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Capacity to consent to sexual relations

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AUTHORS

DR CAMILLA HERBERT

Consultant Clinical Neuropsychologist, Division of Neuropsychology.

DR THERESA JOYCE

Consultant Clinical Psychologist, Faculty for People with Intellectual Disabilities.

DR GEMMA GRAY

Consultant Lead Clinical Psychologist, Faculty for People with Intellectual Disabilities, Oxford Health NHS Foundation Trust.

DR SHAI BETTERIDGE

Consultant Clinical Neuropsychologist and Head of Neuro & Clinical Health Psychology Department St George's University Hospital NHS Foundation Trust.

WITH ADDITIONAL CONTRIBUTIONS FROM

DR GARY MACPHERSON

Consultant Forensic Clinical Psychologist, State Hospitals Board for Scotland & Assistant Professor, Faculty of Psychology and Neuroscience, Maastricht University.

DR COLIN WILSON

Consultant Clinical Neuropsychologist, Regional Acquired Brain Injury Unit, Belfast Health and Social Care Trust, Belfast.

DR SARAH HENRY

Clinical Psychologist.

MR CHRIS JONES

Principal Clinical Psychologist.

ALEXIS HEARNDEN

Barrister at 39 Essex Chambers.

HANNAH FARNDON

BPS Policy Advisor (Professional Practice).

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Purpose of document

This document has been produced by the British Psychological Society's Professional Practice Board's Advisory Group on Mental Capacity.

It provides an overview of:

- a. The legal framework practitioner psychologists should be aware of and use when assessing a person's mental capacity to consent to sexual relations.
- b. The issues and challenges that arise for clinicians when working with vulnerable people whose sexual functioning may be compromised because of an impairment of, or a disturbance in the functioning of, the mind or brain.

This document is not a definitive guide to all aspects of what is a difficult and continually evolving area of the law, and where there are complex professional and ethical issues. However, illustrating some of the problems and sharing management approaches used in practice, the document will assist clinicians to ensure that there are adequate safeguards to protect vulnerable adults or people who lack the mental capacity to make decisions in this area, whilst not being unduly restrictive.

The Society expects that psychologists carrying out mental capacity assessments should be registered with the HCPC. Practitioner psychologists should follow official guidance from the British Psychological Society and the HCPC regarding competence and ensure they work within the recognised limits of their knowledge, skill, training, education and experience.

Although this document is aimed at practitioner psychologists, parts of the document may be relevant to clinicians from other professions who practice in related areas. Throughout this document where case law or legislation is quoted 'P' refers to the individual being assessed.

This document relates to the law (and subsequent case law) in England and Wales. Therefore, the examples used in this document

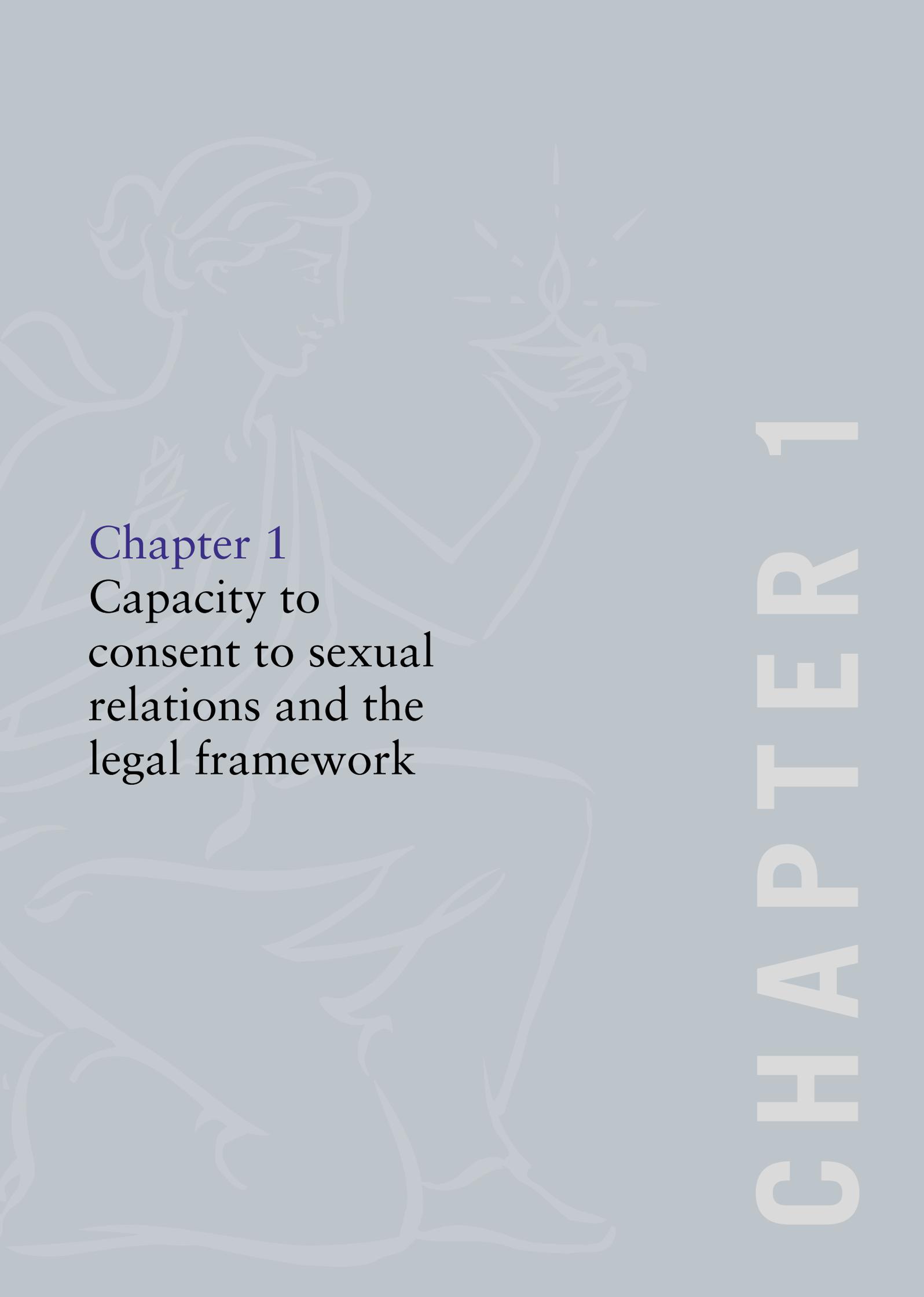
refer to legislation in England and Wales (i.e. Human Rights Act 1998, Sexual Offences Act 2003, Mental Capacity Act 2005, Mental Capacity Act Code of Practice 2007, Care Act 2014). Reference is made to specific legislation in Scotland and in Northern Ireland. Whilst the issues are common across all jurisdictions, the precise legal terminology and case law will vary, and care must be taken to ensure that the appropriate legislation is referred to for any specific case.

For example, different jurisdictions have their own legislation related to sexual offences, which provide definitions related to sexual consent. Whilst there are significant areas of similarities within some of these and the law within England and Wales, clinicians are advised to familiarise themselves with the relevant legislation and case law that applies within the jurisdiction within which they work.

In Scotland the relevant legislation is found in the Mental Health (Care and Treatment) (Scotland) Act 2003 (Section 311) Adults with Incapacity (Scotland) Act 2000. Whilst not directly related to sexual activity, The Adult Support and Protection (Scotland) Act 2007 may also be of relevance, as it has provisions to 'ban' contact between individuals and adults at risk.

In Northern Ireland it is the Sexual Offences (Northern Ireland) Order 2008, and Mental Capacity Act (Northern Ireland) 2016.

Each sexual offences act uses the definition of mental disorder taken from their own mental health legislation.



CHAPTER 1

Chapter 1

Capacity to consent to sexual relations and the legal framework

Introduction

This chapter explains the legal framework practitioner psychologists should be aware of and use when assessing a person's mental capacity to consent to sexual relations including some key judgements and case law examples.

In clinical practice, the assessment of capacity to consent to sexual relations may arise in the context of an allegation of a criminal offence or as part of a more general care plan regarding the management of an individual's welfare, including facilitating their social and sexual development. It is helpful, therefore, to clarify the context of the decision in question.

The essential principles of any mental capacity assessment are set out in the Mental Capacity Act (MCA) 2005 and elaborated in the MCA Code of Practice 2007. These documents are the primary sources of information that should be used to guide an assessment of capacity to consent to sexual relations within a civil context. The first part of the test is diagnostic – is there an impairment or disturbance of the brain; the second part is functional – does that impairment or disturbance mean that a person is unable to understand the relevant information, retain it, use and weigh it or communicate?

Section 27 of the MCA (2005) specifically excludes the making of best interest decisions regarding sexual relationships. In other words, if a person is found to lack capacity to consent to sexual relations nobody can decide that it is in that person's best interests to engage in sexual relations. The decision the courts can take is to determine whether or not an individual has capacity to consent to sexual relations; and if a person lacks capacity, the courts can decide whether orders are required to safeguard that person. For example, the court may make orders under Forced Marriage legislation¹ or restrict a person's contact with another (if they also lack capacity to make decisions about contact). The Mental Capacity Act (2005) definition of what constitutes mental capacity, or the lack of it, in relation to any decision, is outlined in full in the appendix.

During the implementation of the MCA (2005), the presence of Section 27 initially led to a lack of clarity and hesitation for clinicians regarding the relevant legal framework for assessment of capacity in relation to sexual relations within a civil context. Mr Justice McFarlane commented that in relation to sexual capacity 'language has become complicated (e.g. "person specific", "act-specific", "situation-specific" and "issue-specific"). But all decisions, whatever their nature, fall to be evaluated within the straightforward and clear structure of MCA'.

Issues around capacity to consent to sexual relations within a criminal context are addressed in the Sexual Offences Act (2003). This Act specifies that it is illegal to engage in sexual relations with a person with a mental disorder who is 'unable to refuse' for a reason related to a mental disorder because he/she lacks 'the capacity to choose'. In England, Wales and Northern Ireland a person is able to consent to sexual relations² 'if a person agrees by choice, and has the freedom and capacity to make that choice'. Scottish law starts from the assumption that all individuals have the capacity to consent to sexual relations and that on a basic level consent is defined as 'free agreement to conduct'³. An offence will have taken place if the victim did not consent, or the accused had no reasonable belief that they consented.

The Sexual Offences Act (2003) states that: The person [A] commits an offence if they know, or could reasonably be expected to know, that the person [B] with whom they have sex has a mental disorder, and because of this (or for a reason related to it) that they are likely to be unable to refuse. [B] is considered unable to refuse if they lack the capacity to choose whether to agree to the sexual act because they lack sufficient understanding of the nature or

reasonably foreseeable consequences of what is being done. There may be other reasons why they are unable to refuse related to their mental disorder (for example, overwhelming fear or confusion). [B] may also be unable to refuse if they are unable to communicate their choice. The use of inducements, threats or deceptions to obtain sexual activity with a person with a mental disorder is also illegal, as is sexual activity between care workers and people with a mental disorder.

Section 76 of the Serious Crime Act 2015 introduces a new offence of controlling or coercive behaviour in intimate or familial relations.

The relevant legislation under Scottish criminal law is Section 17 of the Sexual Offences (Scotland) Act 2009, which states that a person is incapable of consenting to conduct

where, by reason of mental disorder, the person is unable to (a) understand what the conduct is, (b) form a decision as to whether to engage in the conduct (or as to whether the conduct should take place), and (c) communicate any such decision⁴.

The Sexual Offences Act 2003 is concerned with the criminal courts and criminal offences. The MCA (2005) relates to the civil courts. Since the MCA came into force, case law has been developing to clarify the overlap between the definitions in these two areas in relation to capacity to consent to sexual relations. However, it is essential that where there is any suggestion of a criminal offence having been committed that the police are involved at an early stage. It is the responsibility of the police to investigate any potential crime and to carry out interviews relating to a possible offence.

Age of consent

There is a presumption that men and women can give legal consent to either opposite or same sex relations from the age of 16.

That presumption of capacity will only be rebutted in specific circumstances: for example, where a mental disorder impairs the person's ability to give valid consent because they do not understand the information relevant to the decision.

Adults with capacity are entitled to make unwise and even risky decisions. Equally, relationships can be of any duration and of varying degrees of commitment, however, the need to protect vulnerable people from exploitation underpins the Care Act (2014) and criminal law's approach to sexual relations and the Sexual Offences Act (2003).

Case law

As with other aspects of the law in England and Wales, the courts have developed further guidance on how the statutory framework is to be interpreted in practice.

It is therefore essential that clinicians keep up-to-date with case law in this area so that they understand the way in which the test is currently described by the courts when they are asked to assess the capacity of a specific individual. Practitioners wishing to search for more recent cases can use the Mental Capacity Law Cases and Resources made freely available

online by 39 Essex Street Chambers. There is also a monthly bulletin which is sent out by email: <https://www.39essex.com/resources-and-training/mental-capacity-law/>

The relevant test

SHEFFIELD CITY COUNCIL V E

The test to be applied was set out in 2004 by Mr Justice Munby (as he then was) in *Sheffield City Council v E*. This case involved an application by the local authority to prevent a young woman with a learning disability [E] from marrying an older man [S] who had a history of sexual offences and where they were concerned for her safety. In the context of considering her capacity to marry, he also considered her capacity to consent to a sexual relationship. This was on the basis that sexual relations are an integral part of any marriage and if an individual cannot consent to sex then they cannot validly consent to marriage.

