework to address the rights of persons with disabilities.

The UNCRPD “approach” is about recognising that not everyone starts from the same baseline and that persons with mental disabilities may need support in order for them to exercise their legal capacity. This approach of supporting adults to make their own decisions rather than pursuing substitute decision making (such as guardianship), provides for rights-based decision making to enable the adult to maximise their involvement in their own life choices, despite their disability.

### 3.3. Adults with Incapacity (Scotland) Act 2000

The 2000 Act provides a statutory framework for formal legal intervention in the affairs of an adult who may lack capacity to engage and consent to sexual relations. The Act sets out general legal principles<sup>6</sup> which must be applied by anyone intervening in the affairs of an adult who lacks capacity. They must consider whether any intervention:

- 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 to develop new such skills.

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<sup>4</sup> <https://www.echr.coe.int/Documents/Convention>

<sup>5</sup> <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html>

<sup>6</sup> Section 1 (2)-(4) of the Adult with Incapacity (Scotland) Act 2000

The proper application of the principles allows decision makers and the Court to balance the risks and the rights of those with impaired capacity in relation to decisions affecting their sexual health and well-being.

### **3.4. Mental Health (Care and Treatment) (Scotland) Act 2003<sup>7</sup>.**

The 2003 Act provides the statutory framework for the care and treatment of persons with mental disorder on a compulsory basis. This Act also contains general legal principles<sup>8</sup> which must be taken into account, in relation to sexual health and well-being issues. These include:

- the present and past wishes and feelings of the patient;
- regard to the views of others;
- patient participation;
- maximum benefit to the patient;
- minimum restriction of their freedom;
- not treating them less favourably than someone who is not a patient;
- taking into account their abilities, background and personal characteristics.

### **3.5. The Adult Support and Protection (Scotland) Act 2007**

The 2007 Act deals with the protection of adults at risk of harm and provides a statutory framework to identify and protect individuals who fall into the category of “adults at risk”.<sup>9</sup> This Act also contains general legal principles which are similar to the 2000 and 2003 Acts including the general principle that any intervention should provide benefit to the adult and should be the least restrictive option available.

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<sup>7</sup> [www.opsi.gov.uk/legislation/scotland/acts2003/asp\\_20030013\\_en\\_1](http://www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_1)

<sup>8</sup> Section 1 of the Mental Health (Care and Treatment) Scotland Act 2003

<sup>9</sup> Section 3 of the Adult (Support and Protection) (Scotland) Act 2007.

## 4. The importance of correctly assessing capacity

### 4.1. Capacity to consent or engage

Capacity is a legal test and is directly related to the specific task or decision. The law starts from the assumption that all individuals have the capacity to engage in and consent to sexual relations. If a person has a mental disorder this does not mean that they necessarily lack the capacity for sexual relationships. Some people with a learning disability, for instance, will 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.

In Scotland, the definition of “incapacity” is provided by the Adults with Incapacity (Scotland) Act 2000. It describes a person as incapable of taking a decision if they cannot act, make a decision, communicate a decision, understand a decision or remember a decision made because of mental disorder. A person will also lack capacity if they cannot communicate because of physical disability.<sup>10</sup> A person who can communicate with help or assistance is not regarded as incapable under the Act.<sup>11</sup>

Whilst the 2000 Act does not specifically deal with capacity to engage in sexual relationships, it defines decision-making capacity in general terms which can be applied to a specific task or decision. Any assessment of a person’s capacity to engage in and consent to sexual relations must always be made against this statutory framework. If formal legal measures are considered appropriate by those supporting an adult, then it will usually be for a court to make a final determination.

### 4.2. Situation specific not partner specific

Consideration of a person’s capacity to consent to and engage in sexual relations must be situation specific. Capacity depends on that person having sufficient knowledge and understanding of the nature and character of the sexual act and its reasonably foreseeable consequences.

A person either has the capacity to engage in a sexual relationship or they do not and the assessment of their capacity to enter into a sexual relations should focus on a non-person specific context, at least for the purposes of capacity. Whilst this can be difficult, particularly when those supporting a vulnerable person who engages with a partner who might place them at risk, the focus should be the person’s capacity to consent to and engage in sexual relations generally.

Any concerns around the *risks* that a particular partner might present to a vulnerable person should be addressed through measures under the 2007 Act. It may be that the 2007 Act and the 2000 Act are considered together when the adult lacks capacity. In some circumstances the risks the vulnerable person has experienced and failed to protect themselves from will be relevant.

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<sup>10</sup> Section 1(6) of the Adult with Incapacity (Scotland) Act 2000

<sup>11</sup> Ibid

It is important, however, not to take an overly protective approach in assessing capacity, which risks placing an unfair burden on some people with impaired capacity who wish to engage in a sexual relationship.

### **4.3. Factors to take into account when assessing a person's capacity to engage in sexual relationships**

There is generally little reported Scottish case law dealing specifically with capacity to consent to or engage in sexual relations.<sup>12</sup>

The courts in England have, however, issued a number of key decisions when determining the issue of capacity to consent or engage in sexual relations. Decisions from the Court of Appeal have concluded that this test is not a complex one and the factors that should be taken into account should be as simple and straightforward as possible (see section 4.4).<sup>13</sup>

Decisions in English courts have also recognised that relationships are driven as much by instinct and emotion as opposed to a process of rational choice and weighing up information.<sup>14</sup>

That is to say, people, whether they have impaired capacity or not do not tend to weigh up information in a rational detailed manner when they decide to embark on a sexual relationship.

### **4.4. JB case**

A key decision from Court of Appeal in England is *Local Authority v JB*<sup>15</sup>. The court considered an appeal from the Court of Protection concerning the "relevant information" which a person must be able to understand as part of the functional test for mental capacity in Section 3(1) of the Mental Capacity Act 2005.

