

Capacity of adults with intellectual disabilities to consent to sexual relationships

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ABSTRACT

Background. For people with intellectual disabilities there is a difficult balance to be struck between empowering people to claim their sexual rights and protecting them from abuse. Hypothetically, services should be guided by whether a particular person with intellectual disabilities has the capacity to consent to sexual relationships. However, there has been little agreement on how to define such capacity. This study examines the issue of capacity to consent to sexual relationships using a functional approach.

Method. Adults with intellectual disabilities ($n=60$) and young people presumed in law able to consent ($n=60$) were assessed for their sexual knowledge and vulnerability to abuse.

Results. Adults with intellectual disabilities were significantly less knowledgeable about almost all aspects of sex and appeared significantly more vulnerable to abuse, having difficulty at times distinguishing abusive from consenting relationships. Nevertheless, some adults with intellectual disabilities scored highly on all measures, especially if they had relatively high IQs and had had sex education.

Conclusions. The reasons for the poorer knowledge and increased vulnerability of people with intellectual disabilities are discussed and it is recommended that they should have on-going access to sex education. Implications of the findings for definitions of capacity to consent to sexual relationships are considered.

INTRODUCTION

At the time of the Eugenics movement in the late nineteenth and early twentieth centuries, people with intellectual disabilities were often considered a threat to society, on the grounds that they might reproduce excessively, threatening the national heritage of intelligence (Trent, 1995). This led to the segregation of people with intellectual disabilities in institutions and, in some countries, compulsory sterilization for so-called 'feeble-minded' women [Kempton & Kahn (1991), for example, estimated that over 50 000 individuals were sterilized in the first half of the twentieth century in the USA].

At the same time, some held the view that people with intellectual disabilities were really asexual. This denial of sexuality seemed to be linked to the belief that people with intellectual impairments were 'eternal children' (Kempton, 1972; Craft & Craft, 1983), an example of the 'ignorance is bliss' philosophy as McCarthy (1999, p. 53) has commented.

Thus there were two belief systems, both implicitly negative, about the idea of sexual relationships for people with intellectual disabilities: the first suggested that society needed to be protected from the sexuality of people with intellectual disabilities, while the second held that people with intellectual disabilities needed to be protected from sex (McCarthy, 1999). These perspectives had a major influence over service provision for people with intellectual

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disabilities and attitudes only began to change with the advent of the normalization and rights movements (Bank-Mikkelsen, 1980; Nirje, 1980; Wolfensberger, 1983; Rioux, 1997), which led to a growing empowerment of people with intellectual disabilities and a widening acceptance of their rights in relation to the recognition of their sexual needs. As a result, sex education packages began to be designed and delivered (Kempton, 1972; Craft & Craft, 1983; Cambridge, 1997; McCarthy & Thompson, 1998) and there was some recognition of the need to empower adults with intellectual disabilities to make choices about their sexuality.

Just as this rights perspective began to gain ground, however, evidence emerged of high rates of sexual abuse amongst people with intellectual disabilities (Sobsey, 1994). Brown and Turk's incidence studies suggested that at least 1400 new cases of sexual abuse against people with intellectual disabilities were reported every year in the UK (Brown *et al.* 1995), while McCarthy and Thompson (1997) found very high prevalence rates for abuse amongst referrals to a sex education team (61% of women and 25% of men referred had been abused). Hard (Khemka & Hickson, 2000) reported even higher figures: she estimated that out of a sample of 95 people with intellectual disabilities, 83% of the females and 32% of the males had experienced some kind of sexual assault. It seemed therefore that there was a need to protect people with intellectual disabilities from abuse, as well as an imperative to empower people to make their own sexual choices.

Capacity to make decisions

The decision-making capacity of vulnerable people, including those with intellectual disabilities, has been much debated in recent years, with considerable amounts of research (Grisso & Appelbaum, 1991, 1998; Morris *et al.* 1993; Arscott *et al.* 1999; Wong *et al.* 2000) and policy emerging (e.g. BMA & Law Society, 1995; Lord Chancellor's Department, 1999), as well as new legislation enacted and planned (such as the Scottish Incapacity Act and the Mental Incapacity Bill in England and Wales). The functional approach has been preferred to the diagnostic and outcome approaches to capacity (Grisso & Appelbaum, 1998; Gunn *et al.* 2001; Murphy & Clare, 2003) and there is general agreement

that people should be enabled and encouraged to take decisions for themselves when possible.