Mr Justice Munby also considered whether capacity to consent to both sexual relations and to marriage were ‘issue specific’ or ‘person specific’. He concluded that, like marriage, capacity to consent to sex is issue specific, not person specific. In other words, the person must have sufficient knowledge and understanding of the issue relating to consent to sex, rather than considering it solely in relation to the person with whom they are going to have the relationship. He stated:

‘When considering capacity to marry, the question is whether X has capacity to marry, not whether she has capacity to marry Y rather than Z. The question of capacity to marry has never been considered by reference to a person’s ability to understand or evaluate the characteristics of some particular spouse or intended spouse... In my judgement, the same goes, and for much the same reasons, in relation to capacity to consent to sexual relations. The question is issue specific, both in the general sense and... in the sense that capacity has to be assessed in relation to the particular kind of sexual activity in question. But capacity to consent to sexual relations is... a question directed to the nature of the activity rather than to the identity of the sexual partner.’

It is important to remember this when assessing capacity – whatever the assessor’s views of the suitability of a particular partner, the judgement is not about them, but about the person’s understanding of the act itself and its consequences.

FORCED MARRIAGES

Since 2014 it has been a criminal offence to force someone to marry against their will. This may have the appearance of a person being ‘forced’ (in a traditional sense) but may also include the situation where a person willingly marries, but without the capacity to consent to the union. They may appear happy with what is proposed or what has happened, but still be unable to properly give consent (e.g. *Luton v RS* [2017] 4 WLR 61). Mrs Justice Parker made the point clear in *XCC v AA* [2012] EWCOP 218 when she said that ‘in my view marriage with an incapacitated person who is unable to consent is a forced marriage within the meaning of the Forced Marriages Act (2007)’.

Professionals have a duty to investigate and report situations where they think a forced marriage might be occurring either in the UK or abroad (*Sandwell MBC v RG* (2013) EWHC 2373 (COP), (2013) MHLO 55). Increasingly, practitioner psychologists are receiving referrals for capacity assessments after a person has already married (either in the UK or abroad) or if there are plans for a person to marry and concern has been highlighted in relation to their capacity. These referrals are often extremely time critical and culturally sensitive. They frequently involve the Court of Protection being asked to make declarations with regard to capacity and orders restricting travel (NB A Forced Marriage Protection Order

must be sought in the Family Court, rather than the Court of Protection; some High Court judges can sit in both jurisdictions at the same time). Further information is available from the Forced Marriages Unit based in the Home Office⁵.

There have been a number of cases involving capacity to consent to marriage, and it is important to note that any individual who lacks the capacity to engage in sexual relations necessarily lacks the capacity to

marry. Consequently, any capacity assessment regarding marriage (in the context of forced marriage or otherwise) needs to ensure that assessments are carried out in relation to both marriage and sex. It is important to remember that capacity can be acquired, often by a tailored programme of sex education. Any education needs to be carried out in a timely way, without significant delays and with regard for the person's human rights: see *CH v AMC* (2017) EWCOP 12.

WHAT INFORMATION IS RELEVANT TO THE DECISION?

Identifying the information relevant to a decision is a key part of assessing a person's capacity to consent to sex. Although the 'relevant information' is not defined by the MCA, section 3(4) states that it includes information 'about the reasonably foreseeable consequences of (a) deciding one way or another, or (b) failing to make the decision'. The courts are anxious to ensure that the standard is not set so high that large numbers of people fail to meet it, when in fact they could participate in, and enjoy, a sexual relationship. This would be a discriminatory response to a recognised need to protect the vulnerable.

In *Sheffield County Council v E* (2004) Mr Justice Munby set out the key aspects of the legal test for capacity to consent to sexual relations '– the question comes to this. Does the person have sufficient knowledge and understanding of the nature and character – the sexual nature and character – of the act of sexual intercourse, and of the reasonably foreseeable consequences of sexual intercourse, to have the capacity to choose whether or not to engage in it, the capacity to decide whether to give or withhold consent to sexual intercourse...?' He also pointed out that, 'Her knowledge and understanding need not be complete or sophisticated. It is enough that she has sufficient rudimentary knowledge of what the act comprises and of its sexual character to enable her to decide whether to give or withhold consent.'

The content of the test was further developed in *D Borough Council v AB* [2011] EWHC 101. AB had a moderate learning disability. He was involved in a sexual relationship with another male resident in the care home where he lived. The local authority commenced proceedings seeking a declaration that AB lacked capacity to consent to sex, and also restricting his contact with the other resident and another person.

The judge, Mr Justice Mostyn expressed the test in the following way:

'I therefore conclude that the capacity to consent to sex remains act-specific and requires an understanding and awareness of:

The mechanics of the act;

That there are health risks involved, particularly the acquisition of sexually transmitted and sexually transmissible infections;

That sex between a man and a woman may result in the woman becoming pregnant.'

This requires those assessing capacity to ask questions about the person's knowledge of what happens when people have sex, about their understanding and knowledge of the health risks and about the possibility of pregnancy (if contemplating heterosexual sex). It does

not require an understanding of contraception (although that may be relevant as a separate decision) or the ability to bring up children. It is of note that ‘remote’ factors such as the implications of a pregnancy (e.g. the risk that a child would be removed from its mother) are not included within the ‘relevant information’.

For same sex relationships, Mr Justice Baker in *A local authority and TZ* (by his litigation friend the Official Solicitor) [2013] EWHC 2322 (COP) noted that in the case of a person in respect of whom it is clearly established that he or she is homosexual it is ordinarily unnecessary to establish that the person has an understanding or awareness that sexual activity between a man and a woman may result in pregnancy.

It is implicit in the very issue of whether a person is capable of consenting to sexual relations that they understand that they have a choice; but, recently there has been some debate as to whether or not it should be specified as a separate element of the test or whether it is necessary to understand that the sexual partner can refuse. See:

Mr Justice Mostyn in *LB Tower Hamlets v TB & Other* [2014] EWCOP 53: the test for capacity should include the fact that ‘he or she has a choice and can refuse’; and

Mrs Justice Parker in *London Borough of Southwark v KA and Ors* [2016] EWHC 661 (Fam):
 ‘The ability to understand the concept of and the necessity of one’s own consent is fundamental to having capacity: in other words that P knows that she/he has a choice and can refuse. I am less certain that consent of the other party is fundamental to capacity’

In *IM v LM and others* [2014] EWCA Civ 37, endorsing the approach taken respectively by Mr Justice Mostyn in *D Borough Council v B* [2011] EWHC 101 (Fam) and Mr Justice Hedley in *A Local Authority v*

H [2012] EWHC 49 (COP) the Court of Appeal held that:

- a. A narrow construction of ‘reasonably foreseeable consequences’ as described by Mr Justice Bodey in *Re A (Capacity: Refusal of Contraception)* [2011] Fam 61 was to be preferred (para. 80);
- b. To do otherwise would be to move towards paternalism, away from the promotion of personal autonomy;
- c. The judge’s approach in the court below had been correct when he highlighted the following factors (para. 83 and para. 18):
 - i. P understands the rudiments of the sexual act;
 - ii. P has a basic understanding of the issues of contraception;
 - iii. P has a basic understanding of sexually transmitted diseases;
 - iv. P had sufficient understanding of the fact that sexual relations may lead to pregnancy.
- d. *‘Perhaps yet another way of expressing the same point is to suggest that the information typically, and we stress typically, regarded by persons of full capacity as relevant to the decision whether to consent to sexual relations is relatively limited. The temptation to expand that field of information in an attempt to simulate more widely informed decision-making is likely to lead to what Bodey J rightly identified as both paternalism and a derogation from personal autonomy’* (para. 82).

In 2016 Mrs Justice Parker cautioned against being too formalistic in the application of the test for capacity to consent to sexual relations:

Even though the statutory criteria need to be looked at individually, evaluation of a particular capacity should not simply be practical but also has a holistic element. It is not an

examination in which one has to attain a certain mark in all modules.

The issue specific question is not whether P lacks capacity in respect of contraception, or disease control... but whether overall looking at the relevant information, capacity is proved absent.

WEIGHING INFORMATION IN THE BALANCE TO MAKE A FREE CHOICE

Because of the nature of decisions concerning sexual relations, which are usually a matter of the heart, the question of the ability to use and weigh information is only of limited relevance to the decision:

It is for that reason also that the ability to use and weigh information is unlikely to loom large in the evaluation of capacity to consent to sexual relations. It is not an irrelevant consideration; indeed (as we have emphasised) the statute mandates that it be taken into account, but the notional process of using and weighing information attributed to the protected person should not involve a refined analysis of the sort which does not typically inform the decision to consent to sexual relations made by a person of full capacity. That is the point which Munby J was seeking to make in MN at paragraph 84. It is precisely this point at which Hedley J was

driving in A NHS Trust v P when he observed that 'the intention of the Act is not to dress an incapacitous person in forensic cotton wool but to allow them as far as possible to make the same mistakes that all other human beings are at liberty to make and not infrequently do' (IM, LM & AB v Liverpool CC, para. 81).

Nevertheless, in A Local Authority v H (2012) EWHC 49 (COP), Mr Justice Hedley noted that an individual needs to be able to weigh up the information relevant to capacity, and not just understand it. H had a learning disability and was engaging in extremely risky sexual behaviour, including having multiple partners resulting in an STI. In this case, the court ordered that H should have restrictions upon her to the extent that they amounted to deprivation of liberty, in order to protect her while further efforts were made to enhance her capacity.

MCA code of practice (2007)

When assessing capacity to consent to sexual relationships, and/or advising the courts on necessary restrictions to protect a person who lacks capacity in this area, it is essential to hold in mind four of the five key principles set out in the MCA code of practice (2007), namely:

1. Presumption of capacity – A person must be assumed to have capacity unless it is established that they lack capacity.
2. The right for individuals to be supported to make their own decisions – A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.
3. The right to make ‘unwise’ decisions – A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. Least restrictive option – Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

Forming and expressing your opinion

Within the case law, there have been some helpful themes that have emerged from a practical perspective that clinicians should bear in mind when forming an opinion.

Clinicians have been advised to ensure that the ‘bar’ in relation to capacity assessments isn’t set too high, or higher than one would expect for people without impairments. Mr Justice Baker states that clinicians and the courts must not be unduly influenced by the ‘protective imperative; this is, the perceived need to protect the vulnerable adult (Oldham MBC v GW and PW [2007] EWHC 136 (Fam); PH v A Local Authority, Z Ltd and R [2011] EWHC 1704 (Fam)). It is vital that all practicable steps have been taken to help the person understand the relevant information (which may include specially tailored sex education). The importance of using tangible resources as part of assessments and interventions was also highlighted.

It is important to remember, as Rook and Ward⁶ explained in a text often referred to by the courts, that:

Although there is a clear need to protect the mentally disordered from sexual abuse, it is important that the law is not drawn so restrictively that it denies the mentally disordered their right to engage in sexual relationships... There is in this area an inherent potential conflict between legislative paternalism and sexual freedom; what is clear is that there is a delicate balance to be struck between undue state interference in an individual’s sexual life and the state’s responsibility to protect an individual from exploitation and abuse. (para 7.03.)

In the interest of protecting individuals from abuse and exploitation, practitioner psychologists conducting sexual capacity assessments should consider the role suggestibility might play in their clients’ responses. In addition, any potential sources of social influence or coercion should be considered and commented on as part of

any assessment of sexual capacity. While suggestibility has not been established in case law as a core part of the test of sexual capacity, the authors argue that it is implicit within the legislation regarding sexual consent that P should be able to make a free choice; as such, assessing suggestibility is pivotal to informing the practitioner psychologist’s opinion regarding an individual’s capacity to consent to sexual relationships.

As with all capacity assessments, clinicians will be expected to provide their opinion as to whether the person has or lacks capacity with regard to sexual relations. The assessment report should provide the evidence for how this conclusion has been reached and demonstrate that the assessment has complied with the requirements within the MCA (2005). In reporting an opinion regarding a person’s incapacity it is necessary to show the link between the ‘impairment or disturbance’ of mind or brain and their inability to make the decision. This can often be overlooked with some reports focusing upon the functional part of the assessment. There is a clear requirement to indicate how the inability to make a decision is because of the impairment or disturbance. Reaching a definitive conclusion can, at times, be challenging for practitioner psychologists, but it is important that an opinion is made and expressed based on the information available and subject to new evidence emerging over time.

Key legal judgements

The following are some outlines of key judgements in the area of capacity to consent to sexual relations along with a summary of some of the key aspects. In addition to these, *Oldham MBC v GW and PW* [2007] EWHC 136 (Fam); *LB Tower Hamlets v TB and Ors* [2014] EWCOP 53; and *London Borough of Southwark v KA and Ors* [2016] EWHC 661 (Fam) are also important.