The case involved a 36-year-old man ("P") with a diagnosis of autistic spectrum disorder combined with impaired cognition. P lived in a supported residential placement with an extensive package of care which restricted his ability to socialise and freely access opportunities in the community. These restrictions were in place as P had a tendency to behave inappropriately towards women and expressed a wish to have a girlfriend and engage in sexual relations.

The issue before the Court of Protection was whether or not P had the capacity to consent to such a sexual relationship. When the case was appealed, the Court of Appeal considered the issue of capacity.

#### **Key factors considered in the assessment of capacity in this case**

The Court considered a number of previous English judgements in this area. In doing so it reinforced and highlighted the relevant information which might form part of an assessment

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<sup>12</sup> West Lothian Council v L.Y (Livingstone Sheriff Court AWI9/13)

<sup>13</sup> IM v LM and Others (sub nom Re M (An Adult)) [2014] 3WLR409 <https://www.bailii.org/cgi-bin/redirect.cgi?path=/ew/cases/EWCA/Civ/2014/37.html>

<sup>14</sup> Ibid at para 80

<sup>15</sup> [2020] EWCA Civ 735 <https://www.bailii.org/ew/cases/EWCA/Civ/2020/735.html>



of a person's capacity regarding sexual relations. Practitioners in England have been using these factors as a guide and they include understanding of:

- the nature, character and mechanics of the act of sexual intercourse,
- the fact that the adult can say yes or no to having sexual relations and is able to decide whether to give or withhold consent,
- that a reasonably foreseeable consequence of heterosexual intercourse is that the women will become pregnant,
- that there are health risks involved i.e. sexually transmitted and transmissible infections, which can be reduced by taking precautions such as the use of a condom, and
- the fact that the other person must have capacity to engage in the sexual activity and must consent before and throughout the sexual activity.

#### **4.5. Consider assessing a person's capacity to engage in sexual relations**

One of the key findings in this case was that as sexual relations are mutually consensual then a person who does not understand that sexual relations must only take place when, and only for as long as, the other person is consenting, is unable to understand a fundamental part of the information relevant to the decision whether or not to engage in such relations. In this case it was finally determined (when the case was remitted back to the Court of Protection) that the P did not have the capacity to engage in sexual relations.

This is an important point. The Court recognised a person might want to instigate a sexual relationship, as P wished to. The Court felt that it was important that P was able to understand that the other person must at all times be able to consent or withdraw consent:

*"it becomes clear that the 'information relevant to the decision' inevitably includes the fact that any person with whom P engages in sexual activity must be able to consent to such activity and does in fact consent to it"*<sup>16</sup>

The Court considered that the assessment of capacity of a person in this regard should therefore be expressed in terms of capacity to *engage* in sexual relations, rather than capacity to *consent* to sexual relations. The person must not only understand that they are able to give or withdraw consent at any time, but that the other person also is too.

We consider that this is a good approach in any assessment of capacity. Whilst decisions of English courts are not legally binding in Scottish courts and relate to different incapacity legislation, they can be used as persuasive authority. This key judgement provides very useful guidance on what relevant information professionals should consider when assessing a person's capacity to engage in sexual relations.

The relevant information taken from the JB case above should be used as a guide. The factors to be understood and assessed will of course depend on the individual.

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<sup>16</sup> At paragraph 94

Decisions made in this area are complex and the emphasis should be on supporting adults, undertaking sensible risk assessment and ensuring that decisions are made considering the adult's human rights, safety and emotional health as paramount.

These decisions are a useful guide on factors that should be taken into account in any assessment of capacity. However the legal test in Scotland in determining incapacity is found in section 1(6) of the 2000 Act as we have stated above.

#### **4.6. Other guidance on the assessment of capacity**

Some further useful guidance on assessing the capacity of adults with regard to sexual relationships can be found in Murphy and O'Callaghan (2004)<sup>17</sup>. 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. They consider the following areas to be important when evaluating capacity:

- basic sexual knowledge (e.g. of body parts, sexual relations, and sexual acts);
- knowledge of the consequences of sexual relations, including sexually transmitted diseases and pregnancy;
- an understanding of appropriate sexual behaviour and the context for this;
- an understanding that sexual contact should always be a matter of choice;
- the ability to recognise potentially abusive situations; and
- 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.

#### **Multidisciplinary and carer involvement**

Medical practitioners' assessments of capacity should always include full consultation with those 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 communication needs, the environment where this should take place, and the sensitivity of the subject.

#### **Information and education**

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

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<sup>17</sup> 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

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, to minimise the risks of exploitation, and less on factual information.

Incapacity should 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 impaired capacity as they make the transition to adulthood.

## 5. 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 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 Ms A criticised the lack of transfer of significant information from one agency to another. 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.<sup>18</sup>

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

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<sup>18</sup> Mental Welfare Commission for Scotland (2008) Justice denied – a summary of our investigation into the care and treatment of Ms A <https://www.mwcscot.org.uk/sites/default/files/2019-06/Justice%20Denied%20Ms%20A.pdf>

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

### **5.1. What is the significance of the person's diagnosis?**

It is important to consider the signs and symptoms of the person's mental illness, learning disability, dementia or related condition, and 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 condition 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.<sup>19</sup> 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 condition 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 condition may also find their own feelings change with the increased dependency of the

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<sup>19</sup> <https://www.theguardian.com/society/2009/dec/01/rape-case-cctv-footage-destroyed>

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 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 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 autistic spectrum disorder, 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.

## **5.2. 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 liberty<sup>20</sup>, will determine whether any legislative framework is required to support the care plan. Any intervention or restriction in the affairs of someone deemed incapable requires an application to the court.

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<sup>20</sup>[www.mwscot.org.uk/web/FILES/Publications/Autonomy%2C\\_benefit\\_and\\_protection\\_FULL.pdf](http://www.mwscot.org.uk/web/FILES/Publications/Autonomy%2C_benefit_and_protection_FULL.pdf)

## 6. Consideration and management of risk

As practitioners in this area will be aware, capacity is not the only consideration. A person's mental disorder may affect their judgement or ability to properly assess certain risks and consequences inherent in certain actions or decisions.

