






Sexual offences: A focus on victims with intellectual disability, a vulnerable population

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Victims of sexual offences who have intellectual disabilities (IDs) face many challenges when formal charges are laid. When seeking a just outcome, the legal fraternity relies on valid and reliable testimony in order to prosecute alleged perpetrators. This review article discusses some of these challenges, which could include other comorbid medical and psychiatric conditions, firstly defining ID together with a classification of severity. The authors then provide some insights into the victim assessment unit at Sterkfontein Hospital with regard to the history of the outpatient unit, procedure, methods of assessment, and reporting to the courts. Finally, some important ethicolegal considerations are considered, emphasising the facilitation of legal processes and ensuring justice while preserving autonomy, beneficence and non-maleficence. The review concludes with a recommendation for an analysis of all victims who have been referred to the unit to date.

Keywords: intellectual disability, sexual offences, victims, testimony

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The path to justice in the area of sexual offences in the South African (SA) context is riddled with challenges. These include, *inter alia*, high prevalence rates, lack of awareness of processes following a sexual offence, and difficulties with investigative procedures. These factors often affect outcomes for both alleged perpetrators and victims. When a victim has intellectual disability (ID), this generally adds a further layer of complexity. Failure to address these challenges may have a significant negative impact on a just outcome.

This review addresses some of the major challenges noted from the experiences at a victim assessment unit (VAU) at a forensic psychiatric hospital with a view to driving important legislation in the area of sexual offences when the alleged victims are intellectually disabled.

Intellectual disability: Definition, classification and comorbid conditions

ID is a neurodevelopmental disorder that begins in childhood and is characterised by intellectual difficulties, with a resultant impact on conceptual, social and practical areas of living.^[1] It reflects the 'fit' between the capabilities of the individual and the structures and restricted expectations of the environment.^[2] The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5), criterion A includes deficits in intellectual functions that may or may not be confirmed by standardised intelligence testing.^[1] IQ scores are no longer used to classify severity (mild, moderate, severe and profound). Instead, the DSM-5 now classifies severity on the basis of adaptive functioning,^[3] defined as 'a broad concept referring to an individual's ability to cope with the day-to-day demands of his/her environment.'^[4]

According to the DSM-5, an evaluation of ID includes the following domains: verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, and abstract thinking.^[1] If one considers standardised tests to define intelligence, a score of 100 is considered normal-average, while intellectually disabled people are usually two standard deviations below the average (IQ <70).^[5] Various issues (e.g. co-occurring communication problems, sensory or motor difficulties) can affect assessment.^[5] Tools such as the Supports Intensity Scale, used primarily in the USA, evaluate the support needs of an individual across 49 life activities, including home living, community living, lifelong learning, employment, health and safety, and social activities.^[6] In the SA context, the assessment of individuals with ID is conducted largely on clinical grounds, owing to the lack of standardised tools that speak to the cultural and social diversity of the population. Furthermore, lack of English language proficiency and low educational levels often impede the use of intelligence testing tools such as the Wechsler Adult Intelligence Scale, 4th SA edition.

The classification of ID encompasses the following degrees of impairment: mild, moderate, severe and profound (Table 1).^[1]

Many neurodevelopmental, psychiatric and other medical disorders co-occur with ID, especially communication disorders, learning disorders, cerebral palsy, epilepsy, and various genetic conditions.^[7] The presence of additional conditions often leads to 'diagnostic overshadowing',^[7] which is the tendency to attribute symptoms and functioning to the ID rather than the other comorbid disorders. This bias could lead to under-investigation and under-treatment, which may compound the clinical picture.

