mental welfare commission for scotland

Medication to reduce sex drive

Medicine given for the purpose of reducing sex drive to people who can't consent in Scotland.

Research report

July 2026

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

Medication to reduce sex drive

Contents

Executive summary

Medication given for the purpose of reducing sex drive is used for a very small number of people in Scotland each year, but the impact on their lives and their rights is profound. Arising from its intimate nature, its potential for serious side effects, and its association with public protection concerns, this is an area where clinical practice must be grounded in human rights, legal authority, and good evidence.

Under Part 16 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act) and Part 5 of the Adults with Incapacity (Scotland) Act 2000 (AWI Act), medicines to reduce sex drive can only be given to people who cannot consent where there is specific legal authority, including an independent second opinion from a designated medical practitioner (DMP) or from a medical practitioner nominated by the Mental Welfare Commission. These safeguards are designed to ensure that treatment is of benefit to the person, is proportionate, and is not given for public protection alone, though risk to others will inevitably be part of the overall justification in many cases.

The Commission reviewed its records of referrals for an independent second opinion on the use of medication to reduce sex drive between 2017 and 2023. Over that period, we received 152 referrals: 50 under the Mental Health Act and 102 under the AWI Act. We examined a random sample of 40 cases in detail, using a structured data collection tool and supplementary notes. We did not have access to full health records; our analysis is based on Commission documentation. In addition, we reviewed the very small number of records where the use of medication to reduce sex drive was prescribed to females.

While the sample was small, it appeared to be a clearly defined group. All were adults; no one under 18 years was treated with medication to reduce sex drive. Treatment was authorised exclusively for men. In the 40 cases we reviewed in detail, half had a primary diagnosis of intellectual disability and over one third had dementia, with smaller numbers having severe and enduring mental illness or acquired brain injury. Multiple diagnoses were common. People were treated both in secure and general psychiatric hospital settings as well as in the community.

The literature suggests that non-pharmacological interventions should be used wherever possible before medication is considered, particularly given the limited evidence base. When medication is indicated, good practice involves a multidisciplinary, person-centred approach, careful risk assessment, avoidance of unnecessary polypharmacy, and regular review of the indication and dosage. We found that aspects of this good practice were present, but not consistently.

In our sample there was evidence of environmental measures and psychological interventions being used, more often in forensic settings where psychological services may be better resourced. However, psychological formulation of the problematic sexual behaviours, structured risk assessment tools, and care planning for people's sexual needs were rarely documented in the records we reviewed. The language used to describe behaviours and indications for treatment was inconsistent, with non-specific terms such as "inappropriate sexual behaviour" used more often than more precise terminology. In a number of cases the stated reason for treatment did not clearly match the behaviours described, or there was insufficient detail to be confident about the rationale.

Participation of the person, and of their families and carers, was also limited in the material available to us. All those treated were assessed as lacking capacity to decide about this treatment, but the person's own views were recorded in only around a quarter of cases, and carers' views in about a third. Only one person in the sample had a documented care plan addressing their sexual needs. A small number of people had relevant advance statements in favour of treatment. In a very small number of cases, disagreement from families led the DMP or nominated practitioner not to authorise treatment, illustrating the importance of meaningful involvement and of advocacy where appropriate.

One of the most concerning findings was the number of occasions where treatment appeared not to have been properly authorised. In 15 of the 40 cases (38%) we identified problems that ranged from administrative errors which could invalidate authority, through treatment apparently commencing before any legal authority was in place, to treatment continuing after an existing T3 or Schedule 2 certificate had expired.

At the end of the review period there was no valid certificate on record in 24 (60%) cases we sampled. There is no statutory requirement to notify the Commission when treatment with medication to reduce sex drive ends, so it was not possible to know whether medication had stopped or whether it continued without proper authority, but the level of uncertainty itself is problematic given the seriousness of these treatments.

Treatment plans were often longstanding. In 24 cases (60%) the treatment plan was unchanged over time. In some instances, this may have reflected appropriate continuation of effective treatment, but our records did not consistently show that less restrictive alternatives had been revisited or that the balance of benefit, risk and side effects had been explicitly reviewed. In ≤3 cases (≤8%), the independent second-opinion practitioner amended the proposed plan by changing the proposed treatment plan from a hormonal to a non-hormonal antilibidinal medication, underlining the value of this safeguard.

Taken together, our findings highlight three broad concerns. First, there is an absence of clear, nationally agreed good practice guidance for the assessment and management of problematic sexual behaviours in people who cannot consent to treatment, particularly outside forensic services. Secondly, legal safeguards are not always used appropriately in practice, resulting in gaps and anomalies in authorisation and review. Thirdly, practice in relation to person-centred assessment, non-pharmacological interventions, involvement of people and carers, and regular review of treatment is variable and not always well evidenced in the material available to us.

The Commission concludes that there is a need for good practice clinical guidance in this area, building on the existing evidence and forensic work but explicitly addressing people who cannot consent and the specific safeguards in the Mental Health Act and AWI Act. That guidance should emphasise careful assessment and formulation, prior consideration of non-pharmacological approaches, clear documentation of therapeutic purpose and proportionality in light of human rights, regular review of indication, dose and duration, and genuine involvement of people, families, carers and advocacy. In parallel, health boards and practitioners need to ensure that the correct legal framework is used, that authorisations are valid and up to date, and that governance systems are robust.

The Commission will use these findings to inform its own guidance, its expectations of DMPs and nominated practitioners, and its wider scrutiny of practice in this highly sensitive area.

Introduction

The Mental Welfare Commission (the Commission) has a statutory duty to monitor operation of the Mental Health Act and to promote best practice in its use. The Commission also has duties in relation to the AWI Act.

Part 16 of the Mental Health Act is concerned with medical treatment for individuals subject to the act, including the legal authority required for medical treatment with any medicine (other than the surgical implantation of hormones) given for the purpose of reducing sex drive.