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

It is necessary therefore to identify the risks or potential risks in detail, as well as those who pose a risk, in order to consider how these should be managed. Clear, factual information from 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, including 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) and have a risk assessment and management plan in place. For these individuals, 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 disabilities.

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 person. Adult protection procedures do provide an essential framework in such situations for 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.

### **X v MM case**

The case of X v MM<sup>21</sup> highlighted some 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.

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.

Whilst the way that the courts in England consider the issue of capacity has developed further since this judgement, we consider it a good example of how to support and manage someone when these issues arise. It also provided a practical solution to balance the adult's wishes and views with the risks involved.

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<sup>21</sup> <https://www.bailii.org/ew/cases/EWHC/Fam/2007/2003.html>

## 7. Other factors to consider

### 7.1. 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, and/or 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, same-sex relationships 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 concerns about 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. We therefore suggest that Welfare Guardianship orders should be time limited in order to prompt a reassessment of capacity and risks. Where a guardian has decision-making powers, they should consider on the basis of for 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.

## **7.2. Does consideration need to be given to cultural or and religious values?**

Across and within cultural, ethnic and religious groupings there are huge variations in values, attitudes and practices in sex education, sexual activity, sexual orientation, 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 no premarital sex, and a 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 illness, learning disability, dementia or a related condition 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 of *X City Council v MB, NB and MAB*<sup>22</sup> 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 Pakistan. 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.

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<sup>22</sup> [2006] EWHC 168 (Fam), [www.bailii.org/ew/cases/EWHC/Fam/2006/168.html](http://www.bailii.org/ew/cases/EWHC/Fam/2006/168.html)

### **7.3. Sexual orientation**

Whilst attitudes have changed greatly in the past few decades, attitudes to lesbian, gay, and bisexual and trans (LGBT+) people and behaviours still vary. It is often the case that individuals are presumed to be heterosexual; and this may be particularly likely where someone has impaired capacity and may find it difficult to explain their sexuality, or to access information and education that relates to their sexual orientation.

Staff should ensure that:

- they do not make assumptions about an individual's sexual orientation;
- education and information about sex and sexuality includes the full range of sexualities;
- any support with sexual expression does not discriminate on the basis of sexuality.

There may also be issues where family or proxy decision-makers are unaware of the person's sexual orientation, with the danger that their choices may be overridden; for example a person with dementia who may have hidden their sexuality from family may begin to show interest in the same sex. Families may sometimes disapprove of someone's expressed desires where these are not heterosexual. In these instances careful and sensitive discussion with the family is important. It is not acceptable for an adult's choices with regard to their sexuality to be overridden by family prejudice. Where an adult may lack capacity, care must be taken to ensure that any assessment is carried out on an equal basis, with regard to the situation not the potential partner or their gender (see section 4). Involving advocacy may be important.

### **7.4. Impact of living situation or care setting**

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 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 illness, learning disability, dementia or related condition 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 illness, learning disability, dementia or a related condition 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 enquiry<sup>23</sup> highlighted the issue of patients making allegations and these being "routinely disbelieved".

Lesbian, gay, bisexual and trans individuals may be at risk of prejudice or abuse from other residents or patients, and staff should be alert to this.

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 mind<sup>24</sup>. 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;

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<sup>23</sup>[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4115349](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4115349)

<sup>24</sup> Royal College of Psychiatrists (2007) CR145, Sexual boundary issues in psychiatric settings

- financial irregularities;
- 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.

## 8. Marriage/civil partnership

The decision to consent or refuse to marry or enter into a 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 or 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/civil partnership notices to the registrar for the area no earlier than three months and no later than 15 days before the ceremony. The names must be displayed at the registrar's office for a minimum of 14 clear days 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/civil partnership. 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 the ceremony or of consenting to marriage/civil partnership (Marriage (Scotland) Act 1977 s5(4)(d); Civil Partnership Act 2004 s92(2))<sup>25</sup>. 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 formation<sup>26</sup>.

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'.

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<sup>25</sup> [www.opsi.gov.uk/RevisedStatutes/Acts/wukpga/1977/cukpga\\_19770015\\_en\\_1](http://www.opsi.gov.uk/RevisedStatutes/Acts/wukpga/1977/cukpga_19770015_en_1) and [www.opsi.gov.uk/acts/acts2004/ukpga\\_20040033\\_en\\_6#pt3-ch2-l1g92](http://www.opsi.gov.uk/acts/acts2004/ukpga_20040033_en_6#pt3-ch2-l1g92)

<sup>26</sup> <https://www.legislation.gov.uk/ukpga/2004/33/contents>

## 8.1. The Forced Marriage Scotland Act 2011

Forced marriage can affect anyone, including people with learning or other disabilities, regardless of which cultural community they belong to. Evidence suggests that forced marriage may occur for people with learning disabilities, at a similar rate as to those without.

There is a difference between a forced marriage and an arranged marriage. In arranged marriages, the families of both spouses usually take a leading role in arranging the marriage but the choice remains with the prospective spouses ie they provide full consent. In a forced marriage however, one or both spouses do not (or, in the case of some adults at risk and children and young people, cannot) consent to the marriage and some element of duress is involved. Duress can include coercion by physical, verbal or psychological means, threatening conduct, harassment, threat of blackmail, use of deception and other means. It is also “force” to knowingly take advantage of a person’s incapacity to consent to marriage or to understand the nature of the marriage<sup>27</sup>.

If one or both parties do not, or cannot, consent to a marriage then it may be a forced marriage in terms of the 2011 Act. Whilst the Act does not specifically deal with mental disorder, if a party is forced to marry or is unable to consent due to incapacity, then use of this Act should be considered.