CASE LAW REFERENCE

Sheffield City Council v E [2004] EWHC 2808

SUMMARY OF KEY ASPECTS OF THE JUDGEMENT

Capacity to marry is ‘issue specific’

Mr Justice Munby (as he then was):

‘The question of capacity to marry has never been considered by reference to a person’s ability to understand or evaluate the characteristics of some particular spouse or intended spouse’ (para. 85)

When considering capacity to marry, the question is whether X has capacity to marry, not whether she has capacity to marry Y rather than Z (para. 141(i)).

CASE LAW REFERENCE

Local Authority X v MM, KM [2007] EWHC 2003 (Fam) (Munby J).

SUMMARY OF KEY ASPECTS OF THE JUDGEMENT

Defining what information is relevant to a decision about sexual relations

MM was found to have capacity to consent to sexual relations but to lack capacity to decide on matters of contact:

‘... The question is issue specific, both in the general sense and... in the sense that capacity has to be assessed in relation to the particular kind of sexual activity in question. But capacity to consent to sexual relations is... a question directed to the nature of the activity rather than to the identity of the sexual partner.’ (para. 85)

‘– the question comes to this. Does the person have sufficient knowledge and understanding of the nature and character – the sexual nature and character – of the act of sexual intercourse, and of the reasonably foreseeable consequences of sexual intercourse, to have the capacity to choose whether or not to engage in it, the capacity to decide whether to give or withhold consent to sexual intercourse...?’ He also pointed out that, ‘Her knowledge and understanding need not be complete or sophisticated. It is enough that she has sufficient rudimentary knowledge of what

the act comprises and of its sexual character to enable her to decide whether to give or withhold consent' (para. 86)

It was suggested during the course of argument that there was something inconsistent, indeed illogical, about this: as a matter of logic, it was suggested, a person must have the capacity to consent to contact with a potential sexual partner in order to have capacity to consent to sexual intercourse, because contact, however fleeting, is, in the nature of things, a necessary pre-requisite to sexual intercourse. (para. 94)

I confess that I was myself at one stage puzzled by this. But Mr Sachdeva provided the answer. As always, the question of capacity is issue specific. As I observed in *Sheffield City Council v E* [2004] EWHC 2808 (Fam). [2005] Fam 326, at para. [105], because questions of capacity are issue specific, capacity to marry is not the same as capacity to look after oneself. Someone may have the capacity to marry whilst lacking capacity to take care of her own person. In the same way, someone may have capacity to consent to sexual relations whilst lacking capacity to decide more complex questions about long-term relationships. There is, as Mr Sachdeva points out, no necessary dissonance between the lack of capacity to consent to contact and capacity to consent to sexual relations. The former is a potentially complex concept involving a range of considerations arising in the context of a potentially wide variety of situations, for example, from having a cup of tea with someone to going away with them for a long holiday, whilst the latter is often, and of its very nature, much less complex. MM may well understand what is involved in sexual intercourse with KM – Dr Milne's opinion is that she does – whilst being unable, for example, to appreciate and evaluate all the possible implications and risks for her of staying in contact with KM: the risk, for example, that he will persuade her to leave her placement and go off with him and the consequential risks to her physical, mental and emotional wellbeing were she to do so. (para. 95)

This is not of course to dispute that there is a connection between the two. For Mr Sachdeva also made the important point that if a person has capacity to consent to sexual relations but cannot consent to contact, the capacity to decide on sexual relations is a material factor – in my judgement a highly material factor – in the court's assessment of what is in the best interests of that person in terms of her contact with her sexual partner. (para. 96)...

The inherent jurisdiction must, of course, be exercised in a manner which is compatible with the European Convention for the Protection of Human Rights and Fundamental Freedoms. (para. 100)

Article 8 of the Convention is central to the issues in this case. Article 8 protects the right to 'respect' for 'private and family life.' MM and KM may not be married but, in the sense in which these expressions are used in Article 8, they have hitherto enjoyed a family life together and each of them quite plainly also has a private life. (para. 101)

The court should intervene only where there is a need to protect a vulnerable adult from abuse or the real possibility of abuse: see *Re K, A Local Authority v N and others* [2005] EWHC 2956 (Fam), [2007] 1 FLR 399, at paras [90]–[92], and *X City Council v MB, NB and MAB* (by his litigation friend the Official Solicitor) [2006] EWHC 168 (Fam), [2006] 2 FLR 968, at para. [27]. The jurisdiction is to be invoked if, but only if, there is a demonstrated need to protect a vulnerable adult.

CASE LAW REFERENCE

D Borough Council and AB (2011)

SUMMARY OF KEY ASPECTS OF THE JUDGEMENT

Test of capacity to consent to sexual relations:

Mr Justice Mostyn stated the following:

'I therefore conclude that the capacity to consent to sex remains act-specific and requires an understanding and awareness of:

The mechanics of the act;

That there are health risks involved, particularly the acquisition of sexually transmitted and sexually transmissible infections;

That sex between a man and a woman may result in the woman becoming pregnant.'

CASE LAW REFERENCE

PH v A Local Authority, Z Ltd and R [2011] EWHC 1704 (Fam)

SUMMARY OF KEY ASPECTS OF THE JUDGEMENT

Capacity to make decisions about residence, care and treatment

The Court was asked to decide whether a man suffering from Huntingdon's Disease ('HD') had the capacity to make decisions about his residence, care and treatment. The matter came before the Court by way of an application under s.21A MCA 2005 challenging a standard authorisation made by the local authority permitting Z Limited to deprive PH of his liberty at a care home. PH's capacity was a contested issue and it was agreed that the question of capacity would be determined as a preliminary issue. A jointly-instructed consultant neuro-psychiatrist (a well-respected expert in HD) concluded that PH had the capacity to decide the question of residence. This view was accepted by the Official Solicitor and shared by P's former partner, R, with whom he had continued to live until he was placed at the care home, and to whom PH wished to return. However, the view was contrary to the conclusions of the medical professionals treating PH, and both the local authority and Z Limited sought to challenge the conclusions of the expert.

This judgement is of some considerable importance for the following reasons:

1. It endorsed the conclusion of Macur J in *LBL v RYJ* [2010] EWHC 2664 (Fam) that attention must be given to whether the person must comprehend the salient details relevant to the decision to be taken (i.e. not every detail);
2. it was emphasised that the courts must guard against imposing too high a test of capacity to decide issues such as residence because to do so would run the risk of discriminating against persons suffering from a mental disability;

3. for its careful analysis of the relevant weight to be placed upon the evidence of a jointly instructed expert versus treating professionals (including the dangers of a lack of objectivity on the part of the latter);
4. as an example of the practical difficulties that can be caused by the fact that it is likely in many cases that the jointly instructed expert will only have the opportunity to make one visit and undertake one interview with P, and will, inevitably, only be able to give a snapshot.

The court ultimately preferred the conclusions of the treating clinicians (rather than the independent expert) that PH lacked capacity to make decisions about residence.

CASE LAW REFERENCE

Local Authority v H [2012] EWHC 49 (COP)

SUMMARY OF KEY ASPECTS OF THE JUDGEMENT

Court of Protection judgement to protect the best interests of someone who lacked capacity to consent to sexual relationships

This Court of Protection judgement (Hedley J) concerns a 29-year-old woman H, who had diagnoses of mild learning difficulties and atypical autism (full scale IQ of 64).

The background to the proceedings was that H displayed highly sexualised behaviour and was very vulnerable. H engaged in sexual activity with multiple partners and had displayed a willingness to have sex with anyone, including strangers, who asked her. In 2003 a man had been convicted of her attempted rape. Matters came to a head when H moved in with a man and he drew the attention of the authorities to H's sexual activities.

H was assessed by a psychiatrist, admitted as an informal patient on the same day and was later compulsorily detained under s3 Mental Health Act 1983. Proceedings were issued in the Court of Protection.

Issues in respect of H's capacity to litigate, and to determine her residence and finances were uncontroversial. Hedley J concluded that H lacked capacity to consent to sexual relations and as a result H's care and living arrangements had to reflect this conclusion. Restrictions were significant, which brought with it an obligation on the local authority to be pro-active. There was a requirement for one-to-one supervision during the day and waking supervision overnight. This highly regulated regime clearly constitutes a deprivation of liberty and the restrictions were in place to prevent H from engaging in sexual relations. A DOLS standard authorisation under Schedule A1 to the Mental Capacity Act 2005 was in force.

CASE LAW REFERENCE

Sandwell MBC v RG (2013) EWHC 2373 (COP), (2013) MHLO 55

SUMMARY OF KEY ASPECTS OF THE JUDGEMENT

Forced marriages

The case concerned brothers – GG (39) and RG (38) from a Sikh family. Both had learning disabilities, low intelligence, and had exhibited challenging behaviour from an early age. Their father moved the family to England from the Punjab shortly after RG's birth, but retained property there and frequently returned to India for visits. RG's father later died of a sudden heart attack in England. Each brother had lived for some time in accommodation provided and staffed separately for each of them by the local authority.

There was a large measure of agreement about the declarations and orders required in the case of GG (namely that he lacked capacity in a number of respects).

In terms of RG, prior to his father's death RG's father and the family of a lame woman in her late-twenties had arranged a marriage between his son and their daughter, which took place in India in March 2009. The marriage was formally valid under local law. It appeared that the marriage was arranged because the two may otherwise have found it difficult to marry due to their respective mental and physical disabilities. Despite not being aware of RG's disabilities until the wedding itself, and reacting badly on discovering them as a result, the woman later admitted to caring about and falling in love with RG. She travelled to England herself in March 2010 following RG's earlier return to the country, and visited him regularly in the accommodation provided and staffed for him by the local authority.

The woman said, and the judge accepted, that the marriage was consummated on the night of the wedding, and she and RG had had sexual relations a few times following this. However, a consultant psychiatrist made it clear that RG had no understanding of sex whatsoever, and, accordingly, lacked the capacity to consent to sexual touching. The woman therefore accepted a condition of contact not to touch RG sexually or intimate to him that she desired sexual relations, at the risk of violating s 30 of the Sexual Offences Act 2003. The judge's final order included a declaration that RG lacked capacity to consent to sexual relations.

CASE LAW REFERENCE

Liverpool City Council v IM, LM & AB [2014] EWCA Civ 37

SUMMARY OF KEY ASPECTS OF THE JUDGEMENT

Test of capacity to consent to sexual relations is general and issue specific (rather than person or event specific):

The Court of Appeal considered the approach to assessment of capacity to consent to sexual relations. Sir Brian Leveson P held at paragraph 73:

‘For the avoidance of doubt, every single issue of capacity which falls to be determined under Part 1 of the Act must be evaluated by applying s 3(1) in full and considering each of the four elements of the decision making process that are set out at (a) to (d) in that sub-section. A person is unable to make a decision for himself if he is unable to undertake one or more of these four functions:

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

The extent to which, on the facts of any individual case, there is a need either for a sophisticated, or for a more straightforward, evaluation of any of these four elements will naturally vary from case to case and from topic to topic.’

Sir Brian Leveson P went on to hold at paragraph 79 that:

‘... we hold that the approach taken in the line of first instance decisions of Munby J, Mostyn J, Hedley J and Baker J in regarding the test for capacity to consent to sexual relationships as being general and issue specific, rather than person or event specific, represents the correct approach within the terms of the MCA 2005.’

CASE LAW REFERENCE

A Local Authority v TZ [2014] EWHC 973 (COP)

SUMMARY OF KEY ASPECTS OF THE JUDGEMENT

The test of sexual consent has a low threshold:

Baker J at paragraph 55 (in a case concerning same sex relationships):

'Most people faced with the decision whether or not to have sex do not embark on a process of weighing up complex, abstract or hypothetical information. I accept the submission on behalf of the Official Solicitor that the weighing up of the relevant information should be seen as a relatively straightforward decision balancing the risks of ill health (and possible pregnancy if the relations are heterosexual) with pleasure, sexual and emotional brought about by intimacy. There is a danger that the imposition of a higher standard for capacity may discriminate against people with a mental impairment.'

RESOURCES

My Marriage, My Choice. Provides some examples of questions to use with assessments

<https://www.nottingham.ac.uk/research/groups/mymarriagemychoice/guidelines-resources/index.aspx>

www.bild.org.uk – educational material to support adults to acquire capacity to consent to sexual relations and to learn to safeguard themselves

www.gov.uk/forced-marriage – information about forced marriage legislation and support

www.fpa.org.uk – factsheets and information about the law and sexual health (including Scotland and Northern Ireland)

www.39Essex.com – provides regular legal updates on case law relevant to mental capacity and deprivation of liberty cases

www.mentalhealthlaw.co.uk – summaries and updates regarding case law

REFERENCES

- ¹ Part IVA of the Family Law Act 1996.
- ² Consenting Adults? Guidance for professionals and carers when considering rights and risks in sexual relationships involving people with a mental disorder. Mental Welfare Commission for Scotland. 2011.
- ³ Sexual Offences (Scotland) Act 2009.
- ⁴ Mental Welfare Commission for Scotland (2011). *Consenting Adults? Guidance for professionals and carers when considering rights and risks in sexual relations involving people with a mental disorder.*
- ⁵ www.gov.uk/forced-marriage
- ⁶ Rook, P. & Ward, R. (2004). *Rook and Ward on Sexual Offences* (ed 3). Law and Practice.