Part 5 of the AWI Act is also concerned with the legal authority to give medical treatment, to people who have been certified as being incapable about the medical treatment in question, meaning that they are unable to consent to treatment.

Both Acts require an independent second opinion to authorise the medical treatment as a safeguard to the individual before the medical treatment can be given by their doctor.

A second opinion certificate (the T3 form) authorising the proposed treatment is required from a DMP under the Mental Health Act and a Schedule 2 certificate from a medical practitioner nominated by the Commission (the 'nominated practitioner') under the AWI Act.

The number of people who receive medicine to reduce sex drive each year in Scotland, through the processes described above, is small. In 2024-2025, there were 2,845 T3 certificates issued for medication where 12 (0.4%) were for medication to reduce sex drive.[1] In the same year there were 11 requests for an independent second opinion for people subject to the AWI Act for drug treatment including medicine to reduce sex drive.[2]

Whilst the numbers of people receiving such treatment is small, the impact that this can have on their human rights and their lives is substantial.

We reviewed the Commission records to better understand the circumstances in which medicine to reduce sex drive is authorised under the Mental Health Act and the AWI Act.

Background

Medicine given for the purpose of reducing sex drive (also known as antilibidinal medication) can be prescribed to help people with problematic sexual behaviours (PSBs). PSBs can be defined as sexual behaviours that are socially inappropriate because of their potential to harm the individual (if they are compulsive or excessive) or to harm others (if they are aggressive, intrusive, or coercive).[3] PSBs can lead to criminal charges for the person. They can also pose a significant risk to the public.

Medicines given for the purpose of reducing sex drive work in different ways. Some reduce hormone levels (mainly testosterone) whilst others (some antidepressant and antipsychotic medications) act on non-hormonal pathways. The treatments have a range of action, from reducing a person's sexual drive to completely removing it; this can be referred to as chemical castration. Non-hormonal treatments can have other beneficial effects on PSBs which include reductions in impulsive, obsessional and compulsive symptoms.

In 2022, the Forensic Network in Scotland (a managed care network for forensic mental health services in Scotland) published guidance on the prescribing of sex drive reducing medications in males who are consenting to treatment within forensic settings.[4] It does not address treatment under compulsion for people who are unable to consent or consider the legal safeguards under part 16 of the Mental Health Act or Part 5 of the AWI Act.

There is no similar guidance for people in non-forensic settings who can't consent to treatment, such as the populations of people we are considering here.

Human rights

The giving of medicines to reduce sex drive under compulsory measures requires balancing an individual's human rights (freedom from torture or inhuman or degrading treatment, right to liberty, respect for private and family life, and the right to marry and found a family) with societal considerations in relation to public safety.

Under the Mental Health Act, medical treatment can be given in the "*patient's best interests*" when there is "*the likelihood of its alleviating, or preventing a deterioration in, the patient's condition*".[5] The AWI Act gives the "*authority to do what is reasonable in the circumstances,…, to safeguard or promote the physical or mental health of the adult*" in relation to medical treatment.[6] Both Acts require the medical treatment to be of benefit to the person and would not support the giving of medication for public protection alone.

Article 3 of the European Convention on Human Rights is an absolute convention right, which says that “no one shall be subjected to torture or to inhuman or degrading treatment or punishment”. [7] In the case of *Herczegfalvy v. Austria* [1992] the powerlessness of people confined in psychiatric hospitals is described with the need for vigilance to ensure that the European Convention on Human Rights has been complied with.[8] This case found that treatment which is “a therapeutic necessity cannot be regarded as inhuman or degrading” in relation to Article 3 but requires the medical necessity of a treatment to be convincingly shown.

Article 8 is a qualified right providing that everyone has the right to respect for their private and family life, home and correspondence, and that there shall be no interference in this by a public authority except where there are specified objectives. These objectives include public safety and the prevention of crime. Clinical decisions made in relation to Article 8 must be proportional, therapeutically necessary, and in keeping with accepted clinical practice .[9]

In the case of R (Wilkinson) v. Broadmoor, the Court of Appeal agreed that treatment that was not a medical necessity would amount to a breach of Articles 3 and 8. They also considered the importance of an independent specialist second opinion.[10]

The timely re-assessment of compulsory measures is also important to ensure that a person’s rights under Article 5 are protected. Everyone has the right to liberty and security of person and that no one shall be deprived of their liberty save in specific circumstances and in accordance with a procedure prescribed by law.[11]

What we did

1. We reviewed the literature to find the most up to date research and guidance about medicines to reduce sex drive and treatment of PSBs.
2. We created a data collection form to use when we reviewed the records of people who had had treatment with medicines to reduce sex drive authorised under the Mental Health Act or the AWI Act. This gathered general information about the person as well as information about their legal status and the medicines that were authorised.
3. We searched our database for all referrals between 2017 and 2023 to the Commission for an independent second opinion to authorise the giving of medicines to reduce sex drive under the Mental Health Act and the AWI Act.
4. We randomly selected and reviewed the records of a sample of 40 referrals, using both excel and R for analysis.
5. We also kept notes of important additional information that we found in people's records, where this could not be gathered through the spreadsheet.

We did not access people's full health records during this project. The data that we collected was limited to the information held on the Commission database which includes Mental Health Act and the AWI Act documentation and reports from the Mental Health Tribunal for Scotland. There was a significant variation in the amount of information recorded in each record. We have indicated below where we have made interpretations of the data due to insufficient information.

What we found

Review of the literature

We reviewed the research about the use of medicines to reduce PSBs in people who are unable to consent to treatment and found that whilst there is some evidence about the benefits of treating people with developmental conditions and dementia, it is often inconclusive as to which treatments (medication and/or non-pharmacological treatments, including behavioural therapies) are most effective.[12-15]

The Forensic Network's guidance on medication to reduce male sex drive (2022) recommends that the choice of medication should be determined by the level of risk arising from the person's PSBs.[4] Non-hormonal medication can be used if the risk is low. Hormonal treatments are more appropriate where there is a risk of serious harm.

