Can consent be uninformed? Suggested reform of sexual offences against persons with intellectual disability

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Can consent be uninformed? A proposal for the reform of sexual offences against persons with intellectual disability

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Abstract

In R v Morgan (1970), the Supreme Court of Victoria stated that for incapacity to consent to be proved it must be shown that a person "has not sufficient knowledge or understanding to comprehend (a) that what is proposed to be done is the physical fact of penetration of her body by the male organ or, if that is not proved, (b) that the act of penetration proposed is one of sexual connexion as distinct from one of totally different character." It is my contention that this standard of knowledge is insufficient to allow a person to protect themselves against the commonly recognised consequences of sexual acts, namely pregnancy and sexually transmitted diseases. Although the literature suggests that increasing the benchmark of knowledge to encompass these facts would mean that many persons with intellectual disability would be deemed incapable of consent, I argue that consent that is not based on a standard of knowledge sufficient to allow an individual to safeguard their own interests cannot be considered valid consent. Law reform is required so that consent to sexual acts more closely resembles the informed consent required for medical treatment. Moreover, the provision of adequate sex education, repeated as required, would assist many people with intellectual disability to achieve understanding of both the nature and consequences of sexual acts. The proposed reforms would also allow people who, even after education, are unable to meet the requisite standard more certain legal protection than is currently the case.

***Keywords*:** consent; intellectual disability; sexuality; sexual offences.

In 1981, a 23 year old woman with a mental age of 10 years 8 months went to a country fair. She had no sexual experience and had received no sex education. At the fair, she spent a considerable amount of time and money at the hoopla stall trying to win a large green frog. The attendant struck up a conversation with her, and after a time asked if she wanted to "make love". She agreed and accompanied him to a caravan where intercourse took place. He gave her the toy frog and she returned to the fair, where she chatted happily with friends, showed no distress, and spoke to the man again. Later a second fair attendant approached and offered her a toy panda in exchange for sex. She accompanied him to a truck and intercourse took place a second time. Again she was not distressed after the incident, but when a third man attempted to have sex with her she resisted and ran off. By the time her mother arrived to collect her she was visibly upset (*R v Beattie*, 1981). This narrative raises a number of questions concerning the sexual expression of persons with intellectual impairment. Was this woman capable of consent? What are, or what should be, the markers of capacity to consent? In particular, what facts should a person know if they are to be deemed capable of giving consent to a sexual act?

Current law on capacity to consent to sexual acts

In all Australian jurisdictions with the exception of South Australia, the benchmark of knowledge was established in *R v Morgan* (1970). In that case, the direction given in the County Court was that the complainant must understand five "rudimentary concepts" before valid consent could be given. These were: an understanding of the concept of virginity; an understanding that intercourse can lead to pregnancy; an understanding that most people view intercourse as fundamentally different from other affectionate acts; an understanding that some sections of society view intercourse as "naughty"; and an understanding that penetration is likely to cause rupture of the hymen. This direction was rejected on appeal. The Supreme Court of Victoria stated that for incapacity to consent to be proved it must be shown that "she has not sufficient knowledge or understanding to comprehend (a) that what is proposed to be done is the physical fact of penetration of her body by the male organ or, if that is not proved, (b) that the act of penetration proposed is one of sexual connexion as distinct from one of totally different character" (p. 341). The *Morgan* direction was recently elaborated upon in *R v Mueller* (2005), another case in which it was alleged that the complainant lacked capacity to consent. In the County Court, the jury was directed that "if the complainant has knowledge or understanding of what the act comprises, and of its character… then she has all that the law requires for capacity to consent. That knowledge or understanding need not be a sophisticated one. It is enough that she has sufficient rudimentary knowledge of what the act comprises, and of its character, to enable her to decide whether to give or withhold consent" (p. 6). In the Court of Criminal Appeal this was held to be a correct statement of law.