Chapter 2

Guidance for clinicians supporting vulnerable people with sexual functioning

Sexual functioning is an essential part of human behaviour. Supporting people to achieve 'normal functioning' in this area forms a core part of clinical practice. This section presents a framework to assist clinicians when attempting to support vulnerable adults with safe engagement in sexual functioning. Within this context, we consider the assessment of capacity to consent to sexual relations in everyday clinical scenarios and the resulting actions clinicians may take to enable vulnerable people's safe sexual functioning.

Assessing consent to sexual relations in clinical practice

Assessment of capacity to consent to sexual relations is commonly required in the context of people with intellectual disabilities.

Similar issues arise, particularly in residential/ long-term support settings for people with acquired brain injury, dementia, or people with mental health needs. Often staff in residential and community settings are unsure about whether they can or should be facilitating vulnerable people to develop sexual relations. In these contexts, often the referral question involves broader issues regarding risk management and social functioning. Therefore, it is good clinical practice to conduct a

holistic assessment of the examinee's level of functioning (see Table 1 for a framework of the domains to include in the assessment, as advocated by Herbert and Palmer¹). Exploring the whole context of a referral enables the clinician to clarify the extent to which a particular referral question is one of capacity to consent to sexual relations or whether there are other more general risk management concerns driving the referral question.

A FRAMEWORK FOR THE ASSESSMENT

Herbert and Palmer's framework² places the individual at the heart of the assessment and considers first their personal narrative of relations, then their disability and how this might limit their decision-making ability. Within this context, their knowledge and experience of sexual relations is evaluated. Knowledge is required to meet the legal test for capacity to consent to sexual relations, and a review of a person's experience of sexual relations helps to highlight any possible areas for safeguarding concerns. The other areas of the framework

help the clinician to develop an understanding of the wider context for the person. This specifically includes the impact of family and staff attitudes and of the environment in which the individual lives, that is their home, their community and their opportunities for age appropriate sexual functioning. This is important because it encourages the development of a positive approach to building relationships and intimacy without a narrow focus on sexual relations.

Table 1: A framework for assessing capacity to consent to sexual relations

DOMAIN	ISSUES TO CONSIDER
Relationship narratives	<p>Understanding of emotional aspects of relationships and consideration of 'morality'</p> <p>Potential power imbalance, fear or obligation</p> <p>Coping skills</p>
Intellectual disability or other cognitive impairment	<p>Cognitive, emotional, physical deficits or impairments</p> <p>Decision-making skills</p> <p>Social cognition</p>
Knowledge	<p>Understanding of different body parts and genders</p> <p>Understanding of sexual relationships and different levels of intimacy</p> <p>Understanding of pregnancy and STDs</p> <p>Knowledge of contraception: when and how [note: this is not part of the legal test]</p>
Asserting choice	<p>Ability to use staff in a positive way (asking for help, or asking for private time)</p> <p>Understanding that they have a choice whether to participate in the relationship</p> <p>How to say no and the ability to say no/assert own choice in the moment</p> <p>Knows what to do if the other person says no</p>
Organisation and family	<p>Family context</p> <p>Type of service, policies of service, staff attitudes/beliefs</p> <p>Opportunities to meet other people socially</p>
Environmental	<p>Opportunities to meet people (access)</p> <p>Suitable places to spend time together</p>

RELATIONSHIP NARRATIVE

Before starting an assessment of a person's capacity to consent to sexual relations it is necessary to establish the minimum level of knowledge that the person needs to understand. As detailed in Part 1, case law has specified that the level of knowledge has to be 'reasonable', and not require of the individual more knowledge than would be expected from someone who does not have a disorder of mind and is considered capable of consenting to a sexual relation (e.g. in UK law an adult aged over 16).

Therefore, it is relevant to consider the person's sex education and/or history of relationships, as this can assist in understanding their knowledge base and previous experience. It is important to gain a broader understanding of different types of relationships such as close friendships and boundaries in relationships, as well as how they manage the end of

relationships (e.g. heartbreak). This part of the framework can also be used to explore any history of abusive or exploitative relationships/situations to aid the risk management of any safeguarding issues that might be identified throughout the assessment process.

Much of this work can be done through clinical interview, but there are also some specific tools developed to assist, particularly for those with intellectual disabilities. For example, the Test of Interpersonal Competence and Personal Vulnerability (TICPV)³ uses a multiple-choice format to respond to examples of situations in which individuals may be abused/exploited, and this can assist in understanding the examinee's level of knowledge and understanding. Dodd et al.⁴ have produced an illustrated guide to exploring sexual and social understanding focusing on working with people with learning disabilities.

INTELLECTUAL DISABILITY/COGNITIVE IMPAIRMENT

It is helpful to structure any assessment of the impact of cognitive impairment on decision-making around the four functional tests as set out in the Mental Capacity Act, taking into consideration the information from case law discussed previously;

The ability to understand information relevant to the decision; (as detailed above and defined in case law)

To retain it long enough to make a decision;

To evaluate and weigh up the information; and

To communicate the decision.

UNDERSTANDING INFORMATION

For adults living with acquired brain injury or dementia, unless the cognitive impairment is very severe, it is rare that the acquired cognitive impairment would affect their ability to understand knowledge about sexual functioning learnt before the impairment. However, this is why it is essential to assess prior experience and retained knowledge about sexual functioning, as knowledge

will vary according to previous experiences. Most people with prior experience of sexual relationships will easily meet the legal test outlined in Chapter 1. However, people who acquired their brain injury in childhood and/or people with intellectual disability whose life experiences may have been more restricted, often have more limited sexual knowledge, and less access to sex education, and

therefore may not meet the legal test outlined in Chapter 1. The MCA requires support to be given to enhance understanding and there

are various materials available to assist (see the facts below and Chapter 4 for further information).

RETENTION

The ability to retain information long enough to make a decision is one that in complex assessments is usually addressed through re-visiting the key issues over time and in different formats to ensure that the individual concerned has had the best opportunity to take in the relevant information and evaluate it. It is important to separate out an assessment of capacity from welfare concerns or decisions. If a person is found to lack capacity to

consent to sexual relations then this decision cannot be made on their behalf, but there may be other welfare concerns or decisions which may need to be considered within a best interest framework, and will probably need to be taken by the court; it is helpful if clinicians can outline the relevant underlying cognitive deficits that may have an impact on an individual.

EVALUATING INFORMATION

The ability to use and weigh the relevant information is the hardest area to assess. It is important that this has been shown particularly in assessments of people with acquired brain injury and dementia where executive dysfunction has resulted in subtle but complex difficulties in decision-making and is also highly relevant to individuals with learning disability. Executive functions allow people to:

Initiate and sustain behaviour;

Formulate, monitor and modify goals/plans (problem solving);

Regulate our behaviour and our emotions.

When executive functions are compromised this has a direct impact on a person's ability to evaluate information. This includes information about:

other people's motives and intentions,

what constitutes a risky situation,

the consequence of a particular action,

the options in terms of responding/choosing not to respond.

All of which is relevant to choices that might be made in relation to relationships, including sexual relations.

The extent to which these issues can be assessed using standardised neuropsychological tests is limited. Standardised tests of executive dysfunction may assist in demonstrating the presence of limitations in these aspects of reasoning, but ultimately the assessment of reasoning in relation to the specific capacity question has to be carried out through interview and consideration of relevant history.

Assessing how a person uses and weighs information is the area in which it is easiest to conflate welfare concerns and a lack of capacity (e.g. by concluding that because a person is going to make a risky decision they must lack capacity). A person's individual decision may challenge our assumptions about the decisions made by capacitous adults around sexual relations. Ultimately it is vital to separate the capacity assessment from a welfare decision.

COMMUNICATION

Assessment of communication skills should include written, verbal, signing and/or pictorial means. Within the field of intellectual disability there are those who have good expressive language but whose understanding of the words they are using is more limited, which requires careful evaluation. Within the field of acquired and neurodegenerative brain injury, there are also examples where an examinee may not be able to communicate successfully by any means, for example, if they present with very severe receptive and expressive aphasia or are in a low awareness state. With more severely

impaired individuals, including those in the more advanced stages of dementia, there may be a level of confusion and disorientation in time, person, and place that renders any communication meaningless, as it is not based on any reasoning or evaluation. These cases are rare in terms of referrals within everyday clinical practice, but they do occur, particularly if the individual concerned remains physically unaffected and is, therefore, able to engage in sexual activities.

KNOWLEDGE

This is the area that most closely maps between the definition within the Mental Capacity Act (2005) and the Sexual Offences Act (2003). At the most basic level, an assessment of sexual functioning knowledge should include:

knowledge of body parts,

the mechanics of the act of sexual intercourse,

of pregnancy (unless age or sexual orientation means this is not relevant), and

of sexually transmitted diseases that pose a significant risk to health.

This is rarely the main area of concern with adults with acquired brain injury or with dementia, as in general, this is previously learnt knowledge that is retained. However, Murphy

and O'Callaghan⁵ found that about half of the people with intellectual disability involved in one research project would have been unable to consent to sexual relations because they did not understand about pregnancy and/or sexually transmitted infections. Therefore, for people with intellectual disabilities there are several specific questionnaires and useful resources available that can assist in a structured approach to the assessment of knowledge, for example, McCabe's Sexuality, Knowledge, Experience and Needs Scale for People with Intellectual Disabilities (SEX KEN ID)⁶. This is also the area where there is scope for intervention to enhance knowledge and capacity through appropriate sex education and there are a range of resources designed for particular client groups, for example, sex education packages for people with intellectual disabilities⁷ and/or autism⁸, and sexual knowledge tests.

ASSERTING CHOICE

The more recent cases acknowledge that the ability to refuse is a key element in consent to sexual relations, and within this is the ability to assert a choice. Both criminal and civil law is concerned with protecting those who, for whatever reason, are not able to make a choice or whose choices are vulnerable to coercion or exploitation.

There are particular issues about acquiescence and suggestibility for people with learning disabilities, which have previously been recognised in the legal system. There have been changes in the approach within the court system to reduce the impact of these factors for individuals as witnesses, defendants, and victims. The Gudjonsson Suggestibility Scale (GSS)⁹ can be a helpful measure when this is a concern. However White & Willner¹⁰ found that people with learning disabilities were much less suggestible for actual events that they had recently witnessed. They conclude ‘the results suggest that the GSS is likely to over-estimate how suggestible a person is likely to be when the event in question is personally significant’ (p.649).

ORGANISATIONS AND FAMILY

Consent to sexual relations is, for most adults, a private decision that does not require a formal test or involvement from others. However, for those who have grown up with an intellectual impairment their family members or staff teams can be more closely involved in many aspects of their lives and are concerned for their wellbeing. Similarly, organisations which provide services for people with acquired cognitive impairment have to operate within legal frameworks and provide personal care and support, which may include support in relationships.

For both family members and staff, sexual relations can be a difficult conversation to have and there are many misconceptions and mistaken beliefs about who has the right to take certain decisions. Parents and relatives,

When assessing a particular situation where the aim is to maximise the individual’s freedom to express their sexual desires, it is relevant to explore the extent to which the individuals concerned understand that they have a choice as to whether to participate in the relationship, and how they can say no and/or assert their own choice. Exploring their understanding of what to do if the other person says no is equally relevant. Additional factors to consider are whether a person can use staff or carers in a positive way, for example, asking for help to talk through concerns, or asking for private time to be facilitated.

Concerns may arise if there is a perceived imbalance in power within the relationship, for example, if one individual is physically more frail or a subservient partner. Another warning sign is if there is evidence of inducements, for example, cigarettes, gifts or money. If one partner always gives tangible inducements to the other then there is a far greater risk of the relationship being abusive¹¹.

in general, are often driven by a genuine belief about what is right for the person they love and who they know so well. Staff may also have worked with an individual for a long period and have a perspective on what that person has expressed or desired in terms of relationships. In both cases, family and staff are also individuals with their own values, attitudes, and beliefs about sexual relations. It is important, if possible, to help them understand how their own values, attitudes, and beliefs have an impact on what they convey to the individual with a learning disability or cognitive impairment about what is/is not acceptable. For family members, the legal framework for adults needs to be explained, and, where possible, opportunities provided to explore how this differs from the parental responsibilities they had when their relative was a child

(i.e. they have no legal right to make decisions for their child once they become an adult).

Staff training is crucial in helping to explain how attitudes towards relationships in general and sexuality in particular should not be based on assumptions about physical or mental disability, sex or age. There must be an opportunity for these issues to be explored with staff in a 'safe' setting.

The opportunities and priority given to staff training in relation to sexual relationships and facilitating personal relations in the widest sense will be dependent on the ethos

of the individual service providing support or care. Individuals may have limited choices of activities or opportunities that encourage relationships to develop. Whilst there are areas of good practice, for many services this remains an area that is not actively addressed and services supporting people with disabilities are often cautious about their engagement in this area and may be risk averse. Where sexual behaviour is observed, the specific questions about an individual's capacity to consent to sexual relations may be perceived as difficult or problematic because they challenge a service, rather than because of issues for the individuals concerned.