Given the inconclusive evidence and the risk of side effects, non-pharmacological treatments should be used before medication wherever possible.[13]

Medicine to reduce sex drive can have potentially serious and irreversible side effects and should only be used where there is a clear need.[12, 16-18]

Sexually disinhibited behaviours have been shown to be common in people with dementia. Assessment of those behaviours, the context in which they arise, and the associated risks is essential. Environmental management, education, and involvement of carers and families is also recommended.[13]

High quality treatment in people with intellectual disability is described with reference to multidisciplinary evaluation, comprehensive risk assessment, and a person-centred approach.[14]

Where medication is shown to be necessary, a dynamic multidisciplinary approach is required to ensure a holistic, person-centred management plan.[12-15]

Non-hormonal medications that reduce sex drive should be used as the first treatment choice.[13] Moreover, polypharmacy should be avoided, and treatment plans should be revisited regularly.[14]

Review of referrals to the Commission

The Commission received 152 referrals between 2017 and 2023.

There were 50 referrals for people subject to the Mental Health Act and 102 referrals for people subject to the AWI Act. It is, however, only possible to authorise treatment under the AWI Act for up to 12 months, whilst treatment can be authorised for antilibidinal medication under the Mental Health Act for up to 3 years.

We reviewed the records of 40 out of the 152 people (26%), as below.

Table 1: Sample demographics n=40

Category	**Grouping**	**n (%)**
Gender	Male	40 (100%)
Age at first authorisation	0-18	0 (0%)
	18-24	5 (13%)
	25-44	12 (30%)
	45-64	9 (23%)
	65-84	10 (25%)
	85+	4 (10%)
Primary diagnosis	Intellectual disability	20 (50%)
	Dementia	14 (35%)
	Severe & enduring mental illness	≤3 (≤8%)
	Brain injury	≤3 (≤8%)

Demographics

The age of people in the random sample ranged from 19 to 93 years (at the time that they were initially referred between 2017 and 2023). None of the people were under the age of 18 years.

All (100%) of the individuals were men. There were a very small number of referrals for women out of the total 152 referrals we identified between 2017 and 2023. We chose to review those cases given that the numbers were small and found that the individuals were not receiving medication to reduce sex drive or were receiving treatment in relation to a specific mental health diagnosis and no legal authority was required for antilibidinal medication.

Diagnosis

The majority of people in our sample had multiple diagnoses.

We categorised the main diagnoses as follows:

- Any degree of intellectual disability
- Any type of brain injury
- Any type of severe & enduring mental illness
- Any type of dementia

Where a person had more than one of these diagnoses, we considered which was most likely to be associated with the reported PSBs.

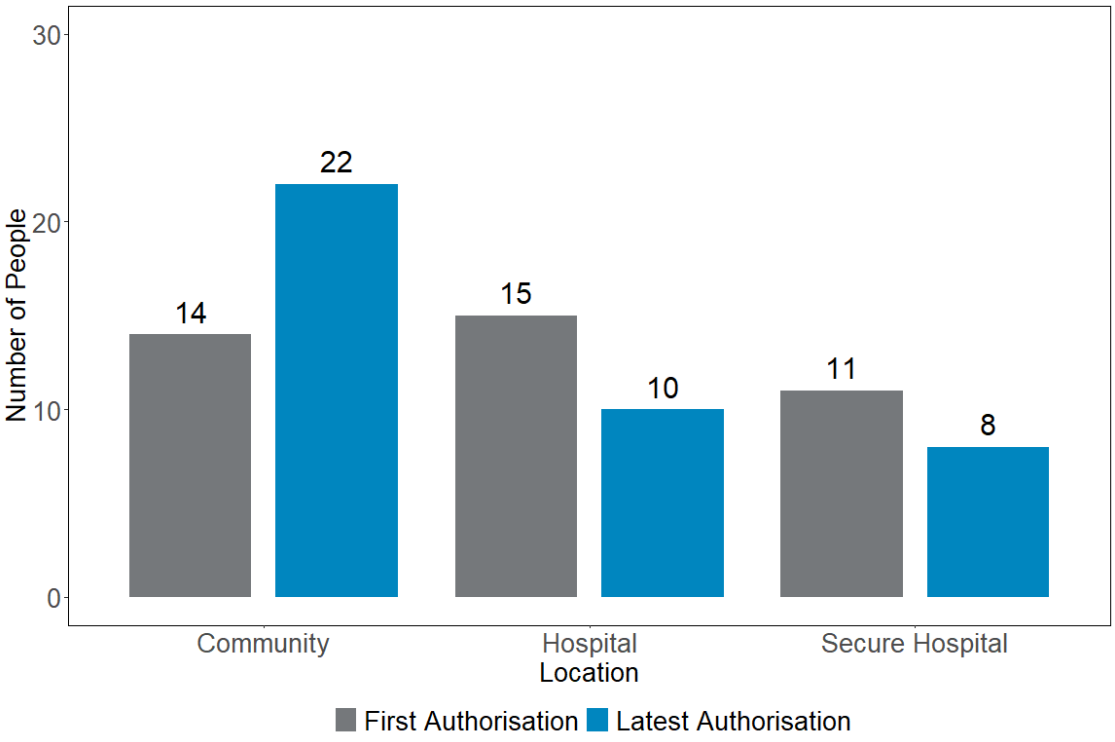
In our sample, 20 people (50%) had a primary diagnosis of intellectual disability, 14 people (35%) had a primary diagnosis of dementia, ≤3 people (≤8%) had a primary diagnosis of a severe & enduring mental illness, and ≤3 people (≤8%) had a primary diagnosis of brain injury.

Location

The people who were referred were in a range of settings and included people in mental health hospitals (general and secure) and people living in the community:

- 26 people (65%) were in hospital.
- 8 people (20%) were discharged to the community after medication to reduce sex drive had been authorised. We were unable to establish if the giving of medication to reduce sex drive had supported discharge from hospital.
- ≤3 people (≤8%) died in hospital after medication to reduce sex drive was authorised. The information available to us did not indicate that the use of medication to reduce sex drive had been a significant factor in the deaths of these people.