Part 1 of the Forced Marriage etc. (Protection and Jurisdiction) (Scotland) Act 2011<sup>28</sup> empowers the civil courts in Scotland to make a forced marriage protection order (FMPO) which can protect both adults at risk of being forced into marriage and can offer protection for those who already have been forced into marriage.

There have not been many cases brought under the 2011 Act; however, existing case law suggests that there has to be sufficient evidence of force or coercion involved.<sup>29</sup>

An ASP case conference should be convened urgently if a forced marriage may be a possibility. FMPOs sought under the 2011 Act can provide for a range of measures to protect a person who is likely to be forced to marry or already in a forced marriage<sup>30</sup>, and may:

- stop a forced marriage from happening, or provide protective measures if the marriage has already taken place;
- be tailored to an individual’s specific needs;
- contain restrictions or requirements to stop or change the behaviour of the person who is pressurising someone into marriage;
- include anyone who is not directly involved but may be helping the person who is demanding the forced marriage.

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<sup>27</sup> Section 1(6) (b) of the 2011 Act

<sup>28</sup> <https://www.legislation.gov.uk/asp/2011/15/contents/enacted>

<sup>29</sup> City of Edinburgh Council against M.S. against re A.S.

B1183/13 2015SCEDIN20

<sup>30</sup> See Section 2 2011 Act



The Scottish Government has issued guidance for practitioners and frontline staff and volunteers within agencies who are likely to come across adults or children and young people threatened with or in a forced marriage.<sup>31</sup>

## 8.2. Case examples

We are aware of a small 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 man who had a history of domestic violence with previous partners. The medical practitioner, following consultation with all parties, provided evidence of incapacity to the Registrar and the marriage did not go ahead.

Another case related to a man with dementia who planned to marry a 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*<sup>32</sup> concerned a woman from an Afghan refugee family who suffered from a schizoaffective disorder and a learning disability. She had been married three times, with the suspicion that the motives were to secure entry to the UK for the partners 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.

The court also looked at her capacity to consent to sexual intercourse determining that it was *"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.

Note that in Scotland there may be remedies under the 2011 Act above where there are concerns that an adult who does not have capacity to consent is forced to marry.

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<sup>31</sup> <https://www.gov.scot/publications/forced-marriage-practitioner-guidance-update-2014/>

<sup>32</sup> [2008] EWHC 636(Fam). <http://www.bailii.org/ew/cases/EWHC/Fam/2008/636.html>

In addition, the way within which the Courts in England approach the assessment of a person's capacity has developed further since this case,<sup>33</sup> and there is now a more comprehensive set of relevant factors that should be considered when assessing a person's capacity to marry and engage in sexual relations. (see section 4)

However, this case highlights that any interventions in this area must be always be proportionate interference with the rights of the adult.

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<sup>33</sup> See JB case above

## 9. Social media and internet use

For all of us, the rapid growth of the internet and significant development of social media networks over recent years have changed the way that we live our lives, communicate, form relationships and engage with one another. This has been particularly evident during the Covid-19 restrictions on physical interactions when human contact has been severely limited for so many of us.

Most social media platforms are free and accessible and play a very positive role in enhancing many people's ability to socialise and engage with others. Social media also now allows individuals to form relationships which can be sexual in nature.

However, the ability of people to engage with others via social media and to access unlimited content also presents risks. Mental illness, learning disability, dementia or a related condition may place someone at an increased risk of abuse or exploitation due to impaired judgement or lack of understanding. For example, a person with a bi-polar illness may be at risk of becoming disinhibited when acutely unwell and post inappropriate information on a social media platform during a manic episode. Some people with a learning disability which impairs their judgement may be at risk from the predatory behaviour of others. There are further risks to those accessing illegal content which can both impact on someone's welfare as well as risk criminal prosecution.

Social media and internet use however plays an extremely important part in supporting people to engage more fully in society and any restrictions on access must be very carefully considered and appropriately risk appraised and balanced. An assessment of capacity in terms of the 2000 Act may be needed. Consideration of the 2003 Act may be required if care and treatment is required to reduce the risks; and the 2007 Act may be required to ensure multi-agency involvement and appropriate protections. The approach required will of course depend on the facts and circumstances relating to the person involved, their capacity and the actions that they are taking which could be placing them at risk.

As every person and situation is unique, a flexible and creative approach is needed in order to both safeguard a person's welfare and their personal autonomy. The approach should not necessarily seek to minimise every risk; people with mental illness, learning disability, dementia or a related condition have the right to access and develop skills to navigate social media and the internet in the same way as everybody else. Any intervention must be proportionate and in accordance with existing legal provisions and the principles discussed throughout this guidance.

### 9.1. Assessment of capacity and social media and internet use

The issue of a person's capacity to understand the nature and consequences of social media and internet use is one that has presented challenges in practice when looking at capacity to engage in sexual interests and relationships. This issue has not been examined in any significant way by the Scottish courts. However recent case law from the Court of Protection In England provides some useful guidance.

In two reported Court of Protection decisions in 2019, the Court addressed both the approach and the relevant factors that should be taken into account when assessing someone's capacity to use the internet and access social media.

The first case (Re A),<sup>34</sup> involved a 21-year-old gay man with a learning disability living in supported accommodation. The local authority raised proceedings following concerns about his capacity to make decisions about his care, residence, contact with others and internet use. There were concerns as A had used social media platforms to share intimate pictures of himself with unknown males. A also sought to access pornography when unsupervised, including sites displaying illegal sexual content. He had made contact through some social media sites with a number of men, some of whom were known sex offenders. He risked both sexual exploitation and criminal charges.

In the second case of (Re B),<sup>35</sup> a woman in her 30s with a learning disability and epilepsy sought to be on her mobile phone constantly. B had sent intimate photos, sexually explicit messages and personal information to men she did not know but referred to as 'boyfriends'. As a consequence, she had met a man who was a convicted sex offender. There were concerns about the risks that this man posed to her, which B did not accept. B had also had expressed a wish to have this man's baby.