ENVIRONMENTAL

The final area to consider is that of opportunity in its widest sense, and challenges services and families to consider equal access. There are many people with a wide range of disabilities who successfully form relationships and do not require any assistance from others in order to do so. However, in spite of legislation ensuring reasonable access to community facilities (Equality Act 2010), the barriers to meeting people are greater if you depend on others for mobility, practical arrangements, or for all your social interactions. Depending on the level of support required by an individual, it can be the case that all meaningful activities are organised by staff, and this limits the range of opportunities available.

For those who want to spend time together, the next challenge is to identify suitable places to meet, access to places or the opportunity for private time, and again, if this needs to be organised by their carers, then this is an additional challenge that is not faced by those without support needs. Models of service delivery do not always facilitate this and anxieties about what is legally permitted within the care role can result in unnecessarily restrictive practice.

Case example

The following case example illustrates how this assessment framework was utilised to assess the needs of two people living in a residential unit who had entered into a sexual relationship with one another.

Two adults, a woman aged 40 (Ms F) and a man aged 35 (Mr G), meet in a brain injury longer-term residential unit and develop a relationship

Care staff observe the couple spend time together and begin to hold hands and kiss, they tell staff that they are boyfriend and girlfriend and would like some private time alone.

The assessment framework outlined above was used to clarify the areas of concern for each of them and to support them appropriately (see Diagram 1 and 2, p.31, for illustration of the assessment outcome).

Ms F had sustained a brain injury in her late 20s and since that time had required a high level of support and care for her day-to-day needs. Prior to her injury, she had a number of short-term relationships but had always talked of settling down and having a family. Since her injury, she had sought relationships with men within the residential settings in which she was placed, and would refer to herself as 'married' to the particular man she was involved with at that time (see Diagram 1: Ms F).

There was less information available about Mr G's sexual history prior to his stroke (eight years previously). He had not been married or in a long-term relationship and his family described him as a private person and they had not discussed personal relationships (see Diagram 2: Mr G).

Following Mr G's stroke, amongst other cognitive impairments, he had a moderate degree of expressive and receptive aphasia, meaning that his ability to comprehend and express himself using language was affected. He required additional time and structured discussions over a longer period of time to elicit a consistent understanding of his views and wishes but he could demonstrate some of his emotions and feelings through his actions. At times, he would appear bored or uninterested during interactions with Ms F (i.e. withdraw from interacting with her), but at other times he would actively seek out her company (see Diagram 2: Mr G).

The residential care setting provided multiple opportunities to observe the couple together in shared areas. For the most part, they were observed to be very caring of each other. Their interactions were usually appropriate in shared areas such as the dining room or lounges, but there were some occasions when other residents commented on them kissing when others were present. There was a policy of people not going into each other's rooms and this did raise the issue of their access to private space/time.

The psychologist interviewed the couple together and each of them separately about their relationship.

The assessment revealed that:

- a. Both had the knowledge from pre-injury experiences required to demonstrate that they fulfilled the requirements of the test for capacity to consent to sexual relationships.
- b. Both were also able to express what they wanted in terms of physical contact, for example, kissing and cuddling and oral sex were acceptable but both expressed distaste at the idea of full intercourse.
- c. What neither party was easily able to do was to set up 'private time' or to judge the appropriateness of their conduct in shared areas.

Action following assessment – a care plan was established in which staff had to prompt them not to engage in kissing in the main lounge or dining area, and redirected them to a smaller private lounge. There was no expression of desire by either Ms F or Mr G to progress their level of intimacy or sexual activity. However, as with all relationships, situations can evolve over time, and it was agreed that the care plan should be reviewed weekly and revised to address any changes or developments in the couple's relationship.

This case example illustrates how using the framework to complete a holistic assessment established that the couple had the capacity to consent to sexual relations but their level of cognitive impairment and the environment they lived in meant they could not organise themselves to engage in their relationship in accordance with societal norms. If both of the people involved have the knowledge outlined in the Mental Capacity Act, and are therefore capable of consenting to the relationship, then the issues that remain to be resolved are often related to managing their safety in the relationship and facilitating communication between them.

DIAGRAM 1: MS F

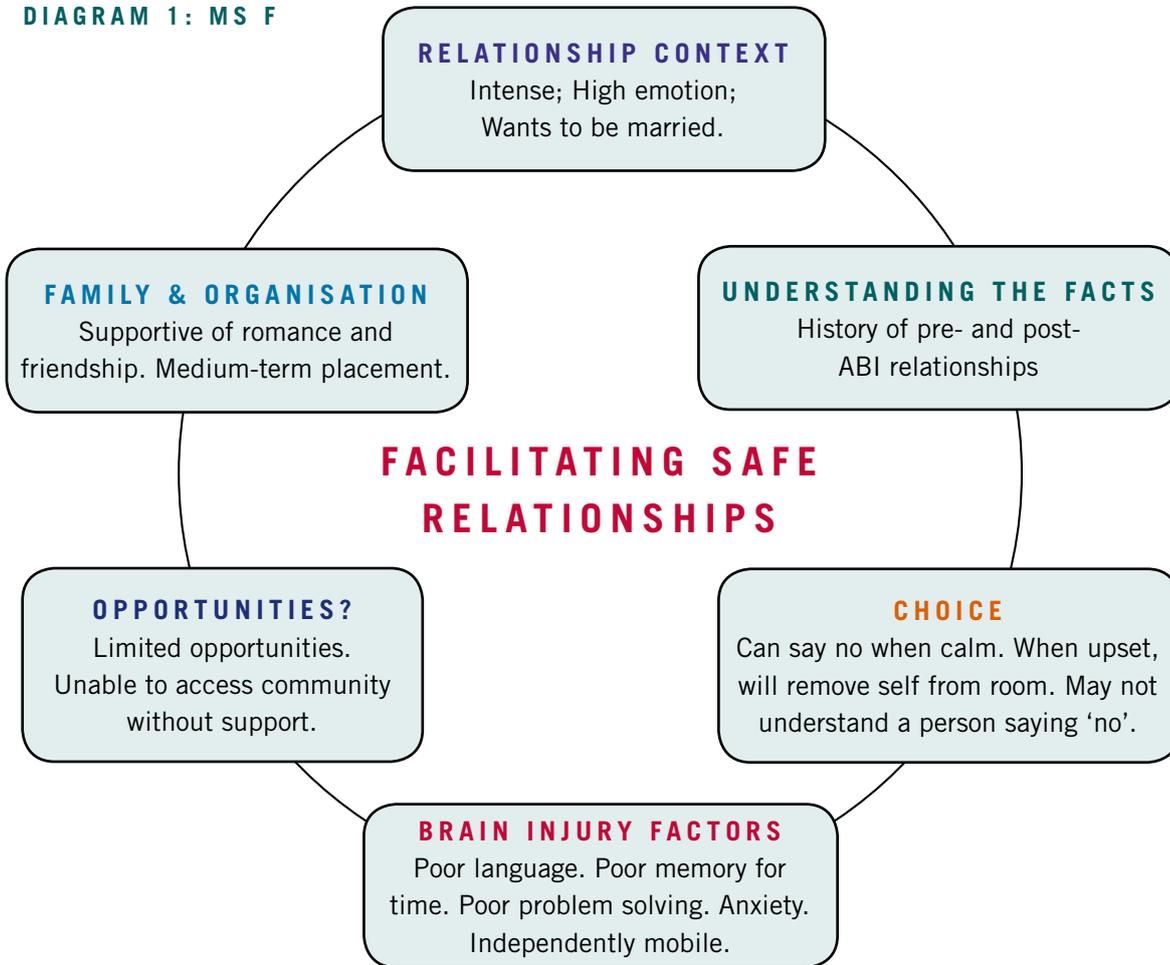
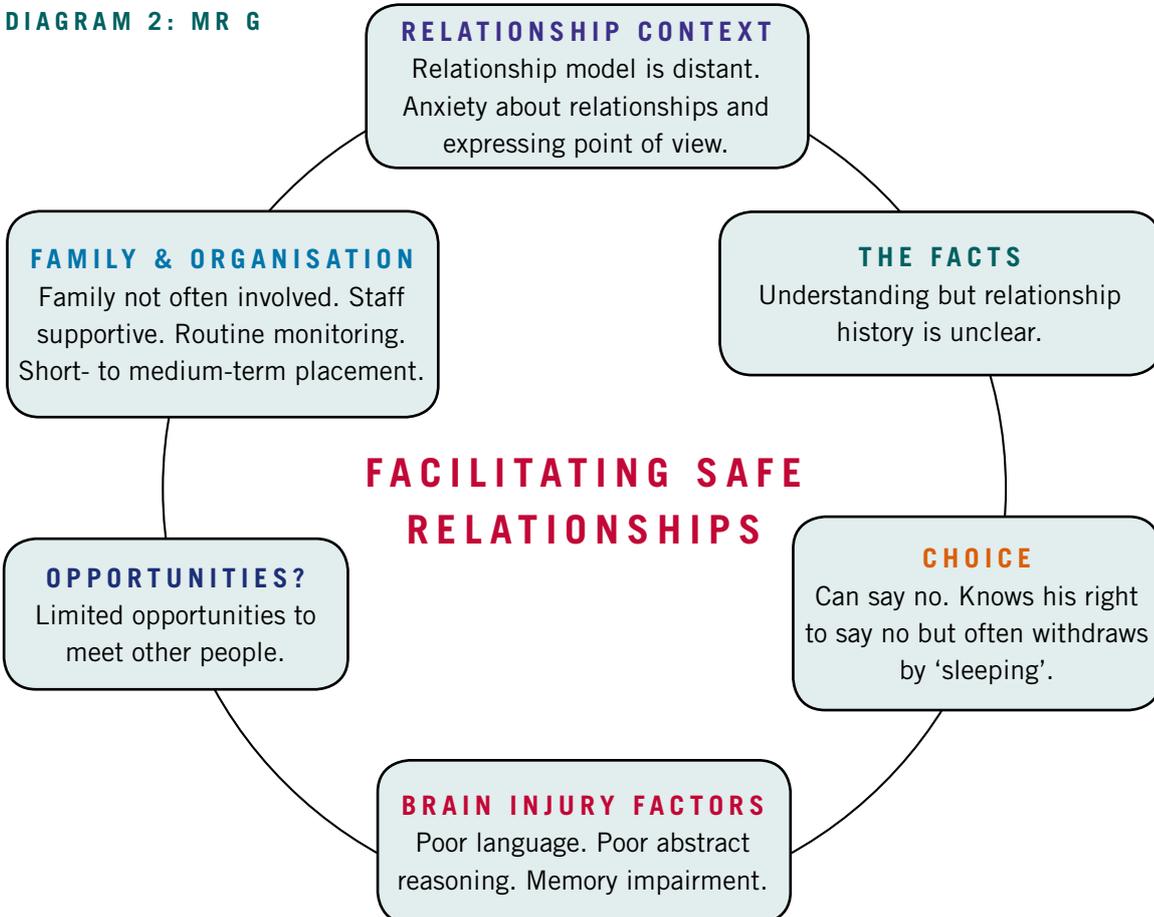


DIAGRAM 2: MR G



In practice, the Court of Protection will often sanction restrictions deemed necessary to prevent serious harm to the person as in his or her best interests. In Chapter 3, the assessment and management of such risks is explored in more detail. Where the person has capacity to consent to sexual relations, but lacks capacity in other areas of decision-making (e.g. contraception due to executive dysfunction), there is a need to focus on facilitating healthy and safe sexual relationships within the care plan but without undue restriction of the person's right to sexual relations. If a person has capacity to consent to sex but lacks capacity to make a decision about birth control, the court may make a best interest decision about contraceptive options. The need to enhance or facilitate intimacy for people as a fundamental right can be problematic within services, particularly where

staff or family members are in conflict about an individual's capacity to make these decisions and/or what they perceive as appropriate or risky for the individual. Assessments in these contexts can benefit from consideration of a wider range of issues than is required under the law in relation to sexual consent. This includes understanding of relationships in a broader sense as well as the attitudes and values of those supporting the individual(s) and the environment in which these decisions are being implemented. The framework described in this section helps clinicians ensure that a holistic assessment is conducted, which weighs all of the relevant factors in the balance to ensure that an individual's sexual functioning is not unduly restricted. Such assessments are essential to assist the development of adequate risk management plans and to give due weight to safeguarding vulnerable adults.

Summary

The assessment of capacity to consent to sexual relations in clinical practice is a sensitive topic, as it touches on one of the core facets of being human. The need for intimacy is an essential part of most people's lives and one that is not always adequately addressed for those in need of support to manage their day-to-day lives.

In clinical practice, when a person is suspected to lack capacity to consent, and sexual relations have occurred, in the first instance this falls within the jurisdiction of criminal law (Sexual Offences Act, 2003), and the police will need to conduct the investigation. The test of consent as defined by the criminal law

in Chapter 1 would apply here and the ability to make a choice free from coercion will be paramount in the police investigation. In the event that a crime has not been committed but the person who lacks capacity to consent to sexual relations is vulnerable to exploitative or abusive relationships then safeguarding duties would arise (i.e. the Care Act, 2014). This may mean steps would have to be taken to protect the person, which may amount to a deprivation of liberty and therefore the care plan would require sanctioning via the Court of Protection or a standard authorisation would need to be applied for if the person is in a registered care home or hospital.