Figure 1: Location at first and latest authorisation



Legal status

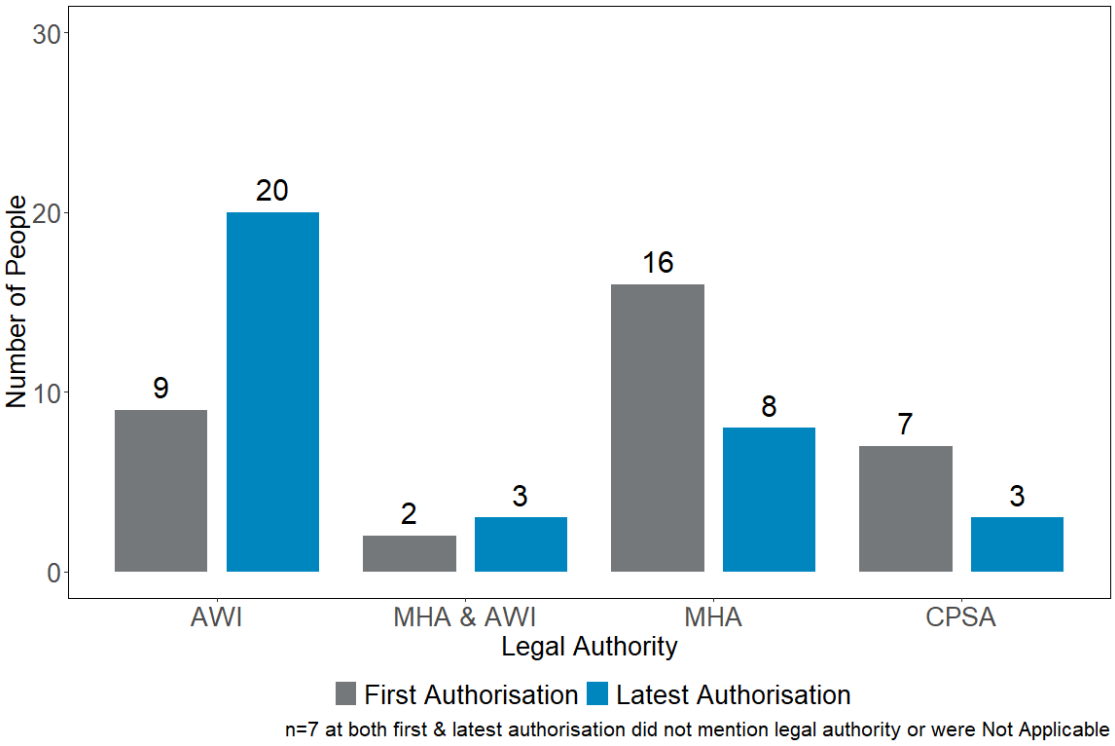
The giving of medication to reduce sex drive was authorised under the Mental Health Act in 18 (45%) people (16 exclusively under Mental Health Act and two under both the Mental Health Act and the AWI Act).

There were 11 (28%) people (nine exclusively under the AWI Act and two under both the Mental Health Act and AWI Act) who were subject to Welfare Guardianship orders under the AWI Act where the giving of medicine to reduce sex drive was authorised.

The giving of medication to reduce sex drive was also authorised under the Criminal Procedure (Scotland) Act 1995 (the 'Criminal Procedure Act') in seven cases (18%). The Criminal Procedure Act provides orders and directions to ensure appropriate care and treatment for individuals involved in criminal proceedings who are deemed to have a mental disorder.

We compared the legal status of individuals when they were first referred with their last recorded legal status between 2017 and 2023. We found that there was an increase in the number of guardianship orders (11 individuals, 28%) which corresponded with the discharge of people to community settings described above.

Figure 3: Legal authority for treatment at first and latest authorisation



Person, family and carer participation

The giving of medication to reduce sex drive was authorised in 38 cases (95%). In each of the 38 cases the person had been assessed as lacking the capacity to make decisions about their treatment.

We looked for evidence that the person, their family and carers had been able to participate in decisions about their treatment, in keeping with the principles of the Mental Health Act[19] and the AWI Act.[20]

We found that the views of the individual were documented in only 11 cases (28%).

We looked in our records to see if people had an advance statement that made reference to the giving of medication to reduce sex drive. An advance statement allows a person with capacity to record what treatment they do and do not want, should they become unwell in the future. Given that many people in our sample had conditions that would impact on their decision-making capacity over long periods of time we did not expect to find an advance statement in many of the cases.

We found an advance statement in our records for ≤3 people (≤8%) that was valid between 2017 and 2023. In all cases the individuals were supportive of the treatments that they were prescribed.

We also considered whether people's sexual needs were considered. Only one person in the sample had a documented care plan for their sexual needs. As we did not have access to people's health records, we cannot be certain that similar care plans were not in place for other people.

We found that the views of families and carers were only documented in 13 cases (33%). In some of these cases the involvement of families and carers had a significant impact on the person's treatment. In these cases, the person's carers were opposed to the giving of medication to reduce sex drive and the DMP or nominated practitioner agreed with them and did not provide authority to treatment.

Reasons for treatment

We found that the language and terminology used in relation to people's PSBs was inconsistent. Non-specific terms such as "Inappropriate Sexual Behaviours" were used in 26 cases (65%) in comparison with 11 cases (26%) where diagnostic terms such as "Hypersexuality" or "Paraphilia" were used.

In 10 cases (25%), the reason for treatment did not relate to the behaviours that were described and in eight cases (20%) the description of the person's behaviour was insufficient as to be clear whether the reason for the treatment was accurate.

In a few cases the reason for treatment appeared to relate to historical PSBs, rather than a description of recent behaviours.