Morgan sets a noticeably lower standard of knowledge than is necessary for informed consent to therapeutic treatment, where the person must understand not only the nature and character of the act, but also the risks, harms and benefits of both allowing and refusing the act. Similarly, consent for participation in research requires that before research is undertaken, there is the "provision to participants, at their level of comprehension, of information about the purpose, methods, demands, risks, inconveniences, discomforts, and possible outcomes of the research" (NHMRC, 1999, p. 12). Returning to capacity to consent to sex, the *Morgan* standard is lower than that of most American states, which require understanding of the nature and consequences of the act (Sundram & Stavis, 1994). In this country, the South Australian *Criminal Law Consolidation Act* 1935 s 49 (6) sets a similar benchmark. Under that section which defines the crime of knowingly having sexual intercourse with a "mentally deficient" person, for charges to be proved it must be shown that the person was unable to understand the nature or consequences of sexual intercourse. The Model Criminal Code Officers Committee (MCCOC; 1999, p. 38) suggested that consent be vitiated where "the person is incapable of understanding the essential nature of the act". The term "essential nature" is left undefined, but could be read to mean understanding that sexual intercourse may result in pregnancy (McSherry & Naylor, 2004). Raising the standard of knowledge required for consent to sex would make it more consistent with the requirements of legal consent to other activities. It would, however, result in more people with mental impairment being found incapable of consenting to sexual acts, a point to which I shall return.

One notable aspect of the *Morgan* standard is its age - it has stood without revision for over 35 years. Amendment to law sometimes occurs as a result of cases coming before the courts where the application of existing law, either through statute or precedent, is thought to produce a result that is in some way inconsistent with contemporary norms or societal beliefs. Of course, if this process of legal development is to occur, it is necessary for cases with features that might provoke legal change to come to trial. Although there is evidence that sexual offences against persons with mental impairment are frequently committed (see for example, Carmody, 1990; 1991;

Victorian Law Reform Commission, 1988; 2005), cases also have a high attrition rate. The person may be unable to report the crime or even to realise that what has happened is a crime (Graydon, Hall & O'Brien-Malone, 2006). They may experience difficulty being believed, or may be reluctant to appear in court (Rosser, 1990). A person found incapable of consent may also be found incapable of giving evidence (NSW Law Reform Commission, 1996). Thus, convictions may be more difficult to secure when the victim has a mental impairment (McSherry & Naylor, 2004). The overall effect is that very few sexual offences against persons with mental impairment are prosecuted. During the period 1996 till 2004, an eight year period, in Victoria only 17 prosecutions under the relevant sections took place (McSherry & Naylor, 2004). As a result, the law pertaining to sexual offences against persons with mental impairment tends to provoke little interest and attention, and can remain entirely unchanged for decades.

In contrast, rulings on the general law pertaining to the vitiation of consent tend to be widely reported. These rulings sometimes create such widespread public comment that they result in legislated changes in statute. Amendment to the law of New South Wales took place following the case of *Papadimitropoulos v The Queen* (1957). A newly-arrived female Greek migrant who did not speak English attended a Registry Office with the defendant. He falsely informed her that they had gone through a marriage ceremony. On the "honeymoon", she consented and engaged in sex with him. After several days he deserted her and the facts came to light. The High Court held that because she was aware of the identity of the man and the character of what he was doing, her consent was not vitiated, even though she had consented on the basis of a belief that she was legally married that had been fraudulently induced by the defendant. As a result of *Papadimitropoulos*, the NSW *Crimes Act* 1900 was amended so that s 61R(2)(a)(ii) now reads "a person who consents to sexual intercourse with another person under a mistaken belief that the other person is married to the person, is to be taken not to consent to the sexual intercourse".

An example of the extent to which fraud may vitiate consent is the case of *R v Mobilio* (1991), in which a radiographer subjected several female patients to vaginal examinations using ultrasound transducers. These examinations had no medical value and were conducted solely for the sexual gratification of the radiographer. He was subsequently charged and convicted of rape. On appeal, the court held that any mistaken belief on the part of the complainant must relate to the nature and character of the act or to the identity of the sexual partner. Therefore, since the patients had consented to the insertion of the transducer into their vaginas, their consent was not vitiated simply because they were mistaken about the reason behind the act. However, it seems certain that the patients would not have consented had they known the real reason for the internal examination. The *Mobilio* ruling has since been reversed in Victorian law. According to the Victorian *Crimes Act* 1958 s 36 (g) there is no consent where a person "mistakenly believes that the act is for medical or hygienic purposes".