The court in both cases concluded that the adults did not have capacity to access the internet or social media and made a number of key findings. The decision in the A case also emphasised the important role that the internet and social media networks play in promoting social inclusion for people with a disability:

*"they offer disabled users opportunities and enhanced autonomy, they provide a means to express social identity, and they enable the learning of new skills, and the development of careers. The importance of creating and maintaining ready access for the disabled to electronic and digital technology is well-recognised<sup>36</sup>"*

## **9.2. Social media and internet should be treated as the same thing in any assessment of a person's capacity**

The Court determined here that use of the internet and the use of social media are inextricably linked and that they should be treated as the same thing for the purposes of assessing a person's capacity.

*"the internet is the communication platform on which social media operates. For present purposes, it does not make sense in my judgment to treat them as different things. It would, in my judgment, be impractical and unnecessary to assess capacity separately in relation to using the internet for social communications as to using it for entertainment, education, relaxation, and/or for gathering information<sup>37</sup>"*

Therefore, it is appropriate to conduct any professional assessment of person's capacity to access social media and the internet as a collective task or decision balancing risk with the clear benefits that there may be for the adult.

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<sup>34</sup> Re: A (Capacity: Social Media and Internet Use: Best Interests) [2019] EWCOP 2

<sup>35</sup> Re B (Capacity: Social Media: Care and Contact) [2019] EWCOP 3

<sup>36</sup> Re A at para 2

<sup>37</sup> Re A at para 26

### **9.3. Social media contact should be treated differently from other forms of social or physical contact**

The judge in the Re A case above stressed the importance of distinguishing the question of capacity for engaging in social media for the purposes of online contact from other forms of contact, or general issues surrounding care:

*"I have reached the clear view that the issue of whether someone has capacity to engage in social media for the purposes of online 'contact' is distinct (and should be treated as such) from general consideration of other forms of direct or indirect contact. I am satisfied that wider internet use is different from general issues surrounding care. There is a risk that if social media use and/or internet use were to be swept up in the context of care or contact, it would lead to the inappropriate removal or reduction of personal autonomy in an area which I recognise is extremely important to those with disabilities<sup>38</sup>"*

It is therefore critical to assess a person's capacity to use social media and the internet in its own right and not to link it with a person's capacity to make and have contact with others or to make decisions about the provision of their care arrangements. This approach in our view accords with the both the principles of the 2000 Act and the concept of capacity being decision specific.

### **9.4. Factors to be taken into account when assessing a person's capacity to use social media and the internet**

The Court in Re A then went on to determine the 'relevant information' that A would need to be able to understand, retain, and use and weigh in his internet use. We consider that these same factors should be taken into account when assessing a person's capacity to access the internet and social media platforms:

- Information and images (including videos) which are shared on the internet or through social media could be shared more widely, including with people the adult doesn't know, without them knowing or being able to stop it. An adult should be aware what sharing is and of its consequences.
- That it is possible to limit the sharing of personal information or images (and videos) by using 'privacy and location settings' on some internet and social media sites. The precise details or mechanisms of privacy settings do not need to be understood but an adult should be capable of understanding that they exist, and be able to decide (with support) whether to apply them or not.
- Placing material or images (including videos) on social media sites which are rude or offensive, or sharing such images with others might cause others to be upset or offended. The adult should understand that rude or offensive material may not only include insulting or abusive material, but also material that is sexually explicit, indecent or pornographic.
- Some people that the adult might meet or communicate with ('talk to') online, who they don't otherwise know, may not be who they say they are.

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<sup>38</sup> Ibid at para 26

- People the adult might meet or communicate with ('talk to') on the internet or through social media may pose a risk to them by lying, exploiting or taking advantage of sexually, financially, emotionally and/or physically or may want to cause harm.
- If you look at or share extremely rude or offensive images, messages or videos online this may result in trouble with the police and result in prosecution.

Whilst the assessment of capacity in this regard will always depend on the individual case, these factors provide a very useful framework when considering a person's capacity.

In the above case, it was determined that A had only partial understanding that the information and images which he shared on the internet or through social media could be shared more widely, including with people he did not know. He had a limited understanding of privacy settings, and only a partial understanding that people might be upset or offended by information shared online. He was not able to use or weigh that information. He had a poor understanding of the risks that people might pose online, and could not understand that people might disguise their identity to take advantage of him. Practical steps had been taken to help him understand the issues, without success. In this particular case it was determined that the adult lacked capacity to use the internet or social media. The judge approved the local authority's plan for him to have limited access to the internet, and even then only under supervision.

In the B case, the Court determined on the evidence, that B did not have capacity to decide to use social media for the purposes of developing or maintaining connections with others. The judge did however suggest that that attempts in the form of practicable help should be offered to B to enable her to acquire capacity<sup>39</sup>. We consider this to be an important factor, highlighting that with support and education, some adults may be able to gain capacity in this area.

Again, the legal test in section 1(6) of the 2000 Act should be applied; we consider however that the factors mentioned above may be a useful guide.

## **9.5. Restrictions on internet and social media use when someone lacks capacity**

If it is considered that a person lacks capacity to use social media and internet following assessment, the risks require to be considered. This will inform any potential restrictions that may be necessary to keep both the adult and others safe.

If the person is unable to consent to any restrictions or refuses to agree to any proposed restrictions, then it is likely that measures will be required under the 2000 Act. Consideration of the section 1 principles should form part of this discussion. It is worth noting, like all restrictions on a person's freedom; a person's rights are likely to be protected by the use of formal measures under the 2000 Act as opposed to "informal" restrictions. It may not be sufficient if the adult in question simply complies with restrictions without any real understanding of what they have agreed to. As everyone has a right in law to engage in such activities, then any restrictions must be in accordance with law. Appropriate powers under a welfare guardianship should be considered (see section 18 for more details on this) . Any powers sought should be the minimum necessary to protect the person's welfare and should

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<sup>39</sup> B case at para 40

be specific and tailored to deal with the decisions that require to be made on the adult's behalf to manage the assessed risks.