Formulation and risk assessment

We looked for evidence of a psychological formulation in people's records. This is a helpful tool that supports a person-centred approach to understanding the interplay between a person's characteristics, their experiences, and their behaviours which can inform treatment plans, risk assessment and management, and psychological interventions. In 38 cases (95%) we could not identify a psychological formulation in the person's records that had contributed to the person's treatment plan.

None of the records referred to, or included, a structured risk assessment that was considered as part of the assessment process.

Use of non-pharmacological treatments

There was evidence that people had been treated with non-pharmacological therapies for the management of PSBs.

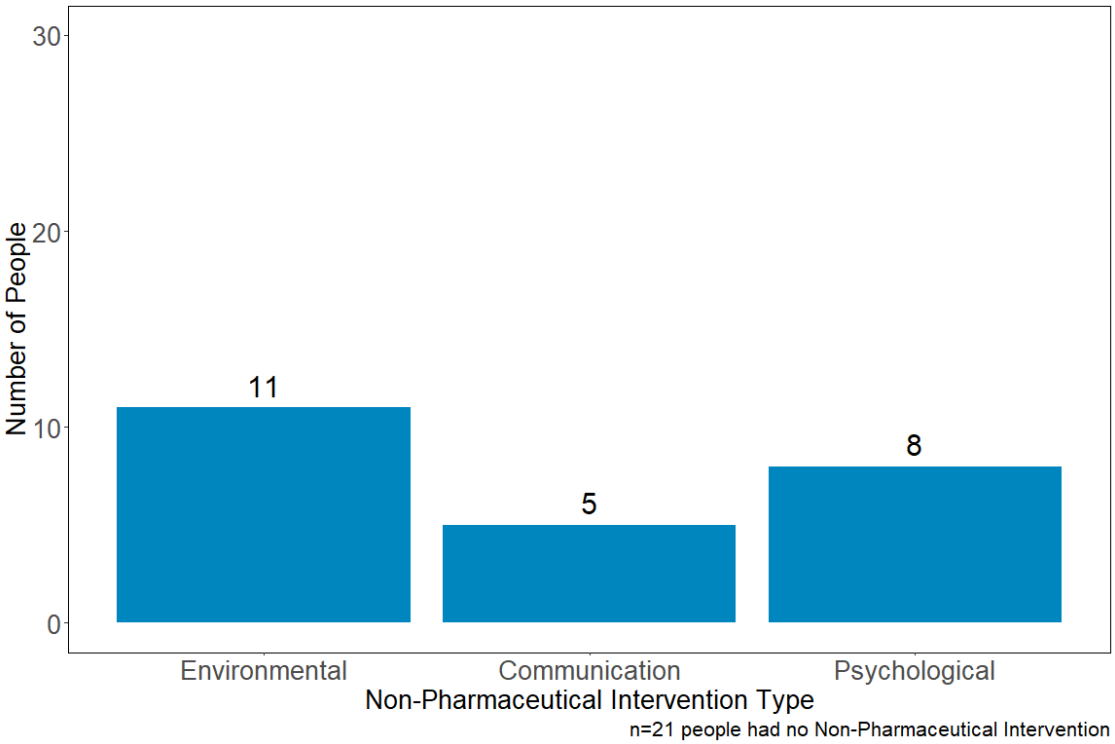
In 11 cases (28%), there was information about environmental interventions including increased observation levels, staff training, the person being moved to a single sex setting, and restricting access to some activities.

In five cases (13%), there was information about people being redirected, distracted, or having a communication strategy in place.

Eight people (20%) received psychological interventions including individual and group therapy.

We also found that whilst environmental and communication interventions were provided across different settings (community, hospital, and forensic hospital), psychological interventions were mostly provided in forensic hospitals, where psychological services may be better resourced.

Figure 3: Non-pharmacological interventions for the management of PSB



Duration of treatment

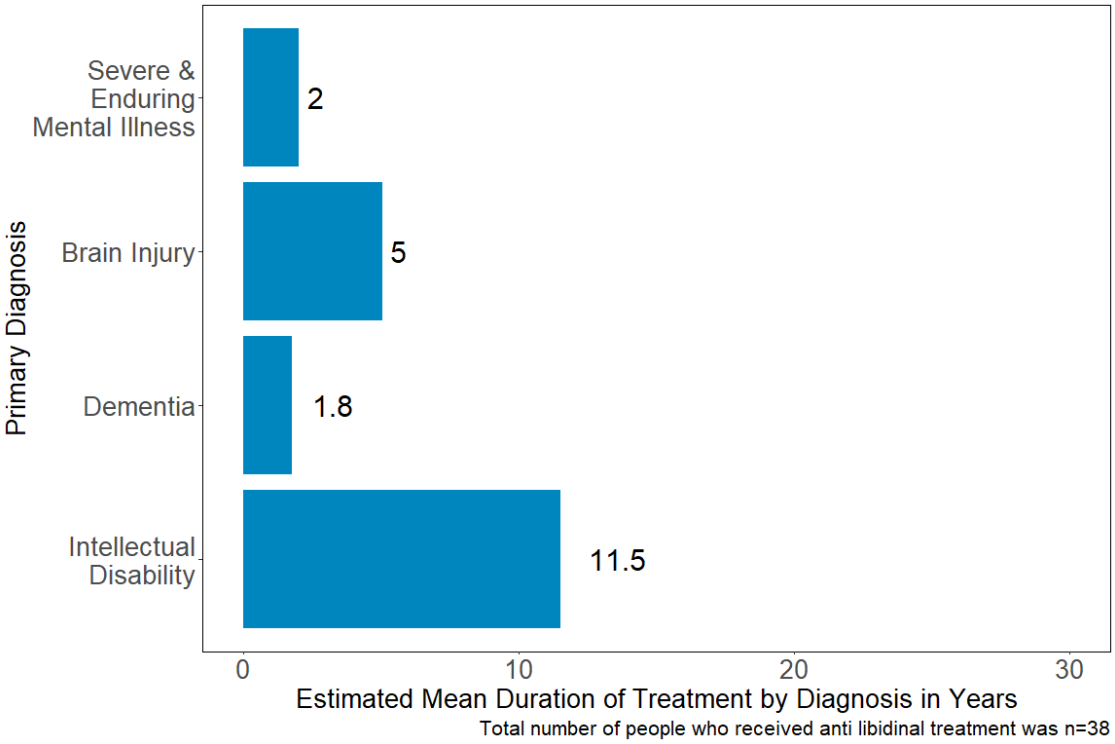
It was difficult to ascertain the length of time that people were given medicine for the purpose of reducing sex drive. There are a number of reasons for this including that some people may have commenced this treatment prior to any referrals made between 2017 and 2023, and that there is no requirement to notify the Commission when treatment with medication to reduce sex drive ends. The average duration of treatment by diagnosis figures (figure 4) are estimations based on the information that we had available in our records.