Table 1. Classification of severity of intellectual disability^(1,5)

Domain	Mild	Moderate	Severe	Profound
Conceptual	Can do practical life skills	Can learn basic skills	Can learn simple tasks; however, owing to major developmental delays, this can lead to difficulties with speech, or minimal communication skills are obtained	This is usually associated with congenital syndromes
Social	Requires minimal/no support	Requires minimal support	Requires supervision	Individual is dependent on others
Activities of daily living	Requires minimal/no support	Requires moderate support	Requires supervision	Individual is dependent on others

In one study on children from low-income backgrounds, there was a four- to five-fold increase in mental health problems among individuals with ID⁽⁵⁾ compared with those without ID. In general, at least 25% of people with ID may have significant psychiatric problems, with the population experiencing significantly increased rates of schizophrenia, depression, and attention-deficit/hyperactivity disorder.⁽⁸⁾

Intellectually disabled individuals remain among the most vulnerable members of society and often face many barriers to healthcare. They experience major health problems and risks, yet pay a 'disability penalty', the result of social exclusion, discrimination and isolation. The varied range of highly complex needs includes mental and other health needs. Their often-problematic behaviour as well as their vulnerability promotes marginalisation. It also results in vulnerability to sexual offences.⁽⁹⁾

Issues of capacity to consent to sexual activity, as well as an inability to express distress, depending on the degree of ID, may lead to victims of sexual offences not reporting crimes or not being taken seriously if they do report a sexual offence. Developments in SA legislation include the mandatory reporting of even suspected abuse and suspected sexual offences in vulnerable groups (including people with ID). The obligation to report such suspected offences falls not only on a wide range of professionals but also on all adult persons, and is legislated by the Domestic Violence Amendment Act 14 of 2021⁽¹⁰⁾ and the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007⁽¹¹⁾ and 13 of 2021.⁽¹²⁾ These Acts may assist the National Prosecuting Authority (NPA) in managing the high prevalence of sexual crime in the country and assist them in successfully prosecuting perpetrators.⁽¹³⁾ However, victims with ID often fall through the cracks in the legal system and may not have a just outcome.

Victims of sexual offences with ID are entitled to fairness in the judgment process, as are perpetrators. An appropriate service for the assessment of these victims is therefore essential, and may aid in an objective, reliable and fair court process. One such service, where victims with established or suspected ID are referred for assessment of capacity for involvement in the legal process, does exist. However, the assessment process has yet to be challenged.

The VAU at Sterkfontein Hospital

A VAU/programme was launched in 2015 at Sterkfontein Hospital's forensic unit. This was born out of need and recurrent requests from the NPA for all Southern Gauteng courts. Until then, the forensic

psychiatric services were mandated to manage all observandi only. This service aims to assist the court's determination in three critical areas according to the Sexual Offences and Related Matters Amendment Act 32 of 2007:⁽¹¹⁾

- the victim's level of intellectual disability
- the victim's ability to consent to sexual acts
- the victim's competency as a witness/ability to testify in court proceedings.

The victim assessment process is conducted on an outpatient basis. An alleged victim of a sexual offence is identified by the court as presenting with established or possible ID. The alleged victim's possible intellectual disability is brought to the attention of the court by the victim themselves, a family member or guardian, or the legal advisor appointed to the case. A referral for assessment to assist the court is then made from the offices of the NPA or the presiding officer. The comprehensive assessment involves a triad approach. After physical examination (by a medical doctor), a thorough clinical interview with cognitive screening measures is conducted by a psychologist from the forensic unit. Collateral information is obtained by the psychologist or social worker as required.

There is a focus on the victim's understanding of the referral, as well as relevant background information. Family medical, psychiatric, occupational and educational histories are documented, as this can provide useful information regarding difficulties that may be historical/genetic in nature, e.g. congenital abnormalities, twinning, family histories of disorders, scholastic difficulties including primary or secondary failures, and special education.

A systematic enquiry that examines the victim's mental health is conducted. This includes exploring a previous psychiatric history, as well as a history of epilepsy. The latter is important, as the neuropsychiatric aspects of epilepsy, untreated or with recurrent seizures, may have an independent or additional impact on the mental state of the individual, both at the time of the alleged offence and during legal proceedings, such as appearing as a witness. Other relevant medical conditions apart from epilepsy, such as cerebral palsy and HIV infection, are documented. Substance use history is also documented, and the victim's adaptive functioning is explored and documented in detail. This information gives the evaluator a good indication of how the victim is able to cope with daily demands. When the reliability of the reporting of activities of daily living is in question, a referral to occupational therapy may be made to conduct a functional assessment.