Much research on decision-making capacity has concerned consent to treatment (Grisso & Appelbaum, 1998; Arscott *et al.* 1999; Wong *et al.* 2000), where generally people are considered to have the capacity to consent (Gunn *et al.* 2001; Murphy & Clare, 2003) if they can make a free choice and can:

(1) understand and retain information about the proposed treatment (its risks and benefits, as well as the alternatives and the risks and benefits of those alternatives);

(2) appreciate the personal significance of the information;

(3) weigh the information in the balance to make a decision;

(4) communicate the decision.

There has been far less consideration of capacity to consent to sexual relationships. In the USA, for example, until recently, there used to be a diagnostic criterion (minimum IQ) applied in order to determine a person's capacity to consent to sexual relationships, at least in some places [Schweir (1994), quoted in Stavis & Walker-Hirsch, 1999]. Nowadays, in the USA, different states vary in their approaches to determining capacity to consent to sexual relationships. Some now require only an understanding of the nature of the sexual act and its voluntariness, others require some understanding of the possible consequences of the act as well, and yet others require an understanding of the moral dimension too (Stavis, 1991; Sundram & Stavis, 1994). Notably, only Niederbuhl and Morris (1993) seem to have tried to operationalize these criteria in a research project. Certainly, such criteria are not always carefully applied in cases of alleged sexual assault brought before the courts, so that Sundram and Stavis (1994) have noted that US courts have sometimes concluded that people with relatively high levels of ability (e.g. an IQ of 64) were not competent to consent.

In the UK, there has also been a diagnostic criterion in place, in that people with severe intellectual disabilities are considered not able to consent in law (see Gunn, 1996; Gunn *et al.* 2001). However, for those with mild intellectual disabilities, according to the BMA and Law Society guide (1995), in order to be able to consent to sexual activity, an individual: (a) must be

capable of understanding what is proposed and its implications; and (b) must be able to exercise choice (It is important to consider whether one party is in a position of power which will influence the ability of the other party to consent.) (British Medical Association & The Law Society, 1995). Capacity to consent to sexual relationships, therefore, seemed to require both basic sexual knowledge and some understanding of the right to say 'No', as well as an understanding of the possibility of abuse [although not all judges in England appeared to accept this (see Murphy, 2000)].

This project was concerned to develop a functional approach to defining capacity to consent to sexual relationships in people with intellectual disabilities. Both empowerment and protection issues were considered. In addition, it was thought important to ensure that any standards for capacity that emerged were no higher than was essential, in order to be certain that there was no unnecessary bar to people exerting their sexual rights. Therefore, in view of the fact that all young people of 16 years of age are presumed to be able to consent to sexual relationships under English law, it was decided that 16-year-olds from the general population would be an appropriate comparison group.

It seemed likely that, in evaluating capacity to consent to sexual relationships, the following areas would be important:

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

The principal aim of this project was thus to assess the sexual knowledge, vulnerability and capacity to consent to sexual relationships in adults with intellectual disabilities and to compare them with young people without disabilities (aged 16–17 years), presumed in law able to consent to sexual relationships.

METHOD

Participants

A variety of residential and day services for people with intellectual disabilities in Kent and South London were invited to participate in the study. Those invited to participate had to have mild to moderate intellectual disabilities, be able to engage in a conversation, using at least short sentences, with the researcher, and be able to understand in broad terms the nature of the study and to consent to participate in the study.

In addition, young people without disabilities, over 16 years, were recruited from two wide-ability schools in Kent. The young people were assumed to be in the normal range for IQ and the only inclusion criterion they had to meet was that they consented to take part.

Measures

There were three main measures and three subsidiary measures employed in the study. The main measures included a somewhat shortened version of the sexual knowledge inventory, Sex-Ken-ID (McCabe, 1994) and two measures of the understanding of abuse, developed especially for the study. These are described further below. The three subsidiary measures were intended to examine participants' social networks, using the Social Network Map (Forrester-Jones, 1998), their general vulnerability in social situations, using the Test of Interpersonal Competence and Personal Vulnerability, TICPV (Wilson *et al.* 1996) and their understanding of the law on sexual offences (using a new measure developed for the study). These three subsidiary measures are further described elsewhere (O'Callaghan & Murphy, 2002).

The Sex-Ken-ID (McCabe, 1994), which is normally presented over three interviews, was shortened somewhat by removing some questions and adding a few new ones, to cover topics not well represented in the McCabe's original version. This new shortened version will be referred to as the Sex-K-ID for clarity (copies of the measures may be obtained from the authors). It included in interview 1 questions about friendships, boyfriends/girlfriends/partners, courtship, and body part names; questions about more intimate sexual matters, such as sexual intercourse, menstruation, contraception,

pregnancy, sexually transmitted diseases, and homosexuality were in interview 2.

The Understanding Consent and Abuse measure (O'Callaghan & Murphy, 2002) employed 10 line drawings, all of which were images from the sex education pack, *Sex and the 3Rs* (McCarthy & Thompson, 1998) (copies of the measures may be obtained from the authors). Five of these images were of consenting situations (a girl and boyfriend walking close together, a heterosexual couple kissing, two lesbian women kissing, a heterosexual couple having sexual intercourse, a homosexual couple preparing to have sexual intercourse) and five of non-consenting situations (a non-consenting kiss, a non-consenting hug, a sexual assault between a man and woman in a café, a sexual assault between a man and a child, and a heterosexual rape). For each of the 10 pictures, participants were asked a series of 10 questions about what was happening in the picture, how each person felt, whether each person had consented, whether what was happening was 'OK' and what each person should do next. Participants' answers were scored (0, 1 or 2) and scores were added across questions to give a total score (maximum score 118).

Five Vignettes were also developed for the study (O'Callaghan & Murphy, 2002) (copies of the measures may be obtained from the authors). These were five short social stories, read to participants, each with four pictures to aid understanding and they portrayed the following situations:

(1) A young woman with intellectual disabilities 'befriended' by a non-disabled man who later assaults her in his flat.

(2) Two young men with intellectual disabilities who become friends and then have a consenting homosexual relationship.

(3) A man and a woman with severe intellectual disabilities, living in staffed housing, who develop a consenting relationship.

(4) A woman with intellectual disabilities, living in staffed housing, who has sexual intercourse with a man with intellectual disabilities in return for cigarettes.

(5) A man with intellectual disabilities who is sexually assaulted by a member of staff.

All the vignettes were followed by a series of questions about what actually happened in the social story and about the participants'

understanding of the situation. Participants' answers were scored 0, 1 or 2 and scores were added across questions to provide a total score (maximum score 178).

In addition, the WASI (Wechsler Abbreviated Scale of Intelligence) was employed to measure IQ with the adults with intellectual disabilities (Wechsler, 1999) and staff were asked about whether each participant had had any sex education, whether they had a history of sexual abuse and whether they knew of any convictions.

Procedure

Once the study had gained ethical approval, the following services were approached and asked if they would like to participate:

(1) three wide-ability schools for non-disabled students in two large towns in Kent.

(2) two day services and five residential services for adults with intellectual disabilities in Kent and South London.

Of those approached, two of the schools agreed to take part and one declined. Of the day and residential services approached, three agreed (one day service and two residential services) and the other four declined, mainly on the grounds that they did not want their service users being asked about their sexual knowledge. Once services had agreed to take part, all service users who met the study criteria (see above) were asked if they would like to participate. Of the adults with intellectual disabilities, 98% of those invited to participate agreed to take part. All participants were paid a small fee for their contribution to the study.

The young people in the schools were all literate and they completed the questionnaires in groups during school time. Researchers were present to provide initial instructions on how to complete the questionnaires and to answer any queries. Adults with intellectual disabilities did not have good reading skills, so all questionnaires were read to them individually and their answers to questions were recorded by the researcher. This had the advantage that the researcher could check whether they were understanding the questions as they went along.

Reliability and analysis

Inter-rater reliabilities were checked by recording the interviews for 10% of participants;

answers were then transcribed by two different raters independently. Mean percentage agreements for the Understanding Consent and Abuse measure and the Vignettes measure were 93.4% and 89.3% respectively (ranges 87–100% and 81–94%).

Analysis was conducted using SPSS (version 11). Non-parametric statistics (Mann–Whitney tests; Spearman correlations) were employed for all ordinal data; *t* tests were applied for testing group differences for interval data (e.g. age and IQ).

RESULTS

Participants

Participants were recruited until there were 60 adults with intellectual disabilities (30 male and 30 female) and 60 young people without disabilities (30 male and 30 female). Overall, 97% of participants classified themselves as white British, reflecting the composition of the general population in the areas of recruitment. As regards religious convictions, 33/60 (55%) of the students and 25/60 (42%) of the adults with disabilities said they were Christian, while 20/60 (33%) and 34/60 (57%) respectively said they had no religious beliefs (and a few were Muslim or had other religions).

The mean ages (and standard deviations) for each group were 37.6 years (s.d. = 10.4) for the adults with intellectual disabilities (ID group) and 16.6 years (s.d. = 0.55) for the young people from mainstream schools (YP group). The mean ages of the women and the men in each sample were not significantly different (37.4 and 37.7 years old respectively in the ID group; 16.6 and 16.7 years old respectively in the YP group).

Students in the mainstream wide-ability schools were assumed to have abilities in the normal range and were not tested for IQ. Adults with intellectual disabilities were assessed on the Wechsler Abbreviated Scale of Intelligence (Wechsler, 1999). The mean IQ was 59.8 (s.d. = 8.9). The minimum IQ was 55 and five people had scores that were above 70 (these adults were kept in the study on the grounds that they had been administratively defined as having an intellectual disability and were receiving intellectual disability services, although of course technically they did not have such a disability). Again, men and women had similar mean IQ

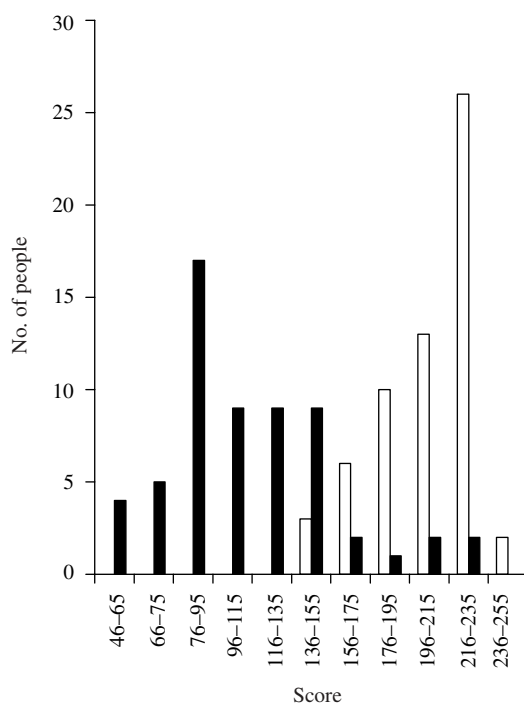


Fig. 1. Total sexual knowledge scores for adults with intellectual disabilities (■, ID group) and young people (□, YP group).

scores that were not significantly different (60.5 and 59.1 respectively).

Evidence from staff, working with the participants with intellectual disabilities, suggested that 49/60 (82%) of them had received some kind of sex education, either at school or in their residential or day service. This compares with the self-report of adults with intellectual disabilities, 33/60 (55%) of whom said that they had received sex education in the past, in answer to a question on the Sex-K-ID. In contrast, 59/60 (98.3%) of the young people said, in answer to the same question, that they had received sex education.

Sexual knowledge

Sexual knowledge scores for the young people and people with intellectual disabilities differed significantly, at $p < 0.001$ in all cases. In the initial interview (interview 1), which covered more basic issues, the mean scores were 37.2 (s.d. = 8.2) for the ID group and 48.0 (s.d. = 6.3) for the YP group. For interview 2, the mean scores were 75.2 (s.d. = 33.9) for the ID group

Table 1. Responses to key sexual knowledge questions from interviews 1 and 2

Questions		Young people (n=60)	Adults with intellectual disabilities (n=60)
Q16. Do you have a boyfriend/girlfriend/partner?	No	29 (48.3%)	24 (40.0%)
	Yes	31 (51.7%)	36 (60.0%)
Q25. Have you ever been out on a date before?	No/don't know	4 (6.7%)	34 (56.7%)
	Yes	56 (93.3%)	26 (43.3%)
Q110. What is a condom?	Correct	26 (43.3%)	5 (8.3%)
	Partially correct	30 (50.0%)	20 (33.0%)
	Incorrect	1 (1.7%)	35 (58.3%)
Q112. What does it do [a condom]?	Correct	54 (90.0%)	8 (13.3%)
	Partially correct	2 (3.3%)	22 (37.0%)
	Incorrect	4 (6.7%)	30 (50.0%)
Q116. Can you name anything else that can be used as a form of birth control?	Correct	44 (73.3%)	5 (8.3%)
	Partially correct	11 (18.0%)	12 (20.0%)
	Incorrect	5 (8.3%)	43 (71.7%)
Q122. What is pregnancy; what does it mean to be pregnant?	Correct	55 (91.7%)	19 (31.7%)
	Partially correct	5 (8.3%)	29 (48.0%)
	Incorrect	0	12 (20.0%)
Q147. What is AIDS?	Correct	11 (18.3%)	1 (1.7%)
	Partially correct	28 (47.0%)	23 (38.0%)
	Incorrect	6 (10.0%)	36 (60.0%)
	No answer	15 (25.0%)	0 (0%)
Q149. What is the best way to stop getting AIDS?	Correct	47 (78.3%)	11 (18.3%)
	Partially correct	6 (10.0%)	3 (5.0%)
	Incorrect	7 (11.6%)	46 (76.7%)
Q158. What is homosexuality?	Correct	45 (75.0%)	8 (13.3%)
	Partially correct	10 (17.0%)	4 (6.7%)
	Incorrect	5 (8.3%)	45 (75.0%)
Q166. What is the legal age for someone to have a sexual relationship?	Correct	50 (83.3%)	17 (28.3%)
	Partially correct	9 (15.0%)	14 (23.0%)
	Incorrect	1 (1.7%)	29 (48.3%)

and 155.1 (s.d. = 19.2) for the YP group. For interviews 1 and 2 together, the highest scores were 228 (ID) and 243 (YP), while the lowest scores 48 (ID) and 150 (YP) (see also Fig. 1).

There were no significant gender differences in scores for sexual knowledge between the men and women with intellectual disabilities. However, the young men and young women in the non-disabled group differed significantly on interview 2 (respective mean scores 147.7 and 162.4, $p < 0.01$) and on their total scores for interviews 1 and 2 combined (respective mean scores 195.4 and 210.7, $p < 0.05$), the women scoring more highly on average.

The sexual knowledge questions covered a wide range of issues and it could be argued that some areas were more crucial than others, especially when considering capacity to consent to sexual relationships. For these key topics, there were significant differences between the knowledge of young people and the knowledge of adults with intellectual disabilities, including in questions on pregnancy, awareness of sexually

transmitted diseases, contraception, same-sex relationships and the law. Table 1 shows the percentage of correct responses by young people and adults with intellectual disabilities on these key topic areas.

Understanding consent and abuse

There were significant differences between the ID and YP groups in their scores for all but one of the 10 sets of questions in the Understanding Consent and Abuse scale, with the young people scoring more highly than the people with intellectual disabilities ($p < 0.001$ for pictures 1, 3–5, 7–10; $p < 0.05$ for picture 6; n.s. for picture 2). Generally (excluding picture 2), both consenting and non-consenting images were understood better by the young people. Interestingly, three service users with intellectual disability scored higher than the highest score for the young people (107). Twelve people with intellectual disabilities scored lower than the lowest score for the young people (less than 52) (Fig. 2).

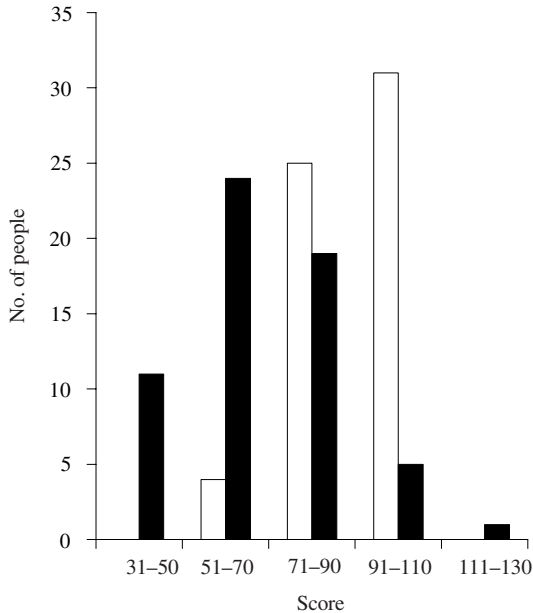


FIG. 2. Total scores for Understanding Consent and Abuse for adults with intellectual disabilities (■, ID group) and young people (□, YP group).

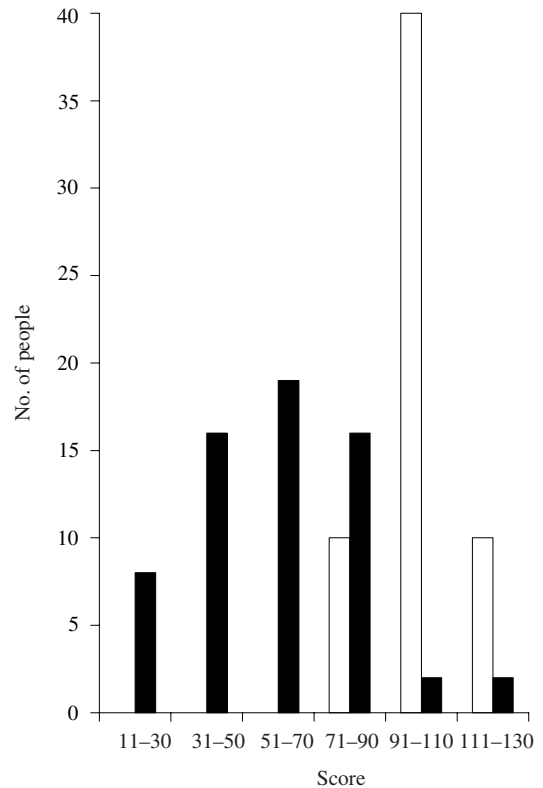


FIG. 3. Total Vignettes scores for adults with intellectual disabilities (■, ID group) and young people (□, YP group).

Pictures of same-sex relationships met with mixed responses. Of the adults with intellectual disabilities, 36.7% said same-sex female relationships were 'not OK' and 45% said this about same-sex male relationships. Fewer young people made negative comments about same-sex relationships: 6.7% said consenting female same-sex relationships were wrong/not OK and 3.3% said this about male same-sex relationships. Some adults with intellectual disabilities also said in response to consenting heterosexual images that 'it was not OK' and/or that the person in the picture should tell their parents/police/staff what had happened (for example, 28% said this in response to the picture of a consenting heterosexual encounter, showing sexual intercourse, whereas only one person from the YP group felt this was 'not OK').

There were no significant gender differences between the men and women with intellectual disabilities in their scores on the Understanding Consent and Abuse pictures; the YP group also showed no differences, except on picture 9 ($p < 0.05$).

Vignettes

The mean scores for the ID group on the Vignettes were significantly lower than those for the YP group, on all five vignettes, for both recall of facts and understanding [mean total fact scores were 17.5 (s.d. = 7.7) for the ID group, 28.7 (s.d. = 3.9) for the YP group; mean total opinion scores were 41.6 (s.d. = 16.4) for the ID group and 71.9 (s.d. = 8.7) for the YP group]. The highest score for the adults with intellectual disabilities was 120, while the highest for young people was 124. The lowest individual scores were 13 (ID group) and 71 (YP group) (see Fig. 3).

There were no significant gender differences for people with intellectual disabilities in their scores for individual vignettes, either for facts or understanding. For non-disabled young people, on the other hand, there were a number of significant gender differences on the vignettes: in vignette 1, on understanding scores ($p < 0.01$),

in vignette 2, on understanding scores ($p < 0.05$), in vignette 5, for facts scores ($p < 0.001$), in vignette 6, for facts and understanding scores ($p < 0.05$; $p < 0.001$ respectively), and for overall facts and understanding scores ($p < 0.01$, $p < 0.01$ respectively). In all cases, the young women's scores exceeded the young men's.

Correlations with IQ

The adults with intellectual disabilities varied considerably in ability. It appeared that IQ was positively correlated with total scores on the sexual knowledge measure, interview 1 ($\rho = 0.35$, $p < 0.01$) and interview 2 ($\rho = 0.28$, $p < 0.05$), with total scores on the Understanding Consent and Abuse pictures ($\rho = 0.43$, $p < 0.001$), with Vignettes total fact scores ($\rho = 0.39$, $p < 0.01$) and Vignettes understanding scores ($\rho = 0.34$, $p < 0.01$). The YP group were not tested for IQ.

The effect of previous sex education

It appeared that previous sex education did make a difference to the scores that people with intellectual disabilities obtained on a number of the measures: people in the ID group who said they had had sex education had a mean score of 39.5 (s.d. = 8.8) on sexual knowledge interview 1, a mean score of 84.3 (s.d. = 37.3) on sexual knowledge interview 2, and a mean score of 73.0 (s.d. = 18.7) for Understanding Consent and Abuse, as compared with 34.3 (s.d. = 6.5), 64.0 (s.d. = 25.4) and 60.0 (s.d. = 16.4) respectively for people in the ID group who said they had not had sex education (these differences were significant at $p < 0.05$, $p < 0.05$, $p < 0.05$ respectively). Results using staff report of people's prior sex education were very similar.

Correlations between measures

For people with intellectual disabilities, there were a number of correlations between measures. Total scores on the Understanding Consent and Abuse measure correlated significantly with sexual knowledge scores for interview 1 and 2 ($\rho = 0.42$, $p < 0.001$ and 0.60 , $p < 0.001$ respectively), and with Vignettes scores for both 'facts' and 'understanding' ($\rho = 0.77$, $p < 0.001$ and 0.75 , $p < 0.001$ respectively).

There were also a number of significant correlations between the various scores for different

measures for the young people: Understanding Consent and Abuse scores correlated significantly with the sexual knowledge interview 1 and 2 scores ($\rho = 0.29$, $p < 0.05$ and 0.29 , $p < 0.05$ respectively); the sexual knowledge interview 1 and 2 scores correlated significantly with the Vignettes total scores, for 'facts' ($\rho = 0.28$, $p < 0.05$ and 0.34 , $p < 0.01$ respectively) and 'understanding' ($\rho = 0.26$, $p < 0.05$ and 0.51 , $p < 0.001$ respectively); Understanding Consent and Abuse scores also correlated significantly with the total score for 'understanding' on the Vignettes ($\rho = 0.26$, $p < 0.05$).

DISCUSSION

Sexual knowledge

The evidence from the Sex-K-ID suggested that the levels of sexual knowledge for people with intellectual disabilities were far lower than for non-disabled 16- to 17-year olds. These differences were particularly marked for Sex-K-ID interview 2, which required more advanced knowledge. There was, however, some overlap between the two groups' scores (see Fig. 1). Others have found similar results (Macdougall & Morin, 1979; McCabe, 1999).

Adults with intellectual disabilities often lacked knowledge in a number of key areas, including pregnancy, masturbation, contraception, birth control, STDs, types of sexual relationships and legal aspects of sex. It could be argued (see below) that not all of these areas are essential for capacity to consent, although most would argue that understanding basic issues of sexual health and pregnancy are essential.

There could be a number of reasons why adults with intellectual disabilities have much lower levels of sexual knowledge. It is clear that they had had less sex education than the young people. They may well also have had less informal sex education (from peers and/or from magazines) and/or information from parents, fewer girlfriend/boyfriend relationships and thus fewer sexual experiences than the young people (O'Callaghan & Murphy, 2002).

Vulnerability

People with intellectual disabilities appeared to be less good at understanding social situations of consent and abuse, at least when portrayed pictorially, than young people (see Figs 2, 3).

Adults with intellectual disabilities showed limited understanding of consenting and non-consenting situations and often considered a consenting situation as 'wrong', while non-consenting situations were sometimes *not* recognized as abusive. This suggested that they were more vulnerable to abuse, as others have also found (Wilson *et al.* 1996), perhaps partly because they do not recognize abusive situations. This apparently increased level of vulnerability may be partly accounted for by the limited sexual knowledge of adults with intellectual disabilities. Without sufficient knowledge and education, it is difficult to decide what is and is not acceptable socio-sexual behaviour in other people.

Implications for capacity to consent

The results of this study have far-reaching implications for the issue of capacity to consent to sexual relationships. The fact that adults with intellectual disabilities had far less sexual knowledge and were less able to spot abusive situations than young people aged 16 years, who are presumed able to consent in law, raises the question of when a person 'knows enough' to be safe, so that they can be protected from abuse whilst at the same time maintaining a right to freedom of sexual expression. Can a minimum criterion be set for capacity to consent to sexual relationships? In the past, in the UK and the USA, this criterion was often based on IQ, where it was applied at all (Gunn, 1996; Stavis & Walker-Hirsch, 1999).

There are a number of possible ways in which such a criterion could be set. It could, for example, be set at a level equivalent to the knowledge and understanding of the lowest-scoring non-disabled 16-year-old, on the grounds that in law all these young people are presumed to be able to consent. However, were it set at this level most of the people with intellectual disabilities would be deemed unable to consent, since there was relatively little overlap in their scores (see Figs 1–3). Alternatively, the criterion could be set in a statistical way, as two standard deviations below the norm for the young people, on the grounds that this is how 'abnormally low' levels are determined in other areas, such as IQ, height, blood tests results and so on. This would mean, however, that there would still be large numbers of people with intellectual disabilities

considered unable to consent to sexual relationships and it would also mean that about 2.5% of young people would fall below the criterion level.

The third alternative would be to set the criterion in terms of a social minimum of knowledge required to engage in sexual relationships. Using the analogy of consent to treatment (Grisso & Appelbaum, 1998; Wong *et al.* 2000; Murphy & Clare, 2003), it could be argued that capacity to consent to sexual relationships should similarly require people to understand what sexual relationships are, the risks, benefits and alternatives of such relationships and the fact that they have a free choice about engaging in them. Kaeser (1992), however, would argue that knowing all this in any detail would be far too restrictive, since in his view people should merely need to be able to consent to the sexual activity, while their staff and carers could know about and protect them from harmful consequences.

A less stringent suggestion for determining capacity to consent to sexual relationships, made as part of the consultation on the Home Office review of sexual offences legislation, was that people should at least know: (1) that sex is different from personal care; (2) that penetrative vaginal sex can lead to pregnancy; and (3) that penetrative anal sex is associated with a risk of HIV/AIDS [Foundation for Learning Disabilities (Home Office, 2000, p. 71)].

A study by Kennedy and Niederbuhl (2001) in the USA examined the views of over 300 psychologists on the criteria required for determining the capacity to consent to sexual relationships. They found a wide range of opinions but, in general, knowledge related to pregnancy, sexually transmitted diseases, basic gender differences, sexual conduct and personal safety were rated as most important, while biological issues (such as the meaning of ovulation, impotence, menopause) and moral issues were rated as far less important.

Clearly, the number of people who would be construed as having the capacity to consent to sexual relationships would be higher if the basic criterion were set lower. There is a careful balance to be struck between requiring people to know enough without requiring them to know everything. Even with a minimal definition of the kind proposed by the Foundation for

Learning Disabilities (see above) about 50% of the people with intellectual disabilities in the current research would have been deemed unable to consent. Many more would fail if the criterion were set higher.

Finally, it is important to note that, for an individual, capacity to consent to sexual relationships, however defined, is not likely to be a static phenomenon. There was clear evidence in this study that sex education was associated with higher levels of knowledge and lower levels of vulnerability amongst people with intellectual disabilities. There needs to be better provision of sex education, particularly on-going sex education, as opposed to the 'single inoculation' model, in order to allow people with intellectual disabilities to exercise their sexual rights, while at the same time protecting themselves from abuse.

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