It was also possible to consider whether people had ongoing treatment with medicine to reduce sex drive during the sample period by looking at how often they were referred for a second opinion. It is worth noting that a T3 certificate authorising

treatment under the Mental Health Act can be valid for up to three years whereas the Schedule 2 certificate providing legal authority under the AWI Act is only valid for up to 12 months.

In 16 cases (40%), people were referred only once during the sample period, in 12 cases (33%) on two occasions, in seven cases (18%) on three occasions, and in four cases (10%) five or six times over the six-year period.

Figure 4: Estimated average duration of treatment by diagnosis in years



Choice of pharmacological treatments

The Forensic Network recommends that non hormonal medications are used when a person's PSBs are low risk and the use of hormonal medications when the risk is high.

In this audit, we defined the risk of serious harm to the individual and/or others as:

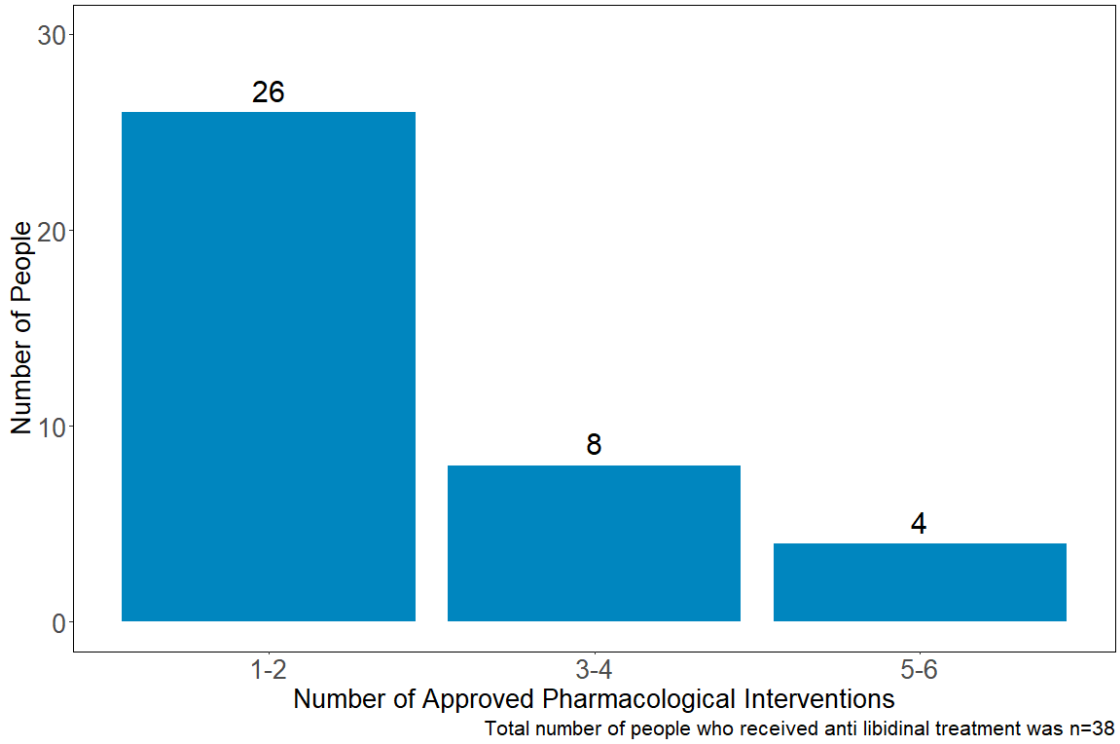
> "a risk which is life-threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible".[3]

Following the Forensic Network's recommendations, we expected that 31 people (78%), should have been treated with a non-hormonal medication as they were not considered to meet the definition of risk of serious harm. We found that in six (15%) of those cases that hormonal medication had been authorised where we would have expected that non-hormonal medication was indicated. As discussed elsewhere, the

Forensic Network guidance is in relation to treatment of people in forensic settings who have the capacity to consent to treatment, and its recommendations are not necessarily applicable to the people in our sample.

We reviewed the numbers of different medications that were authorised in each case and found that 17 people (43%) had more than one psychiatric medication prescribed that might have had an antilibidinal effect, with the maximum number of prescriptions being six. Medications were authorised for other medical reasons than treatment to reduce sex drive. In some cases, medications were prescribed that had an antilibidinal effect and they may or may not have been chosen for that reason. Where medication is authorised with more than one indication it is important that this is recognised, and the treatment properly authorised.