In the Queensland case *R v Pryor* (2001), a sleeping woman was lifted from her bed and taken into the hallway of her home by an intruder, where penetration took place. The woman's de facto husband was in the house, and she believed it was he with whom she was having sex. She was unaware that this was not the case until after ejaculation had taken place. When she realised that the man was a stranger, she called for help. Her assailant was charged and convicted of rape. The conviction was appealed. It was argued that since the defendant had done nothing to constitute impersonating her husband, consent was not vitiated. This argument was rejected and the appeal was dismissed. Williams JA stated, "Her instinctive responses did not constitute a comprehending consent… Once she comprehended what was happening - a complete stranger was having intercourse with her - she made it clear that she was not a consenting party" (p. 21). On the basis of this ruling it appears that the accused is liable even if he has not actively induced the false belief on which consent is based.

In the nineteenth century, it was ruled that a man who had deliberately infected his wife with gonorrhoea, a fatal disease at that time, was not guilty of either assault or rape because the wife's consent had not been obtained by fraud (*R v Clarence,* 1888). This ruling was recently reversed in the Canadian case *R v Cuerrier* (1998). A HIV-positive man had unprotected sex with two women without informing them of his condition. Both women consented to sex, but both testified that they would not have consented had they known that the defendant was HIV-positive. The failure of the accused to disclose his state of health was held to amount to fraud.

The cumulative effect of the rulings referred to above is that consent must be not only free and voluntary (e.g., Question of Law No. 1 of 1993; WA Criminal Code s 324g) but is also "a free and informed exercise of the will" (*R v Shaw*, 1995, p. 111). It appears that the effect of these rulings is that consent may be vitiated by false beliefs as to the relationship between the parties, the purpose of the act, the identity of the sexual partner and their health status. Furthermore, at least in some circumstances, the incorrect belief need not have been induced by the accused. "A consent that is not based upon knowledge of the significant relevant factors is not a valid consent" (*Cuerrier*, p. 127).

What are "significant relevant factors"?

Specific items that vitiate consent on the grounds of ignorance have been left undefined within law because the court would not want to limit the category of case that might be considered. To assist in establishing some parameters for significant relevant factors some consideration of concepts that govern decision-making is required. Somerville (1994) characterised voluntariness, capacity, and autonomy as "gate-keeping" concepts that supported other principles of decision-making, such as fairness, justice and respect for persons. In law, voluntariness and capacity must be present, but what of autonomy? Somerville makes reference to the fact that meanings often differ depending on the discipline of reference: what a lawyer understands by the term "autonomy" may not be the same meaning attributed by a psychologist or a philosopher. For example, the Kantian concept of autonomy is based on the ideal of moral worth: only a selfless impersonal decision was considered to be moral (Matthews, 1999). But consent to sex is neither selfless nor impersonal, so Kantian autonomy is irrelevant in this context. On the contrary, the person giving consent is concerned, or would be concerned if they had the relevant knowledge, with their own best interests. It follows that capacity to consent should rest upon the person having both the ability to recognise their own interests and sufficient knowledge to make a decision that is consistent with those interests.

These interests would include the person's own mental and physical wellbeing, and may extend to their financial situation. Specifically, capacity to consent should rest upon understanding that pregnancy and sexually transmitted disease can result from sexual intercourse. Such understanding need not be a sophisticated one, to paraphrase *Mueller*, but should be sufficient for the person to understand the potential ramifications of his or her choice. Although it is not unusual for a person with unimpaired cognition to overlook or ignore their own interests in some situations, for example while they are sexually aroused, this person recognises the risks of unprotected sex. They are aware of the possible consequences and may avail themselves of prophylactic measures either at the time of the act or post hoc. On the other hand, a person who is not aware of the potential consequences of their decision is constrained not only in making the initial choice, but is also prevented from taking corrective action. They know nothing of either the risk or the remedy. Persons who consent to sexual acts without knowledge of the potential consequences are in an equivalent moral position to the patient who makes a treatment decision without being

informed of the associated risks. But whereas the patient may sue their doctor for negligence and/or battery, outside of South Australia the person who agrees to a sexual act without knowing its consequences is held to give valid consent.

Balancing protection against sexual autonomy

An advantage of retaining the *Morgan* standard is that the sexual autonomy of persons with mental impairment would be preserved. Persons with the requisite knowledge of the nature and character of the act would be free to exercise their right to sexual expression, unless of course the behaviour violated some other statutory provision. Keeping requirements for consent to a minimum allows the maximum number of persons with mental impairment the freedom to express their sexuality, especially since the average level of knowledge regarding sex appears to be lower than the same knowledge in the general population. Evidence obtained in Australia and overseas has consistently shown that only about half the population with intellectual disability reports having ever received any sex education, in contrast to almost all members of the general population (McCabe, 1999; O'Callaghan & Murphy, 2002). Some of the people with intellectual disability in O'Callaghan and Murphy's study had received their only education over 30 years previously. Persons with intellectual disability have significantly less sexual knowledge and experience than persons with physical disability, whose knowledge is again significantly less than that of non-disabled individuals (McCabe, 1999). In comparison to mainstream 16-year-olds, adults with intellectual disability have much less knowledge about a large number of aspects of sex including emotions, bodily functions, consent, consequences, legal aspects, and personal safety (O'Callaghan & Murphy, 2002). In fact, the evidence obtained by O'Callaghan and Murphy suggests that increasing the standard of knowledge to encompass understanding of both the nature and consequences of sexual activity would mean that about half the population with mild to moderate levels of intellectual disability would be found incapable of consent (O'Callaghan & Murphy, 2002). Given that people with intellectual disability have historically had expression of their sexuality discouraged, have been subjected to involuntary sterilisation for eugenic purposes, have had many of their rights denied and have been devalued and stigmatised (Graydon, in preparation), it may seem unacceptable to raise the standard of consent to a level which is out of the reach of such a large proportion of this population.

The right to sexual expression notwithstanding, this population with its particular vulnerabilities has a competing right to protection. Recall the paradox that the incidence rate of sexual offences against persons with mental impairment is higher than that found in the general population, and yet these crimes are reported at an even lower rate than other sexual crimes (Victorian Law Reform Commission, 2005). An advantage in increasing the standard to include knowledge of consequences is that it would be likely to lead to more convictions (McSherry, 1998). Expert evaluation of capacity would probably be facilitated if it had to be demonstrated that the complainant possessed or did not possess at least some understanding of the relationships between sex and pregnancy and sex and STDs. In instances where such understanding could not be established, the prosecution's task of proving incapacity would be an easier one.

What position should the law take?

Given the incongruence between *Morgan* and the knowledge necessary for consent to other acts, it is my proposal that consent to sexual acts should more closely resemble the test for consent to therapeutic treatment. This notion might be challenged on the

grounds that the situations are not analogous: a medical decision is potentially life-threatening whereas a decision to engage in sex is not. Yet serious and even fatal complications have always been and continue to be a possibility associated with sexual activity. A woman who is ignorant of the relationship between sex and pregnancy is unwittingly putting her health and even her life at risk. Admittedly that risk has been reduced over time and in modern Australia the death rate due to childbirth is less than 1 in every 1000 births (ABS, 2004) but the risk does still exist. Moreover, having a child carries serious financial consequences for both parents; in Australia in 2002 it was estimated that raising a child from birth to age 20 cost on average $264,000 (Percival & Harding, 2005). Of course, this financial commitment exists only if the parents actually raise the child. People with mental impairment and especially with intellectual disability are at heightened risk that their children will be removed from their care (Gallagher, 2001), a proceeding which is understandably upsetting.

The other commonly recognised consequence of sexual activity, sexually transmitted diseases (STDs), has remained curiously unmentioned in law despite the fact that the associated risk has increased significantly since *Morgan* was decided. In 1970 STDs were treatable. It was not until the early to mid-1980s that HIV-AIDS was recognised and the seriousness of infection was revealed. It is now common knowledge that one's life may well be threatened by unprotected contact with a HIV-positive partner. But the person who is ignorant of the existence of HIV and how it is transmitted is unable to make a valid choice. Ignorance renders them powerless to assess risk. They would be unaware that some sexual activities are associated with significantly greater risks than others. Some men with intellectual impairment regularly cottage, that is engage in homosexual prostitution in public toilets; these men tend to function at a lower cognitive level than the men who buy their services (Cambridge & Mellan, 2000). As a result, they lack power; the lower functioning person is almost always the receptive partner (Thompson, 2001). They may be unaware of safe sex practices, but even if they do have that knowledge they may be powerless to compel their partner to use a condom. The standard set by *Morgan* allows some of the most vulnerable members of society to consent to acts which expose them to a high degree of danger. If a medical procedure had comparably serious consequences, the patient would have to be informed even if there was only a remote risk (*Rogers v Whitaker*, 1992). The serious consequences of sex warrant that an understanding of the nature and consequences of the act should underlie a valid consent.

The major objection to raising the standard of consent for sexual acts is that approximately half the population with intellectual impairment would probably be unable to achieve the required standard, which would arguably violate the right to sexual expression and interfere with autonomy. But recall that only about half this population report having received sex education; there may be a causal link between having received sex education and achieving capacity to consent. This suggestion is supported by the small amount of available evidence. In comparison to people who reported that they had not received sex education, those who had attended formal classes knew significantly more about all aspects of sex that were examined (O'Callaghan & Murphy, 2002). The level of sexual knowledge has been found to be negatively correlated to the incidence of sexual assault, at least among people with mild cognitive impairment (McCabe, 1992). Thus it appears that the provision of sex education is not only an effective means of increasing knowledge, but also fulfils a protective function. However, caution should be exercised in interpreting this data. It may be that sex education was given only to higher functioning participants, so their higher level of knowledge could be attributable as much to their IQ as to the education. But if sex education was withheld from participants who functioned at a lower level, it is difficult to see how they could acquire sufficient knowledge to achieve capacity. People with varying degrees of mental impairment can certainly learn and achieve in other areas of life, so why not in the area of sexuality? In general, people with intellectual disability are interested in sex and wish to have the opportunity to gain knowledge

about many aspects of sexuality (McCabe, 1999). It may be that sex education programs need to be tailored to suit the general level of cognitive ability in each audience. Following each presentation, an evaluation of the change in knowledge of each participant may be useful (McCabe, 1999). Service providers may need to repeat sex education a number of times to allow opportunities for factual information to be understood, internalised and normalised.

For people who currently do not understand the consequences of sex but who would be able to acquire that knowledge given appropriate education, introduction of a more stringent standard of knowledge actually supports autonomous decision making. Currently the sexual choices of such people may not only be dangerous but arguably lack authenticity. But given supplemented education, these people would be in a better position to make choices that are in their own best interest. For them, an increased knowledge requirement accompanied by augmented opportunity to acquire information about sexuality would be no threat to their right to sexual expression. On the contrary, it would support a more informed decision-making process. On the other hand, it follows that people who are unable to meet the *Morgan* standard would be unable to meet a more stringent test of consent, and thus, their status as incapable of consent would be unaffected. People who would fall into this category are likely to have severe or profound levels of impairment. These people stand in need of the protection of the law. For them, an increase in the standard of required knowledge is likely to provide greater protection than is currently the case under *Morgan*. But the people that would be most affected by my proposal are those who are able to meet the *Morgan* standard but who, even with education, would be unable to understand the consequences of sex. Should we prioritise their sexual freedom at the expense of the safety of all persons with mental impairment? I do not believe that we should. Under *Morgan*, the risk to the perpetrator of repercussions from sexual offences against persons with mental impairment is low. A more stringent standard of knowledge accompanied by better education should have a deterrent effect. An increased standard of knowledge, and hence more knowledgeable consent, should mean that the partners of persons with intellectual disability take greater care to ensure that there is real consent before proceeding. They may come to understand that establishing consent is more than a matter of just asking if the other person will “make love”. It involves ensuring the autonomy of each person is preserved to the greatest possible degree and that each person is accorded the respect they deserve.

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