RESOURCES

British Psychological Society (2019). *Mental Capacity: What makes a good assessment?* Leicester: Author.

*The last taboo: A guide to dementia, sexuality, intimacy and sexual behaviour in care homes*¹² – includes case examples, short questionnaires, and quizzes that help staff to understand and discuss relevant issues.

Simpson, G. (2003). *You and me: A guide to sex and sexuality after traumatic brain injury* (2nd edn). South Western Sydney Area Health Service. Available from: Brain Injury Rehabilitation Unit, Liverpool Health Service, Locked Bag 7103, Liverpool BC 1871, NSW Australia. <http://www.sswahs.nsw.gov.au/liverpool/biru/>

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CHAPTER 3

Chapter 3 Risk assessment and management

This chapter will consider some of the risks that may be encountered following the assessment of an individual's capacity to consent to sexual relations. This is done using frequently asked questions and case examples to illustrate some of the issues that can arise in clinical practice.

Outline

There are four possible outcomes of an assessment of capacity to consent to sexual relations:

1. The person has capacity (but there may be a need to manage the risks around unwise decisions).
2. The individual has the capacity to consent to the relationship in question, but may lack capacity to make decisions in other areas that restrict their ability to participate in a sexual relationship.
3. The individual may need support to gain the required knowledge and consider relevant issues.
4. The individual lacks the capacity to consent to sexual relations.

Each of these outcomes carries with it potential risks and uncertainties regarding how the individual's sexual functioning should be managed appropriately and proportionately in everyday life. This chapter will consider some of these risks, using frequently asked questions and case examples to illustrate some of the issues that can arise in clinical practice.

Risk of harm

The Safeguarding of Vulnerable Adults (SOVA) legislation (originally established as part of the Care Standards Act 2000 and then superseded by the Care Act 2014) and the development of local Adult Safeguarding Boards provides a legal framework within which the risks associated with supporting vulnerable people to engage in sexual functioning can be assessed and managed.

Many adults have the capacity to make decisions (including 'unwise' ones) but may still be vulnerable to harm. Conversely, identifying that an individual lacks capacity to make a decision does not automatically mean that she or he is a vulnerable adult.

Within organisations or specific care settings, there may need to be consideration of the impact of a sexual relationship between two service users on other residents, balancing privacy and dignity for all concerned.

For some individuals (particularly those with severe cognitive impairments and/or challenging behaviour, including sexual disinhibition and reduced insight into the impact of their behaviour on others), there may be agreement regarding their mental capacity but disagreement on the management approach to minimising the harmful impact of their behaviour (for them and for others).

Assessing and managing risk (case examples)

Below are some case examples in which complex risk management issues related to sexual functioning have arisen in clinical practice and case law.

Each case details a brief summary of how the MCA (2005), and safeguarding legislation has been used to empower capacitous individuals to participate in sexual relations, while also keeping individuals safe through a reasonable intervention in relation to areas in which they are not capacitous. The case examples are organised into the three potential outcomes from an assessment of capacity to consent to a sexual relation where the individual lacks capacity to some extent.

1. The individual has the capacity to consent to the relationship in question; but may lack capacity to make decisions in other areas that restrict their ability to participate in a sexual relationship.

1a Safeguarding a 39-year-old lady (MM) who had a moderate learning disability and paranoid schizophrenia (Local Authority X v MM and KM, 2007)¹

There were concerns with regard to her long-term relationship with her partner of 15 years (KM), who had been diagnosed with psychopathic personality disorder and alcohol misuse. He had been violent towards her, allegedly used her money for alcohol, and encouraged her disengagement from psychiatric services.

MM's capacity to make numerous decisions were before the court. These included her capacity to decide where and with whom to live, with whom she should have contact, her capacity to litigate, her capacity to manage her financial affairs, and her capacity to enter into a marriage contract.

It was acknowledged that MM had capacity to consent to sexual relationships. The court found that she lacked capacity in all of these decisions except for sexual relations, and as a result made best interest decisions related to residence and contact. The Official Solicitor acted as her litigation friend because she lacked capacity to litigate. The court ordered that a care plan should be drawn up in support of facilitating MM's contact and sexual relationship with KM (this had some practical complexities given KM's abusive behaviour towards professionals and at times being under the influence of alcohol).

Without this care plan, it was argued that the care regime would be a disproportionate interference with her right to a private and family life and would have resulted in a breach of her Article 8 Human Rights.

1b Safeguarding a 20-year-old man with acquired brain injury and capacity to consent to sex, but vulnerable to exploitation due to executive dysfunction:

Mr AA, a young man living with family members in the community after a traumatic brain injury (TBI), states he wishes to pursue casual sexual relationships and/or form a new partner relationship.

Mr AA expressed to his support worker that he feels sexually frustrated, and wants to be able to 'go out and meet girls'. His support worker shared this information with his psychologist due to concerns about Mr AA being vulnerable.

The assessment framework outlined in Chapter 2 was used to clarify the areas of concern for Mr AA and to support him appropriately.

Mr AA had sustained a brain injury in his early twenties and since that time had required a high level of support and care for his day-to-day needs, including having a paid support worker five days per week with family support at all times at weekends. He had input from a multi-disciplinary team of therapists funded by a personal injury claim.

Prior to his injury, he described himself as 'very successful with women' and he had a number of relationships as well as a number of casual sexual partners who he saw regularly. He reported that he had not always practiced safe sex. After his injury, Mr AA reported he had 'grown up' and wanted to meet and settle down with a single partner.

Following Mr AA's brain injury, amongst other cognitive impairments, he had significant memory problems that meant he could struggle to reliably recall information provided to him. He also had significant executive difficulties, tending to be disinhibited in his disclosure of personal information, poor at regulating personal space with familiar and unfamiliar people, and freely sharing his thoughts and beliefs in public spaces without regard to the risk of offending others.

The therapy team working with Mr AA were concerned that his executive functioning problems might make him vulnerable to making risky or unwise decisions in relationships, and that this might make him vulnerable to financial exploitation by people who might seek to form relationships with him in order to obtain financial or material benefits. The psychologist was concerned that those around him might unduly restrict Mr AA from engaging in relationships in an effort to protect him from these risks.

The psychologist working with Mr AA interviewed him and his support worker about his views on relationships and understanding of sex.

The assessment revealed that:

- a. Mr AA had the knowledge from his pre-injury experiences to demonstrate capacity to consent to sexual relations.
- b. He was able to clearly express what sexual activities he would like to participate in, and what the risks of different sexual activities were. For example, he understood that penetrative vaginal intercourse carried risks of pregnancy and sexually transmitted infections. He understood that the risks of these could be minimised but not eliminated by use of condoms. He understood that both partners had the right to say no to any sexual activities at any time.
- c. What he found difficult to understand was that a person might seek to form a relationship with him (including a sexual relationship) in order to abuse or manipulate him in some way. He did understand that others were concerned about this risk and expressed his frustration that this worry might prevent him from having what he called 'a normal life as a young man'.

Actions following assessment:

- a. The psychologist agreed with Mr AA that it would be helpful to have a conversation together with his mother about his wish to have women visit him at home when she was not there.
- b. Mr AA agreed that his mother would be less worried about this if his support worker was in the house, but in a separate area. He agreed his mother would be less worried about the risk of women seeking to 'take advantage of him' if he was open with those around him about the kind of conversations he was having with women. He agreed that because of his memory problems, it would help reduce other people's worries if he was willing to show his support worker his WhatsApp messages on a regular basis.
- c. Mr AA agreed it would be sensible to have a supply of condoms in the house, as he would be more likely to use them if they were readily available to him at the relevant point in time. He agreed it would be sensible to have a sexual health check and get more information about risks, and his support worker arranged for them to do this together.
- d. The psychologist worked with Mr AA, his family and team to establish times in the week when he could invite women over to his home, and what support he needed from his support worker during these times.
- e. It was agreed that the level of support needed would be regularly reviewed, with Mr AA keen to reduce this over time.

2. The individual may need support to gain the required knowledge and consider relevant issues.

2a Enhancing capacity to say 'no' to sex

Ms NK, a 23-year-old woman with a brain injury is acting in a sexually impulsive manner in the community. She chats up men in local bars and goes home and has sex with them at their houses.

It is important to note that there are people over the age of consent who may choose to behave in this way, and may be vulnerable to emotional abuse, financial exploitation, or the risks of pregnancy/STDs. Such decision-making might be viewed as unwise but is generally considered capacitous.

In this case, the objective of the assessment was to identify to what extent her choices were based on beliefs and values from before her injury versus a lack of insight into her dysexecutive behaviours. In particular, it was noteworthy that she did not demonstrate any regrets or distress after the events, but was also clearly unable to refrain from impulsive decision-making in the event due to dysexecutive behaviours.

She was found to have capacity to consent to sexual relations and the following was advised as part of the care plan:

- a. If risky situations suggestive of an offence under the Sexual Offences Act arose, support workers would report them to the police and safeguarding team.
- b. There needed to be a much fuller risk assessment of the situation and how to support this woman to compensate for her executive dysfunction in order to minimise harm to self or others from her sexual relationships.
- c. Safeguarding legislation (in accordance with the Care Act 2014) should be utilised to help devise a risk management plan involving all stakeholders.

The outcome of the holistic assessment indicated there were issues around her cognitive ability to make decisions (she tended to act impulsively), furthermore, she had limited experience of relationships, and how to move from flirting behaviour to building a relationship.

She actively wanted advice regarding possible exit strategies when she found herself in a difficult situation, and she benefited from role-playing or prompting to help her act on previously discussed alternative plans. Regular reviews of these strategies were built into her care plan for support workers to practice with her. Over time, observation indicated that she was able to utilise the skills in novel situations without prompting.

2b Educating about the law in relation to prostitution

A 32-year-old man with acquired brain injury living in a shared supported living home in the community organised for a sex worker to a visit his home.

Mr EP suffered a brain injury in a road traffic accident five years previously, he was able to ring up a sex worker and organise a visit to his home himself. Assessment indicated he clearly had the capacity to consent to sexual relations.

However, it was unclear initially whether he understood fully the law in relation to sex with trafficked or coerced workers (i.e. in England, Wales, and Scotland the exchange of sexual services for money is legal but it is illegal to have sex with trafficked or coerced sex workers).

In addition to the potential criminal offence, there were a number of other areas of vulnerability or risk to be considered. For example, Mr EP was living in a shared community house with staff support. Mr EP had not considered the impact of his choice to use a sex worker in his home on the other residents who were co-tenants in his accommodation, and the issue of their's as well as his privacy and dignity had not been thought through.

It was also unclear whether he was considering 'safe sex' precautions or the broader implications/risks of inviting a sex worker into his home.

Staff who supported the four residents in the home were concerned about their position and whether they had committed an offence or put the other service users at risk. It is a crime to aid the delivery of sex services (e.g. soliciting, owning or managing a brothel, pimping or pandering). If a carer knowingly aids a client to access sex services, they are liable to prosecution under criminal law.

Through discussion with Mr EP and collaborative evaluation of the risk assessment, it was possible to identify a management plan that enabled Mr EP to organise for 'private' time in a way that did not involve staff or place the other residents in a position that compromised their rights.

After education and support was provided by the psychologist, Mr EP was able to understand the law in relation to trafficked/coerced sex workers and agreed to a management plan that prevented him or staff breaking the law. This involved relocating Mr EP to a flat with warden-controlled housing and a self-contained entrance so he could have guests enter and exit without staff knowledge. Mr EP advised staff when he was planning to have 'private time' and staff vacated his premises during the agreed period. Provision of an emergency alarm that alerted a call centre if pressed was provided in case of emergency during these periods. Mr EP was taught how to use this through role-play of various scenarios. Mr EP agreed not to leave any valuables on display in his property during visits from sex workers and bought a concealed safe to house his valuables.

2c Supporting the sexual partner to consider relevant issues

The wife of a male resident in a facility for people with dementia wants to visit and have ‘private time’ with the male resident (her husband).

The referrer queried ‘does capacity to consent need to be assessed in this situation because they have been married for 30 years?’. The referrer was advised that the timescales of the marriage or relationship are not relevant in terms of current capacity to consent to sexual relations. In other words, it doesn’t matter how long someone has been in a sexual relationship, the issue of capacity to consent would always apply if there is a disorder of mind that brings into question their capacity to consent.

In this scenario there was consensus that the individual concerned had the knowledge and understanding of the sexual act to satisfy the definition in case law, but there was a question mark over the male resident’s ability to choose/refuse, depending on the stage of the progression of his illness.

Through working with the wife, the psychologist identified behaviours initiated by the husband in foreplay that were identified to indicate an active choice by her husband to engage in sex. When these behaviours did not occur spontaneously it was taken to indicate that her husband was communicating a desire not to have sex at that moment.

Regular reviews of his capacity to consent were built into his care plan. Education about the law regarding capacity to consent to sexual relations was provided to the wife, and emotional support from psychology was provided to help her adjust to the change in her intimate relationship with her husband.

A useful resource here was: *The last taboo: A guide to dementia, sexuality, intimacy and sexual behaviour in care homes*.

3. The individual lacks the capacity to consent to a sexual relation

3a Care plan to restrict opportunity to have sexual relations approved by the Court of Protection (COP) under DoLS²

A 29-year-old woman with a diagnosis of mild learning disability and atypical autism (see *Restricting Contact (re H)*, 2011). She had a ‘very early and a very deep degree of sexualisation’.

Ms H had been known to social services extensively throughout her life (as a child and adult). She was noted to be highly vulnerable and had been the victim of sexual offences.

She came to the attention of the local authority (which resulted in the court application) due to very serious concerns raised in relation to her sexual activities (sex with strangers, group sex, attempting sex with a dog).

Following a hospital admission, Ms H moved to accommodation where she was supervised on a one-to-one basis at all times both in and out of the house. She was not free to leave. She had activities to engage in (and two jobs) but did not do any of these without one-to-one supervision.

The court found that she lacked capacity to consent to sexual relations. It was noted that this regime constituted a deprivation of her liberty (a DoLS authorisation was in place) and that the purpose of the restrictions was to prevent her from engaging in sexual activities (given that she lacked capacity and they would be harmful to her).

3b Care home implement restricted contact to prevent engagement in sexual relations between two residents

A 73-year-old male resident wants to have a sexual relationship with a female resident who is not his wife. His wife, who lives separately, is distressed by this and wants staff to prevent the relationship occurring.

The man was found to have adequate premorbid knowledge and understanding of the sexual act, and to be capable of making a choice about an extramarital relationship. However, it doesn't matter if he wants to have an extramarital affair or not – the same questions about his capacity to consent to sexual relations apply. The chosen partner's capacity still has to be assessed too.

A more detailed assessment of his relationship history and what was important to him was recommended to help establish whether this belief system was secondary to dementia or a premorbid belief system.

This revealed that he had previously been a person who had particular views about marital fidelity and his current behaviour was not in keeping with his previously expressed views.

His cognitive state had declined on formal testing and it was noted via observation that he had difficulty recognising individuals or relationship boundaries.

He was deemed to lack the mental capacity to make this decision for himself. The service established risk management plans to protect both residents from engaging in sexual relations. This involved some restrictions that required registration with the local authority as a Deprivation of Liberty Safeguard (DoLS).

3c Management of sexual disinhibition in a client with dementia

Mr CB is a care home resident who has lost the ability to discriminate between his wife and other females, and is actively seeking sexual contact indiscriminately with any female resident or staff.

The capacity to consent to sexual relations was found to be severely compromised, as Mr CB was in the more advanced stages of dementia.

His challenging behaviour of a sexualised form was found to arise due to impaired understanding of choice. He was assessed as lacking capacity to consent to sexual relations.

Mr CB had previous sexual experience of relationships prior to his dementia, and retained a sense of his 'rights' and entitlements, without the awareness of his current condition, which caused additional conflict in terms of managing the situation.

Interventions need to be proportionate to the likelihood and seriousness of the risk. A full risk assessment including a more holistic view of Mr CB's relationship narrative from before his impairment and his current cognitive profile helped identify the management approaches. This included one-to-one distant supervision while in communal areas where he had access to female residents. Male carers for personal care tasks, if possible, or two to one during all care tasks if staff were female.

The guidelines on how to respond was sufficiently restrictive to seek a deprivation of liberty authorisation via his local authority, and this was approved by the DoLS assessor.

The person-centred behaviour management approach was found to be successful at eliminating the sexually disinhibited behaviour. Pharmacological approaches were also considered and although no drug is licensed in the UK for the treatment of sexual disinhibition a referral was made to a consultant neuropsychiatrist who prescribed a medication where reduction in libido is a side effect. This had good effect.

Summary

Situations involving sexual relations and capacity can raise complex ethical and legal issues and are also affected by the personal beliefs and values of staff, family members, and the individual's wider community. Each situation must be assessed on a case-by-case basis and in an environment that facilitates shared and non-judgemental discussion. The question of capacity to make the decision to engage in sexual relations is an important one, but it is rarely the only question to be discussed. Supporting people to maintain or develop relationships in a safe manner requires a greater emphasis on the systematic exploration of sex and relationships within our care planning and risk management approaches.

RESOURCES

Fanstone, C. & Andrews, S. (2009). *Learning disabilities, sex and the law – a practical guide* (2nd edn). London: Family Planning Association.

Jones, C., O’Nishi L, Young, S. et al. (2008) *Sex Rules OK!* (an accessible sexuality policy). Ridgeway Partnership (OLDT) and Oxfordshire County Council.

www.sexualrespect.com – resources on sex and sexuality for health and social care professionals.

www.shada.org.uk – the Sexual Health and Disability Alliance (set up in 2005 to replace SPOD and support health and social care professionals who work with disabled people).

REFERENCES

- ¹ Case example reproduced with permission from www.39Essex.com – barrister Chambers which provides regular legal updates on case law relevant to mental capacity and deprivation of liberty cases.
- ² Case example reproduced with permission from www.39Essex.com – barrister Chambers which provides regular legal updates on case law relevant to mental capacity and deprivation of liberty cases.

Chapter 4

Supporting sexual functioning in clinical practice

This chapter covers some key issues that frequently occur within routine practice and explains the law in reference to them. Many of the issues can be complex, requiring an understanding of the law, risk, and ethics, and every case should be evaluated on an individual basis taking all of these factors into account.

The assessment of capacity to consent to sexual relations is only one of the decisions related to sexual functioning that clinicians may be required to assess. In clinical practice, decisions related to a person's mental capacity to engage in normal age appropriate sexual functioning (e.g. masturbation, use of pornography, dating agencies, social media relationship platforms such as Tinder and Grindr, and escort agencies) frequently arise.

In accordance with the MCA, the assessing clinician must ensure all practical steps have been taken to enable the person to have capacity. Whether ultimately the individual is deemed to have capacity or not, the treating team will be required to develop care plans to ensure all practical steps are taken (i.e. at the material time a decision is made) to enable the person to have capacity; whilst also ensuring appropriate measures have been taken to safeguard the person from exploitation or harm. In this chapter we provide some guidance for assessing knowledge in these areas, and resources to assist with enhancing capacity, and replacing harmful behaviour with something functionally more appropriate.

Sex and relationships education

Sex and relationships education (SRE) can help to maximise or improve a person's capacity to make decisions. Practitioner psychologists may be involved in running sessions (group or individual), devising programmes or acting in an advisory capacity to others carrying out this work. However, other health or education professionals may also take a role in providing this education.

The need for people with intellectual disabilities to have accurate SRE in an accessible form was pioneered in the UK by Ann Craft¹. Since then, there has been a steady growth in access to good SRE for people with intellectual disabilities and resources to support it².

In relation to children, The Education Act (1996) makes SRE mandatory in state schools, including special schools, but parents have a right to withdraw their child. Pupils are required to be taught about the biological facts of human growth and reproduction, and about sexually transmitted infections as part of the science component of the national curriculum (Education Reform Act 1988). Parents do not have a right to withdraw children from this aspect of education.

The Sexual Offences Act 2003 (SOA) states that under section 41 a care worker who causes a person with a mental disorder to watch a sexual act may be guilty of an offence. This includes looking at images of sexual activity.

At first sight this could seem to limit sex education using visual images, but in fact an offence is only committed if the perpetrator is showing images 'for the purposes of obtaining sexual gratification'. Therefore, sex education programmes should be carefully planned and documented to demonstrate the educational benefit and the intent of the work.

Psychologists have devised assessments for assessing and measuring sexual knowledge and identifying gaps^{3,4,5,6}. These can be used to support the design and implementation of sex education programmes to meet individual needs for optimal learning.

Whilst some of these resources are also useful for adults with acquired brain injury, particularly when the level of cognitive impairment is quite profound, there is a need for material which reflects different life experiences.

Masturbation and sex aids

Masturbation is a completely normal form of sexual expression.

Practitioner psychologists are frequently required to respond to referrals involving concerns about masturbation or a failure to masturbate⁷. Advice is often required to maximise the chance of successful

masturbation. Often the role of the psychologist involves working with caregivers to help clarify the attitudes and behaviours of caregivers that may impede opportunities to masturbate.

THE LAW

Diagrams, pictures and DVDs can be used as part of a sex education programme to teach about masturbation and sex aids. The sex education programme which is being implemented should be carefully planned and detailed in the individual's care plan.

Care workers need to ensure they are working within the law and can demonstrate that they are doing it to impart information to educate, and not for their own sexual gratification (SOA Section 41).

Problems arise when individuals cannot learn in this way, and may require practical assistance to learn to masturbate successfully,

with or without aids. Under the SOA (Section 38), a care worker commits an offence if he or she:

- a. Intentionally touches another person (B);
- b. The touching is sexual;
- c. B has a mental disorder.

This offence is regardless of the mental capacity of the person with a disability. Therefore, the sexual touching of a person with a 'mental disorder' (e.g. learning disability) is illegal and should never be used as an educational technique.

PROVIDING OPPORTUNITY

For individuals with more severe intellectual impairments, sometimes with additional physical impairments, masturbation is likely to be the sole form of physical sexual gratification. Opportunities to engage in this form of sexual functioning should be facilitated regularly in accordance with societal norms

(i.e. in a private space). It is essential to ensure that people with a disability are not overly restricted from accessing their own genitalia. For instance, people who wear incontinence products should be free of them for part of each day.

MANAGING RISK OF HARM

There is a risk of harm to individuals (both physical and through frustration) who fail to satisfy themselves due to ineffective technique and use of makeshift aids (such as hairbrushes and bottles). Carers should minimise harm by enabling access to safe aids wherever possible. There are safe aids from reputable suppliers

specifically designed to assist with both male and female masturbation. NHS sexual health clinics can advise on suitable and safe aids and suppliers.

Dating agencies

Dating agencies exist to arrange introductions for people looking for either an intimate relationship or companionship.

'Mainstream' dating agencies have existed for a very long time, and one service for people with (mostly) physical disabilities called the Outsiders Club was founded in 1977⁸. Neither of these met the needs of people with learning disabilities, and in 2007 the first specialist dating agency opened in London⁹. There are now about a dozen such services across England and Scotland^{10,11}.

Mates 'n Dates¹² is an example of a specialist dating agency for people with learning disabilities founded in 2007 in Oxfordshire¹³. The idea for this came from a clinical psychologist who secured funding through the local Partnership Board and developed a partnership with other providers of Learning Disability services. It has approximately 200 members, who pay an annual fee. In its early days it had considerable input from the psychology service, although this has not been maintained in recent years. The agency sits within Guideposts Trust and they have staff who run it with support from around 20 volunteers. Many students/trainees from the Trust often become involved within their own

time. There are safeguards in place within the application process including an initial interview and references sought to maintain the safety of all of its members. Mates 'n Dates organises social events, including an annual grand ball and nightclub evenings. It supports individual dates with chaperones if requested and supports a group called MINGLE for people who identify as LGBT.

There has not been the same level of development for people with brain injury, although Headway¹⁴ (the national charity for people with brain injury) runs local support and social groups and other local initiatives such as the ROCK club in Northampton to bring together people for social activities.

Practitioner psychologists may be asked to assist with judgement about balance of risk, assessment of capacity (if contested), and recommendations for enhancing capacity. There is a role for practitioner psychologists to support dating agencies in a consultancy position, to support consideration of issues of capacity and risk management, to prevent difficulties arising.

THE LAW

Dating agencies need to be cautious about how much support is offered to facilitate a member to engage in a relationship, as the SOA stipulates that 'care workers' need to be seen to be facilitating the wishes of members, rather than causing or inciting sexual activity that would not otherwise have occurred to the

member with a 'mental disorder' (SOA Section 39). There have not been any instances of anyone threatening legal proceedings against a specialist dating agency; however, care should be taken to ensure that it is the person's capacitous wish to participate in the agency.

MENTAL CAPACITY

Dating agencies do not test an applicant's mental capacity. If an individual signs up to the service, it is assumed that they know what they are entering into (which may or may not be the case). The following points are a guide to

assessing an individual's knowledge/capacity to sign up to a dating agency (in addition to a test of capacity to consent to sexual relations):

By joining a dating agency, you are saying that you would like to meet someone to make a 'special' relationship.

The dating agency charges money for putting people in touch with one another.

The person you 'date' may well want a sexual relationship with you, but you can choose whether or not to do this, and to change your mind at any time. The other person can do the same.

To agree to a 'date' does not commit you to anything other than the 'date'. The other person may not want to 'date' again. You may not want to 'date' again.

Some applicants to a specialist learning disability dating agency may lack the capacity to fully understand the agency, and/or lack

the capacity to consent to sexual relations. However, if the person is expressing a wish to join, then the agency should carefully consider how this person is matched with other people to ensure that people are not placed in abusive situations. Extra support should be given to the individual to maximise their capacity to consent to joining the agency if this is their wish. Education around the key points of capacity (as detailed above) can be seen as a starting point for helping the person to enhance their capacity.

Not all relationships formed via dating agencies result in sexual relationships. Intervention in a relationship involving someone who lacks capacity to consent to sex should be made when there is evidence that sexual activity is likely, or that it is felt that harm is being done. Otherwise, people who lack capacity may be denied any friendships in case they become intimate and may be denied any form of intimacy in case it leads to sexual intercourse¹⁵.

RISK OF HARM

There is a risk of harm if dating agencies do not carefully consider the people they match up if these people lack capacity in specific areas.

Social networking sites and chat rooms

Research shows that people with learning disabilities have more limited social networks¹⁶ and social media websites and chat rooms offer many what appears to be an immediate social network.

Amongst people with brain injuries, the majority continue to use multiple social networking sites as they did pre-injury but their neuropsychological impairments can impact on the ability to use social media safely¹⁷. Therefore, people may find it hard to weigh the risks against what can be seen as a valuable opportunity to increase their social life. Equally, it offers people opportunities to stay in contact with friends who they may otherwise lose touch with because of logistical issues such as transport difficulties.

Developments in technology mean that social media on the internet is available through a wide range of sources. This means limiting someone's access to its use would be very difficult without close supervision and control, which would amount to a deprivation of liberty. Additionally, it is possible that the individual would try to then access the restricted items whilst keeping it secret from caregivers, which could place them in potentially risky situations.

Although many healthcare workers express concerns about how their clients use social media, few directly ask about it or support clients to manage their use safely¹⁸. The emphasis needs to be on supporting vulnerable people to access social media safely and enhancing their capacity to understand the risks involved so they can keep themselves safe. There are specific social media sites for people with particular diagnoses (e.g. for people with learning disabilities there is Special Friends Online), but it is still important to enhance their capacity to understand the principles of keeping themselves safe online.

In this context, the psychologist may be required to assist with assessment of capacity to engage in social media, advice on enhancing capacity, and/or replacing harmful behaviour with something functionally similar (i.e. via differential reinforcement of a website with greater regulation than the one where harm has occurred).

THE LAW

Laws about the use of inducement, threats or deception and people with a mental disorder are covered in Sections 34 to 37 of the SOA (2003). For children (all children, not just those with an intellectual disability), there is additional protection from grooming on the internet (SOA, Section 15).

At the time of writing this document there was no case law in this area yet, but a court of protection Judge, involved in a recent mental capacity assessment regarding the use of social media provided the following guidance regarding what should be included in the 'relevant information' test:

1. That some people using social media may present as nice but may actually want to hurt or abuse others.
2. A basic understanding of the various ways in which people may be abused online including physically, sexually, financially.
3. That there are steps which can be taken to minimise these risks.
4. A basic understanding of what these steps may be, such as not responding to people you don't know, blocking them, not giving our personal details, or else talking to staff/friends/family before sending anything personal or meeting somebody in the real world whom you've met online.

The psychologist involved in the case also argued that additional information should be included in point two above, this included the fact that people can be abused online

MENTAL CAPACITY

No test of capacity happens automatically before accessing internet and electronic forums. The following points are suggested as a guide to the information an individual should be educated about to help enhance an individual's understanding of the information relevant to a decision whether or not to use social networking and how to keep themselves safe if so:

Don't give out personal information like your address, bank details, or telephone number.

You don't have to do what someone says.

You can switch off the computer at any time/leave the website when you want.

People might pretend to be someone else on the internet and deceive you.

It may not be safe to meet up in person with people you meet online. If you

emotionally (through saying hurtful things), and that there is a risk of identity theft and a risk of obtaining a computer virus through deceptive links distributed via social media.

do this, take a friend, family, or staff member for safety.

If you feel scared or upset about something you see or something someone says to you online, you can report them (by referring to the specific procedures for the website you are using and/or via the police).

Resources currently available for enhancing capacity:

Surrey police have developed an easy-to-read guide designed to support people to keep themselves safe online from a range of threats.

http://www.surrey.police.uk/Portals/0/pdf/easy-read/internet_safety_July13.pdf

Another useful resource is the Safernet website, which produces a range of materials including a leaflet specifically designed for people with learning disability.

<http://safernet.org.uk/for-people-with-ld>

RISK OF HARM

Serious risks include financial loss, public degradation and abuse, grooming and deception leading to actual physical or sexual abuse if meetings are set up. If an individual lacks the mental capacity to make the

decision to engage in social media platforms, and harm is being done, care providers can take steps to block access in the best interests of the individual (alongside work to enhance capacity).

Pornography

In addition to internet pornography, trends to photograph one's own body parts and send them to others via social media platforms, has opened up a whole new area of vulnerability for those with a disorder or disturbance in the mind or brain.

Similarly 'revenge porn' (i.e. the act of posting sexual pictures of an ex-partner on public social media platforms) is also an area that clinicians should be mindful of especially for patients prone to impulsivity secondary

to acquired brain injury. It is essential that vulnerable adults are taught about the legislation in relation to these acts and therefore the risk of being charged with a crime if they engage in either activity.

THE LAW

There are laws prohibiting making or looking at or distributing certain sexual images including those involving children (Criminal Justice and Public Order Act 1994), bestiality, or life-threatening images (Criminal Justice and Immigration Act 2008). Pornography available on the 'High Street' will be legal but it is easier to access more extreme images on the internet and the legality of these may be harder to establish. Additionally, there are sections of the Sexual Offences Act (SOA) relating to people 'with a mental disorder' relevant to the use of pornography:

Section 33 – prohibits 'causing a person with a mental disorder impeding choice to watch a sex act'. This makes it illegal to show someone who lacks the capacity to consent pornographic images for the gratification of the perpetrator. In addition, it needs to be shown that the perpetrator should reasonably have known that the person lacked capacity to choose to watch a sex act.

Section 37 – is similar, except that it makes illegal showing the images 'by inducement, threat or deception', and has no restriction to people who lack capacity, referring instead to a person with a mental disorder.

Section 41 – makes illegal the showing of images by 'care workers', regardless of capacity, but again, only relates to activity for the gratification of the perpetrator. This fully allows, for example, the use of explicit images in properly constituted sex education.

Good practice suggests that people who live in shared accommodation should keep pornographic images private, unless it is certain that everyone who is exposed to the material is both capacitous and consenting.

Secure services for people with learning disabilities will have a very restrictive policy preventing the use of pornography, following The Ashworth Enquiry¹⁹.

MENTAL CAPACITY

No assessment of capacity happens automatically before purchasing pornography or accessing the internet. An assessment of mental capacity may be important if prosecution is sought under Section 33 of the SOA. The following points are suggested as a guide to aid assessing and enhancing an individual's knowledge around pornography:

Pornography is pictures of sexual acts that are normally private.

These pictures are people acting (pretending); women (for example) do not necessarily behave like this in real life.

Some people get very upset by pornography, so it should be looked at in private.

Most pornography is not illegal, but it is against the law to look at anything showing sexual pictures of children or people having sex with animals, or people hurting other people deliberately.

You must not show other people pornography without asking them first. You must not show pornography to children.

RISK OF HARM

There is much debate about the harm versus benefit of using pornography generally²⁰. Possible harm includes being frightened by images, becoming addicted to using pornography to the detriment of other aspects of life, and copying actions (ignoring consent and resistance as if they were the norm

and acceptable, or becoming the victim of assault, as if it were the norm). If a person lacks capacity, and harm is being done, care providers should take steps to block access in the best interests of the individual (alongside work to enhance capacity).

Commercial sex workers

There are an estimated 80,000 people working in prostitution in the UK²¹.

Although concentrated in cities, every town hosts sex workers. The trade is divided into 'indoor prostitution' or 'street prostitution', depending on whether the sex worker has a property at which to serve the client. Typically, brothels are advertised as 'massage parlours' or 'saunas' and sex workers who visit a client at home are often described as 'escorts' or 'masseurs'. Charges vary enormously. A small-town brothel might charge about £80 per hour.

Many sex workers in Britain use illegal drugs and many have household debts to meet.

The majority of indoor prostitutes are non-UK citizens, and some will not have legal rights to work in this country²².

There are sex workers who advertise themselves as keen to serve people with disabilities²³; in practice, their customers are generally people with physical disabilities.

THE LAW

The law in the UK asserts that the exchange between consenting adults of sexual services for money is not illegal. However, advertising, soliciting in a public place, and running or working in a brothel (any place where two or more sex workers operate) are all illegal (SOA, 2003).

The result of a 2006 review²⁴ was to make laws against prostitution tougher by shifting the focus from the prostitute to the customer. It is now an offence to pay for the services of a prostitute 'subjected to force' regardless of whether the customer was ignorant of the status of the prostitute (Policing and Crime Act, 2009).

People with intellectual disabilities, generally men, may use sex workers and risk criminal proceedings, as would any other customer.

In addition, there are particular difficulties preventing 'care workers' (of any description) assisting people to find or use sex workers.

Section 39 of the SOA prohibits 'care workers' from 'causing' or 'inciting' someone with a 'mental disorder' to engage in sexual activity, regardless of capacity. This means that although workers may be able to provide advice to individuals who are already using sex workers, they cannot take any part in setting up contact with sex workers or suggesting better ways of doing it²⁵.

MENTAL CAPACITY

Sex workers do not routinely consider their client's capacity. If someone with an intellectual disability is using a sex worker, it may be helpful, in addition to the assessment of their ability to consent to sexual relations, to consider what other information they need to evaluate in order to make the decision to use a sex worker. The following knowledge points are suggested as a framework for discussion.

The sex worker will offer a service as a job of work.

They will determine start and finish times.

You, the customer, can say what you want; the sex worker will say what they will offer and what they will not. You should be happy with this before agreeing to use the worker.

You will need to pay an agreed sum of cash to the worker (whether or not you make full use of her/his service).

The sex worker will not want a relationship with you, other than to give sex in exchange for money.

The sex worker will expect you to be clean before your session.

She/he will expect you to use a condom (if penetration is involved), and can provide this but you should also have one with you.

You can change your mind and ask to finish at any point.

You are not committing a crime simply by using a sex worker.

It is normal to be careful about to whom you talk about using a sex worker; many people may disapprove of using a sex worker.

In relation to using sex telephone lines, there are similarities to using sex workers for what needs to be known. The following knowledge points are suggested as a framework for discussion.

The person you are talking to is pretending to be someone and not everything they say is true. They might say things to make you stay on the telephone longer, as this makes more money.

The person you are talking to will not want a relationship with you.

You will be charged for the time you spend on the telephone and there should be an understanding of the cost involved.

You should make telephone calls to sex lines in a private place.

You can finish the telephone call at any point and hang up.

RISK OF HARM

There is much debate about the harm versus benefit of using sex workers²⁶. Possible harm to the individual with a cognitive disability includes being exploited financially by the sex worker. If the individual lacks the mental capacity to understand the nature of the relationship, and harm is being done, care providers can take steps to block access to sex workers in the best interests of the individual (alongside work to enhance capacity) but should consider the extent to which these actions may amount to a deprivation of liberty.

There is a risk of significant financial harm in using sex telephone lines if usage is frequent or prolonged. Steps should be taken to enhance capacity in understanding the costs of these services and supporting people to weigh up the consequences of the decision to spend their money in this way. If people lack capacity to make this decision, then care providers can take steps to block or manage access to these telephone lines (for example, having a cap on the amount that can be spent on a mobile telephone each month).

Summary

Practitioner psychologists should be aware that often vulnerable adults wanting to use sex services are trying to compensate for psychological difficulties (e.g. loneliness, a desire to be normal/like their peers, and/or difficulties adjusting to disability after suffering acquired brain injury). There is a risk of psychological harm if vulnerable people engage in the use of sex services without adequate support and safeguards in place. Establishing the client's motivation for seeking to use sex services is important. Do they seek to alleviate psychological distress or sexual frustration? Clients requesting to use sex services should be supported to explore the rationale for their decision over several sessions. This ensures that the client has been given adequate time to develop a trusting therapeutic relationship in which they feel safe to discuss openly the true motivations for their request. It also means the practitioner psychologist can explore alternative psychological interventions that might be more effective at alleviating their psychological distress in the long term.

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Appendix

THE MENTAL CAPACITY ACT (2005)

The Mental Capacity Act (2005) includes a set of guiding principles and definitions of capacity as set out below. All legislation was drafted using the pronoun 'he' (to refer to men and women) and the following text is cited directly from the legislation.

THE PRINCIPLES

1. A person must be assumed to have capacity unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decisions made, under this Act or on behalf of someone who lacks capacity must be done, or made in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

THE ACT DEFINES CAPACITY AS FOLLOWS:

For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain (whether permanent or temporary).

The Act states that a person should be considered unable to make a decision if he is unable to do any of the following steps in decision-making:

Understand the information relevant to the decision;

Retain that information;

Use or weigh that information as part of the process of making the decision;

Communicate his decision (whether by talking, sign language or other means).

The fact that a person is able to retain information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.

NOTE:

The Mental Capacity (NI) Act (2016) four step test of capacity is defined differently and practitioners therefore should pay particular attention to those aspects when establishing a person's capacity.



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St Andrews House,
48 Princess Road East,
Leicester LE1 7DR, UK

 www.bps.org.uk  0116 254 9568  mail@bps.org.uk

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