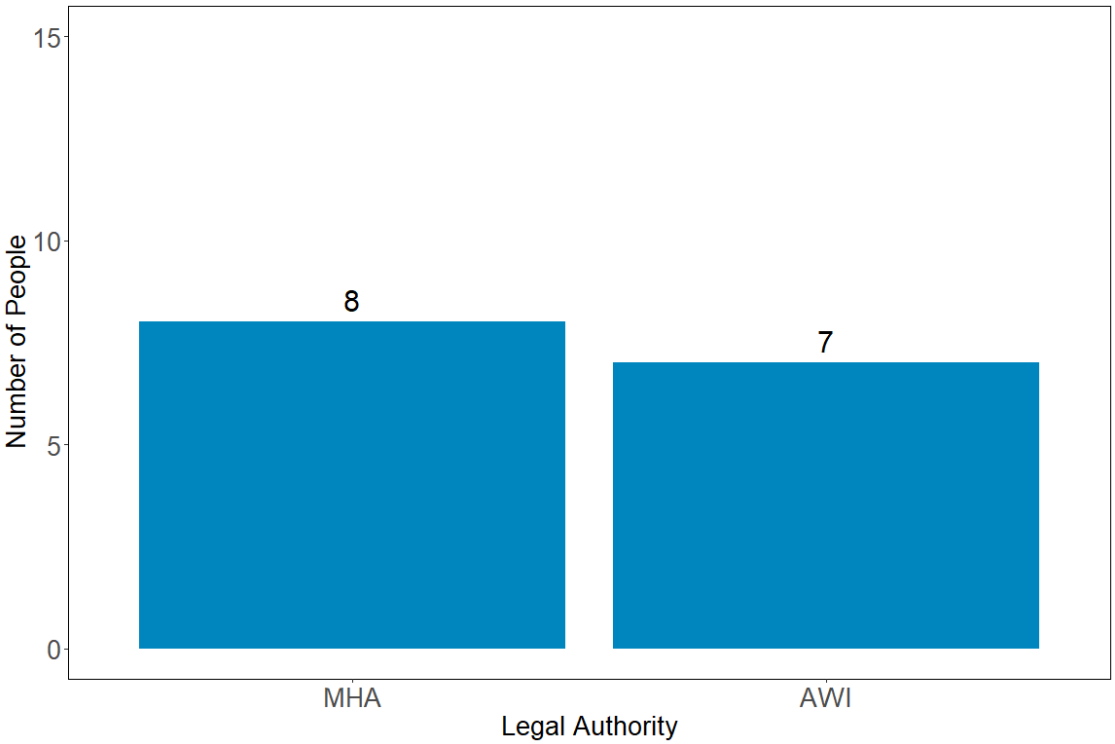
Figure 5: Number of psychiatric medications authorised which might have had an antilibidinal effect



Treatment without authority

In 15 cases (38%) the giving of medication to reduce sex drive was not properly authorised (figure 6). This included administrative errors that could invalidate the authority, cases where it appeared that medication had been given before any legal authority was in place (unauthorised treatment) and treatment continuing after the authority had expired where there had been delays in requesting a further second opinion when the previous authority had expired (lapsed authority).

Figure 6: Treatment without authority



In 24 cases (60%) we reviewed there was no valid T3 or Schedule 2 certificate in place at the end of the 2017-23 period. It is not clear from our records whether the treatment had stopped or whether, in some cases, the giving of medication to reduce sex drive continued without the proper legal authority in place.

Treatment plans

In 24 cases (60%), there was no change in a person's treatment plan when they had been referred on more than one occasion. This may reflect that the person's treatment was effective and continuing to meet their needs, but we could not support this with any evidence that a less restrictive approach had been considered within our records.

In a number of cases the responsible medical officer's treatment plan was changed by the independent second opinion practitioner. In ≤3 cases (≤8%), the responsible medical officer's treatment plan had included a hormonal antilibidinal medication, and this was changed by the DMP to a non-hormonal medication.

Key findings

We reviewed the available research about the treatment of PSBs in people who are unable to consent and found that there are significant gaps in the evidence base and a need for further research in this area.

We also found that there is a lack of good practice guidance and prescribing guidelines which can support good practice, particularly for people in non-forensic settings who are unable to consent to treatment

The Commission received 152 referrals between 2017 and 2023 for a second opinion from an independent practitioner. People were more likely to be referred when subject to the AWI Act (102 cases vs. 50 cases under the Mental Health Act).

Medication to reduce sex drive was authorised exclusively for men in the age range of 19 to 93 years. No one under the age of 18 years was treated with antilibidinal medication.

In the sample of 40 cases that we reviewed, 50% had a primary diagnosis of intellectual disability, over a third had a primary diagnosis of dementia, the remainder had a diagnosed brain injury or severe and enduring mental illness. Multiple diagnoses were common.

People were referred from general and secure psychiatric hospitals as well as people living in the community. Eight people (20%) were discharged from hospital settings to the community after medication to reduce sex drive had been authorised. There was also a move from the use of the Mental Health Act to the AWI Act with 11 people (28%) becoming subject to welfare guardianship over time. Whilst the move to less restrictive settings under the AWI Act may suggest that people had benefitted from treatment with medication to reduce sex drive, the numbers are too small to be definitive.

There was minimal information in people's records about psychological formulation, risk assessment or care planning to meet a person's sexual needs.

There was evidence that people had been treated with non-pharmacological therapies for the management of PSBs with environmental interventions (28%), communication strategies (13%) or psychological therapies (20%) documented in the 40 cases that we reviewed.

There was a lack of consistency in the way that PSBs were described and in the choice of antilibidinal medication used in keeping with the lack of good practice guidance and clinical guidelines.

There was limited information in our records to show that the views of people, and their families and carers were considered. The views of people were recorded in one quarter of the cases and the views of their carers in approximately one third of the cases we reviewed. In two cases the views of the carers led to a change in the person's treatment plan and no legal authority for medication to reduce sexual drive was given.

In ≤3 cases (≤8%), the person's treatment plan was changed following the independent second opinion.

Conclusion

Medication to reduce sex drive is given to a small number of people in Scotland each year when that medication has been authorised following an independent second opinion under the Mental Health Act or the AWI Act.

Medication given to reduce sex drive is associated with significant side effects, and it is right that there are robust clinical and legal safeguards in place to ensure that when medication is given to people who are unable to consent, that it is only given where it has been shown to be necessary and whilst ensuring that the individual's human rights are protected.