Steps that might enhance a person's capacity or minimise risk should be considered, such as education, informal supervision and support or monitoring with the person's agreement, although any such agreement must always be consensual. The person should not feel coerced or have restrictions on internet access forced upon them without appropriate legal measures in place.

## **9.6. Staff support and intervention for persons with capacity**

A person may be considered to have sufficient capacity to engage with social media and the internet but place themselves at risk due to vulnerability, poor judgement or erratic behaviours. In these circumstances intervention under the 2000 Act will not be appropriate as the 2000 Act requires the adult to be incapable of making such the relevant decision.

Practical options such as education, care, support and seeking the person's agreement to monitor their use of the internet or check their web history with them may be a proportionate way of minimising the risks of social media and the internet. A multi-agency approach may be needed when someone is at risk, with possible use of the 2007 Act.

Staff need to be aware of the risks to adults, as well as children, of internet grooming. Internet 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. The National Crime Agency Child Exploitation Online Protection resource, thinkUknow<sup>40</sup> may be useful.

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<sup>40</sup> <https://www.thinkuknow.co.uk/>

## 10. Capacity, consent and the criminal law

The right to sexual expression assumes that the individual consents to the sexual activity. 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;
- 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 2009<sup>41</sup> 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, including 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 to communicate such a decision. This definition corresponds with the definition of incapacity in the Adults with Incapacity Act 2000. However it should be noted that the standard of proof in establishing incapacity under the 2000 Act is lower and on the balance of probabilities rather than the criminal standard of beyond reasonable doubt. The 2009 Act also makes clear that there is 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)<sup>42</sup>. We are aware of very few prosecutions under these provisions.

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<sup>41</sup> [www.opsi.gov.uk/legislation/scotland/acts2009/pdf/asp\\_20090009\\_en.pdf](http://www.opsi.gov.uk/legislation/scotland/acts2009/pdf/asp_20090009_en.pdf)

<sup>42</sup> [www.opsi.gov.uk/legislation/scotland/acts2009/pdf/asp\\_20090009\\_en.pdf](http://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 disorder<sup>43</sup>. Ms 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 evidence<sup>44</sup>.

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.

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<sup>43</sup> Mental Welfare Commission for Scotland (2008) Justice denied – a summary of our investigation into the care and treatment of Ms A <https://www.mwcscot.org.uk/sites/default/files/2019-06/Justice%20Denied%20Ms%20A.pdf>

<sup>44</sup> [www.opsi.gov.uk/legislation/scotland/acts2004/asp\\_20040003\\_en\\_1](http://www.opsi.gov.uk/legislation/scotland/acts2004/asp_20040003_en_1)

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

It is important that staff providing care in any setting 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 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. Staff must accept the person's own sexual identity and their choice of partner, provided as in any form of relationship the relationship is a mutual one and not abusive or coercive in any way. Staff training should raise awareness of equality 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. 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 the 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. 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 support<sup>45</sup>.

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<sup>45</sup> <http://www.scotland.gov.uk/Publications/2007/07/04093127/3>

## **12. How should staff respond to requests for assistance in sexual matters?**

### **12.1. 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 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.

### **12.2. 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, contraception that is reversible 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 of the Act for resolving these.

### **12.3. Promoting Sexual Health**

Individuals may need staff assistance with organising or attending regular check-ups or treatment for sexually transmitted diseases. 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.

## 12.4. Pornography

Requests for other kinds of assistance can raise issues for care staff. 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)<sup>46</sup>

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 acts likely to result in a person's severe injury (s42). Information is also available on the BBFC website.<sup>47</sup> Where materials are being accessed that are believed to be illegal, staff should immediately seek advice from 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

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<sup>46</sup> [www.scotland.gov.uk/Resource/Doc/274212/0082013.pdf](http://www.scotland.gov.uk/Resource/Doc/274212/0082013.pdf)

<sup>47</sup> <http://www.bbfc.co.uk>

forum to discuss such moral and ethical issues and where dilemmas arise, they should contact the local authority which 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.

## **12.5. Sex aids**

Requests for 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. 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.

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.

## **12.6. Masturbation**

Masturbation is an acceptable and natural part of an individual's sexual behaviour. Some individuals due to their mental illness, learning disability, dementia or related condition 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.

## **12.7. 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.

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.

## 13. Adult protection duties and interventions

There are a variety of statutory measures by which the local authority can investigate situations of risk, harm or abuse. These are the Adults with Incapacity (Scotland) Act 2000, Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adult Support and Protection (Scotland) Act 2007. These acts have slightly different emphases but overlap in many of their provisions. 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 process<sup>48</sup>. If matters are taken to court, measures under the Vulnerable Witnesses (Scotland) Act 2004 can assist both witnesses and the accused when giving evidence<sup>49</sup>.

### 13.1. Adult Support and Protection Act duties

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 the adult 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 the adult may accept the help on offer. Local authorities have general duties under Section 12 of the Social Work (Scotland) Act 1968<sup>50</sup> 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.

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<sup>48</sup> [www.scotland.gov.uk/Topics/Justice/law/victims-witnesses/Appropriate-Adult/Guidance](http://www.scotland.gov.uk/Topics/Justice/law/victims-witnesses/Appropriate-Adult/Guidance)

<sup>49</sup> [www.opsi.gov.uk/legislation/scotland/acts2004/asp\\_20040003\\_en\\_1](http://www.opsi.gov.uk/legislation/scotland/acts2004/asp_20040003_en_1)

<sup>50</sup> [www.opsi.gov.uk/RevisedStatutes/Acts/ukpga/1968/cukpga\\_19680049\\_en\\_1](http://www.opsi.gov.uk/RevisedStatutes/Acts/ukpga/1968/cukpga_19680049_en_1)

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 practice<sup>51</sup>, contractual agreements with local authorities and in adult protection policies required by the Care Inspectorate. 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.

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. 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.

### **13.2. Adults with Incapacity Act duties**

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 pursue<sup>52</sup>. It must also investigate complaints about welfare attorneys and welfare guardians or 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.

### **13.3. Mental Health Act duties**

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.

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<sup>51</sup> [www.scotland.gov.uk/Publications/2009/01/30112831/4](http://www.scotland.gov.uk/Publications/2009/01/30112831/4) Chapter 2 para 13

<sup>52</sup> [www.publicguardian-scotland.gov.uk/](http://www.publicguardian-scotland.gov.uk/)



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.

### **13.4. What intervention may be required following investigation?**

Usually any interventions to minimise the risk to sexual health and wellbeing or the risk of potential sexual offending are undertaken with the person's agreement and as part of their care plan. However, the person may not have the capacity to consent to the proposed intervention. This should be taken into account when considering whether or not more formal interventions under the legislation will be more appropriate. Using formal action may better protect the person's rights, due to the level of external or judicial scrutiny.

Where the person is non-compliant or reluctant to accept support, it is easier to consider that statutory intervention may be required. 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.

If someone is reluctant to accept support and supervision, or where the care plan in any way restricts an activity that another person would be free to do, then the use of legislation must be considered, to protect the person's rights. For example:

- 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, if 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 might need detained in hospital under the 2003 Act, with close supervision on the ward and escorted when off the ward until risks have subsided.

### **Case study**

A middle-aged man living in supported accommodation had been repeatedly stealing women's underwear from washing lines and 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 support 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.

### **13.5. Interventions under Part 5 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, they must 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 nominate a 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 Practice<sup>53</sup>. 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.

### **13.6. Protection under Part 6 of the 2000 Act: guardianship and intervention orders**

Whilst the 2000 Act does not specifically deal with decision-making in relation to sexual relationships and sexual behaviour, it provides a general mechanism for the court to make a determination on whether someone lacks capacity to make decisions in relation to their welfare. As stated earlier in this guidance, the issue of capacity to engage in or consent to sexual relations has not come before the Scottish courts in any significant way.

Where the capacity of an adult is an issue and there are concerns about protection against sexual exploitation and manipulation in relationships then powers may be sought under a welfare guardianship order to access sex education, counselling or medication including contraception. This may allow for a care plan designed to address the sexual risks to be put in place. The powers that might be needed will require careful consideration as to their relevance, practicality and likely effectiveness.

Powers under a welfare guardianship order when someone lacks capacity to engage or consent to sexual relations can relate to residence, supervision, contact with others, care and support, education and training, social media and internet access and medical treatment. The

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<sup>53</sup> [www.sehd.scot.nhs.uk/mels/](http://www.sehd.scot.nhs.uk/mels/)

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.

### **13.7. Access to a solicitor and the role of safeguarders under the 2000 Act**

The adult should be notified of any application for guardianship and given as full an opportunity as possible to make representations and instruct a solicitor if they have the capacity to do so. In any the situation where the adult lacks capacity to instruct a solicitor the court can appoint a safeguarder under the 2000 Act. The Sheriff is required to consider whether it is necessary to appoint a safeguarder in every case.

Safeguarders are appointed to safeguard the adult's interests, which includes ascertaining their views wherever possible. A safeguarder is particularly important when powers seek to place restrictions on an adult that affect their fundamental rights around liberty and personal relationships, and will help ensure that the adult's own position is represented and protected throughout the court process. The role of the safeguarder comes to an end either on the order of the Sheriff or when the case is determined.

### **13.8. If the adult refuses to comply with the guardian**

Where the adult 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 to comply with their decisions. The guardian must consider whether the section 70 order is likely to make a difference to whether the adult complies.

To make a section 70 order, the Sheriff will 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 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 or civil partnership, cannot be taken by anyone else on behalf of the adult. (See above on marriage/civil partnership Forced Marriage legislation.)

### **13.9. 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), a temporary banning order, or a removal order (expires seven days after the person is moved). Any intervention should be guided by the principles (see section 3.5).

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

### **Case study**

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.

### **13.10. Interventions under 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 in order to provide treatment to people with mental disorder. 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 residing at a specified place, attendance at certain places and times for medical treatment, being in receipt of community care services, giving access for certain people involved in the adult's care and treatment, and the 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.

A person's rights are likely to be better protected when formal action is taken if there are concerns about their capacity consent to a proposed care plan for their mental disorder. The Mental Health Tribunal for Scotland decides whether or not to grant a CTO and patients can also seek to apply to revoke a STDC.

Use of the 2000 and 2003 Acts can occur at the same time. For example, an individual could be subject to both a community CTO, due to the need for medication, and welfare

guardianship, due to the need for other powers, such as determining who the person has contact with, or monitoring their communications.

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 also 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.

At present mental health law in Scotland is under review.

### **13.11. Interventions under 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.

## 14. 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.

## Appendix 1 – Useful links

### Acts including amendments

[www.opsi.gov.uk/legislation/revised](http://www.opsi.gov.uk/legislation/revised)

### Codes of Practice

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](http://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](http://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](http://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 <https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-persons-authorised-under-intervention-orders-guardians/pages/7/>

Adults with Incapacity (Scotland) Act 2000: Code of Practice: For local authorities <https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-local-authorities-exercising-functions-under-2000-act/>

Adult Support and Protection (Scotland) Act 2007: Revised Code of Practice 2014 <https://www.gov.scot/publications/adult-support-and-protection-revised-code-of-practice/pages/1/#:~:text=The%20Adult%20Support%20and%20Protection%20Act%202007%20%28referred,professionals%20under%20Part%201%20of%20the%20Act.%202>

### Links to other organisations

Alzheimer Scotland [www.alzscot.org](http://www.alzscot.org)

Bipolar Scotland [www.bipolarscotland.org.uk/](http://www.bipolarscotland.org.uk/)

British Institute of Learning Disabilities [www.bild.org.uk/](http://www.bild.org.uk/)

Dementia Services Development Centre (DSDC), Stirling University [www.dementia.stir.ac.uk](http://www.dementia.stir.ac.uk)

Enable (Scotland) [www.enable.org.uk/](http://www.enable.org.uk/)

Equality and Human Right Commission [www.equalityhumanrights.com](http://www.equalityhumanrights.com)

Family Planning Association [www.fpa.org.uk/Shop/](http://www.fpa.org.uk/Shop/)

Forensic Network Scotland [www.forensicnetwork.scot.nhs.uk/](http://www.forensicnetwork.scot.nhs.uk/)

Headway – the brain injury association [www.headway.org.uk/home.aspx](http://www.headway.org.uk/home.aspx)

The Mental Welfare Commission for Scotland [www.mwcscot.org.uk](http://www.mwcscot.org.uk)

National Autistic Society Scotland [www.autism.org.uk/what-we-do/scotland](http://www.autism.org.uk/what-we-do/scotland)

SAMH – The Scottish Association for Mental Health [www.samh.org.uk/](http://www.samh.org.uk/)

Support in mind <https://www.supportinmindscotland.org.uk/>

SCLD – Scottish Commission for People with Learning Disabilities [www.sclld.org.uk/](http://www.sclld.org.uk/)

Scottish Human Rights Commission [www.scottishhumanrights.com](http://www.scottishhumanrights.com)

Scottish Huntington's Association <https://hdscotland.org/>

Sexuality and dementia [www.alzscot.org/pages/info/sexuality.htm](http://www.alzscot.org/pages/info/sexuality.htm)

### **Links to some publications from the Mental Welfare Commission for Scotland**

Consent to treatment: a guide for mental health practitioners. 2018

<https://www.mwcscot.org.uk/node/230>

Rights, risks and limits to freedom: principles and good practice guidance for practitioners considering restraint in residential care settings. 2021

<https://www.mwcscot.org.uk/node/508>

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

<https://www.mwcscot.org.uk/node/440>

Other Mental Welfare Commission for Scotland publications are available from [www.mwcscot.org.uk](http://www.mwcscot.org.uk)



## Appendix 2 – Case studies

### Case Study 1

John is 17, has a psychotic illness and has been placed in an adult ward awaiting a supported accommodation place. He is a voluntary patient. He is immature and vulnerable, particularly in relation to drug and 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 is separated from her husband and has children. She has been admitted for the first time with a bipolar affective disorder and is detained. Despite guidance from nursing staff, the couple's sexual behaviour on the ward was proving difficult for other patients: the couple were kissing and fondling in public areas of the ward. 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 then detained.

The relationship has continued. Both have four 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 and engage in sexual relations. It was felt that John had capacity for 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 health 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 two hours per day in the day room.
- Staff had separate discussions 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 John and ensured he had condoms. They offered the woman a pregnancy test.
- Efforts were made to expedite John's placement in supported accommodation.

### Case Study 2

Margaret is 40 and 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 five children, all of whom have been taken into care and adopted. Tom, the father of her youngest two children, was physically, emotionally and financially abusive of her. He was eventually sentenced to four 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. This was in part in an attempt to stop her house being used as a 'drinking den' by locals as had been the case due to her vulnerability. 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 loath to go out with them.

- Attempts continued to persuade Margaret to cooperate with the support, either in her flat or 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 review of the files held by the social work department to collate significant concerns over the years relating to her physical and mental health and incidents of abuse with the associated evidence. 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 had contact with, specifically 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 had contact 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**

Ahmed is 28 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 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. Ahmed 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, Ahmed 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 contacting prostitutes for him and the other items, as well as 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 Ahmed'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 Ahmed'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 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 Ahmed, 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 Ahmed's own accounts and from previous discussions with his family that he had 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 Ahmed 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 Ahmed's sexual knowledge and his ability to understand sexual risk. They felt that they had been open enough with Ahmed 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 Ahmed's rights and respected the rights and responsibilities of staff.
- Staff were also to ask Ahmed 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 Ahmed'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 seems 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.

### **Case Study 5**

Kasia is 32, has a mild learning disability and lives alone. Kasia accepts a few hours support each day as she can struggle with routine and basic tasks. She is vulnerable to exploitation and has two children who live by agreement with her mother. The children's father is her ex-partner and he has abused Kasia and other individuals in the past. This information about the ex-partner is known to police and social work who suspect that this ex-partner continues to try and have sexual contact with Kasia.

Kasia is vulnerable to exploitation by others including her ex-partner. Kasia has recently formed a relationship with another individual through Facebook and met this person very quickly without letting her support staff know that she was doing so.

Kasia's support staff are concerned because Kasia is at risk to her ex-partner still and they worry she is unable protect herself. Kasia wants to join a dating app and has mentioned this to support staff. Kasia enjoys being a member of some platonic chat groups and pursues her interest in animal welfare through membership of online campaigning groups where she has met some friends.

Kasia may need to be assessed in terms of capacity to engage in sexual relationships and there may be a need for support and education. Kasia could access supports to obtain legal advice in case she needs to take steps to protect herself from the ex-partner and the multi-disciplinary team could consider whether any steps are needed in terms of the Adult Support and Protection Act.

Consideration as to whether a guardianship order or intervention is needed to monitor or support Kasia's social media or internet use may be necessary although she engages in support voluntarily and may wish the support and help of staff to do so if she has the capacity to make decisions but needs assistance. Kasia derives benefit from her access to social media and her animal welfare interests. If Kasia needs intervention following an assessment of her capacity the care plan will need to support and promote her use of the internet whilst ensuring her safety.

## Appendix 3 – 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 (other than individuals aged 16-18 and detained under the Mental Health Act)

**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.

**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, dementia, learning disability, personality disorder and related conditions, 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.



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