Cognitive screening measures such as the Mini-Mental State Evaluation or the Montreal Cognitive Assessment are used.^[14,15] These are not comprehensive measures of neuropsychological or cognitive abilities, but can give an indication of general cognition. If difficulties pertaining to cognitive functioning are identified, notwithstanding the language and education obstacles, further neuropsychological testing is conducted.

Once all information has been gathered, a diagnostic formulation is made with regard to the presence or absence of ID according to the DSM-5. It includes both intellectual and adaptive functioning deficits in conceptual, social and practical domains. Comment is then made regarding the following:

- the ability to appreciate the nature and reasonably foreseeable consequences of a sexual act
- the ability to appreciate the nature and reasonably foreseeable consequences of such an act, but the inability to act in accordance with that appreciation
- the ability to resist the commission of any such act
- the ability to communicate his or her willingness to participate in such an act
- competency as a witness.^[11]

Owing to the vulnerability of people with ID, recommendations are made in the report with regard to the provision of further assistance to the victim. This may be in the form of psychological counselling/support or the engagement of social work services to assist the victim in the legal process.

Having the VAU at Sterkfontein Hospital, with the process as outlined, has distinct benefits and advantages, as evident from the comprehensiveness of the assessments. While awaiting an in-depth study into the nature of the assessments, as well as the outcome of those assessed, we explore important ethicolegal considerations in the following section.

Ethicolegal considerations

Interests of justice

The ability of a victim to understand court processes and provide testimony serves the interests of justice. Just as an accused has the right to a fair trial, it is in the interests of the victim and society at large that an alleged perpetrator be tried so that justice may be served (Criminal Procedure Act 51 of 1977,^[16] sections 77 - 79). Faith in the justice system on the part of the general population is an important factor that gives credibility to the criminal justice system. This faith is enhanced when justice is seen to be done. It is therefore important that all reasonable effort be made to determine a victim's fitness to provide testimony so that the legal process may be supported.

Facilitation of the legal process

The determination of a victim's fitness to testify allows assessors to understand the victim's overall level of functioning. The court can then be advised on appropriate measures that may be recommended to accommodate the victim in the court setting, such as providing testimony through an intermediary when it may provoke anxiety for a victim to face an alleged perpetrator in court. Such measures could assist the overall legal process.

Respect for autonomy

Autonomy is one of the pillars of ethics that underpins good clinical practice.^[17] A comprehensive assessment allows an assessor to make a sound judgement of the victim's functioning and thereby not arbitrarily make a recommendation that infringes on a victim's autonomy. A thorough assessment is able to determine whether they are capable of involvement in a legal process that is aimed at achieving justice. Recommending that a victim is able to be involved, when this is appropriate and reasonable, promotes the autonomy of the victim.

Beneficence towards victims

Comprehensive assessment of the victim's ability to testify promotes their inclusion in the legal process and can help to empower them. This inclusion is beneficial for victims in that it helps them feel part of a process that may otherwise be intimidating. A process that encourages inclusion prevents arbitrary exclusion on the basis of ID. It guards against automatic exclusion solely on the basis of a previous diagnosis without a focused inquiry. It protects against arbitrary exclusion as a result of a focus on factors that may not necessarily be relevant to participation in the legal process. All this is in the interests of the victim of a sexual offence.

Addressing stigma against those with ID

Individuals with ID may endure discrimination on the basis of their diagnosis. This is a deep-seated problem that extends to many areas in society.^[18]

The justice system is one tool that can be utilised to address unfair discrimination. When a legal process for victims with ID is facilitated, it contributes towards challenging the automatic stigma that often disadvantages them. It assists in combating an unfair denial of participation in a legal process. In addition, it protects those who may not have the functional capacity to be a part of the legal process. It accomplishes this by preventing their inclusion in a process that may be damaging to them and thereby stigmatise them further.

Conclusion and recommendations

Assisting the justice system in the matter of sexual violence towards individuals with ID is important and just. The human rights principles pertinent to victims of sexual assault with ID must be upheld. It is recommended that knowledge around the vulnerable population of victims with ID be improved by means of further research. The first step would be to establish the magnitude of the problem, i.e. how many victims of sexual offences are referred, how many are assessed as not fit to testify due to ID and/or comorbid psychiatric disorder/s, and whether the methods used are valid and reliable.

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