There is an urgent need to develop good practice guidance for the assessment and management of PSBs in people who can't consent to treatment. This guidance should describe the approach to non-pharmacological and pharmacological treatments as evidenced by the available research, with regards to the principles of the Mental Health Act and the AWI Act, and to ensure people's human rights are protected.

The views of people, and their families and carers should form an integral part of decision making in relation to people's treatment plans with support for communication and the involvement of advocacy services to ensure that their views are known.

Glossary

Word	Explanation
Antilibidinal medication	Medication to reduce sex drive.
Responsible medical officer	The consultant psychiatrist responsible for a person's care and treatment.
Designated medical practitioner	A consultant psychiatrist appointed by the Mental Welfare Commission for Scotland to provide an independent second opinion on certain medical treatments under part 16 of the Mental Health Act.
Nominated Practitioner	A consultant psychiatrist appointed by the Commission to provide an independent second opinion on certain medical treatments under part 5 of the AWI Act.
Inappropriate Sexual Behaviours	A catch-all non-clinical term.
Hypersexuality	A clinical term with contested definitions that reflects the complexity of its presentations and causes. The definition that we used in our analysis is an increased frequency and/or intensity of sexual desire enacted via uncontrollable impulsive and/or compulsive behaviours that cause the person's significant distress and/or impaired functioning. There is a debate around whether it constitutes a diagnostic entity as it is not formally recognised in the 5th edition of the Diagnostic & Statistics Manual (DSM-5) after being initially considered. It was described in the 10th edition of the International Classification of Diseases (ICD-10) as "excessive sexual drive". In the 11th edition of ICD this was replaced by "Compulsive Sexual Behaviour Disorder".

Paraphilia also known as Paraphilic Disorder	A recognised mental health condition in both DSM-5 and ICD-11. The latter defines it as “persistent and intense patterns of atypical sexual arousal, manifested by sexual thoughts, fantasies, urges, or behaviours, in which the focus of the arousal pattern involves others whose age or status renders them unwilling or unable to consent…Paraphilic Disorders may also involve other atypical sexual arousal patterns if they cause marked distress to the individual or involve significant risk of injury or death.”

Acknowledgements

We would like to thank Dr Ahmad Allam for leading on this work during his placement at the Commission.

References

1. MHA monitoring report 2024-25
2. Adults with Incapacity monitoring report
3. Johnson, C., Knight, C., & Alderman, N. (2006). Challenges associated with the definition and assessment of inappropriate sexual behaviour amongst individuals with an acquired neurological impairment. Brain Injury, 20(7), 687–693. DOI: 10.1080/02699050600744137
4. Forensic Network (2022). Medication to Reduce Male Sex Drive: Guidance on Referral, Assessment, And Pharmacological Treatment. Link: https://forensicnetwork.scot.nhs.uk/wp-content/uploads/2022/12/Anti-Libidinal-Guidance-2022.pdf
5. Mental Health (Care and Treatment) (Scotland) Act 2003
6. Adults with Incapacity (Scotland) Act 2000
7. European Convention on Human Rights
8. Herczegfalvy v. Austria App. No. 10533/83, Eur. Ct. H. R. 58 (1992)
9. Medical treatment under Part IV of the Mental Health Act 1983 and the Human Rights Act 1998: review of Article 3 and 8 case law Published online by Cambridge University Press: 02 January 2018
10. R (Wilkinson) v Broadmoor Hospital [2001 266994323.pdf
11. Hutchison Reid v United Kingdom (ECtHR, 2003) bing.com/ck/a?!&&p=893a64dab325ec5904053c1a2b47c282b0903c30c88976467c0537c4d572777cJmltdHM9MTc2MjU2MDAwMA&ptn=3&ver=2&hsh=4&fclid=0c1ee1a6-bda2-671b-3ad6-f464bc5d6673&psq=hutchison+reid+v+the+united+kingdom&u=a1aHR0cHM6Ly9odWRvYy5lY2hyLmNvZS5pbnQvYXBwL2N
12. Series, Dégano (2005). Hypersexuality in dementia. Advances in Psychiatric Treatment, 11(6):424-431. Doi:10.1192/apt.11.6.424
13. Roels, Goethals, & Jeandarme (2024). Pharmacotherapy in sexual behavior disorders and intellectual disability. Tijdschr Psychiatr, 66(1):30-35. PMID: 38380485.
14. Dredge, & Rose (2022). Non-pharmacological treatment for individuals with autism spectrum conditions who display harmful sexual behaviour. International Journal of Developmental Disabilities, 69(6), 783–796. Doi: 10.1080/20473869.2022.2028418
15. Ben-Sheetrit et al. (2023). Estimating the risk of irreversible post-SSRI sexual dysfunction (PSSD) due to serotonergic antidepressants. Annals of General Psychiatry, **22**, 15. Doi: 10.1186/s12991-023-00447-0
16. European Medicines Agency (2020). Restrictions in use of cyproterone due to meningioma risk. Link: https://www.ema.europa.eu/en/news/restrictions-use-cyproterone-due-meningioma-

risk#:~:text=The%20occurrence%20of%20meningiomas%20(single,cumulative%20doses%20of%20cyproterone%20acetate.
17. Semet et al. (2017), The impact of drugs on male fertility: a review. Andrology, 5: 640-663. Doi:10.1111/andr.12366
18. HM Prison & Probation Service (2023). Risk of Serious Harm Guidance 2020. Link: https://assets.publishing.service.gov.uk/media/652cf8c9697260000dccf834/Risk_of_Serious_Harm_Guidance_v3.pdf
19. Chapter 1: Overview - Mental Health (care and treatment) (Scotland) Act 2003: Code of Practice Volume 1 - gov.scot
20. Adults with Incapacity (Scotland) Act 2000: principles - gov.scot

If you have any comments or feedback on this publication, please contact us:

Mental Welfare Commission for Scotland
Thistle House,
91 Haymarket Terrace,
Edinburgh,
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk