

**Protection or paternalism? A critical evaluation of
Australian legislation relating to sexual acts
involving persons with intellectual disability**

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I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary education institution.

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Abstract

As a result of the development and recognition of human rights and of the principle of normalisation, in recent decades sweeping changes have occurred in the living conditions of many people with intellectual disability. The United Nations Declaration on the Rights of Mentally Retarded Persons (1971) contains statements to the effect that, as far as possible, the lives of disabled persons should resemble those of their non-disabled peers, and this presumably extends to sexual expression. However, the words “as far as possible” imply that in some circumstances, limitations on a right may be justifiable. One such circumstance is where a competing right exists, for example, the right to sexual expression has to be balanced against a right to protection. Under some conditions, the provision of protective measures may fall to the criminal justice system, which may be used to afford protection to persons with intellectual disability. Australian jurisdictions have used three different approaches in current legislation: to set a minimum standard of sexual knowledge that must be present before the person is deemed capable of consent to sexual activities; to prohibit sexual relations with persons holding power or authority over the person; and to proscribe all sexual exploitation. This thesis contains proposals for reforms to each category of legislative provisions. First, it is suggested that the standard of knowledge required to support consent should more closely resemble the knowledge required for informed consent to medical procedures. Second, restrictions on sexual activity with persons with intellectual disability based

on employment status should be relaxed where the role of the staff member does not confer power to coerce people with intellectual disability. Third, with regard to the prosecution of offences against incapable persons with mental impairment, it is proposed that the charge should be sex without consent. On the other hand, it is argued that prosecution under criminal law is inappropriate where a vulnerable but capable person is deemed to have been exploited. The thesis contains a number of further recommendations for the reform of anomalies which exist between the general law of sexual offences and those committed specifically against persons with mental impairment. It is suggested that marriage be abolished as a defence to sexual acts with an incapable person and that offences against persons with mental impairment carry equivalent penalties to general sexual offences. On the basis of literature reviewed in this thesis, two additional proposals have been made. First, that education in the sexual rights of persons with intellectual impairment should be given to carers so that they do not unduly inhibit the development of sexual relationships by that person. The second proposal is that reform should be accompanied by the provision of repeated, appropriate, detailed and specific sex education of all persons with intellectual impairment and that this education should be based on needs identified in the aforementioned research. The tentative outcome of proposals contained in this thesis is that persons capable of consent would enjoy enhanced freedom to exercise their right to sexual expression, and those incapable of consent would be afforded more certain protection.

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Chapter 1: Introduction

The focus of this thesis is those sections of Australian law that define sexual offences where one person is incapable of consent due to mental impairment. Due to that incapacity, any sexual act involving that person constitutes sex without consent. In Australian jurisdictions, such crimes are defined separately in legislation from other sexual offences in which the external element is that the act is non-consensual. A benefit of these special sections is that they afford protection to vulnerable persons with mental impairment, because such persons may acquiesce to another person's sexual advances without any real understanding of sexual acts. There are, however, costs associated with this approach such as paternalistic interference in the basic rights of those affected by this legislation. This thesis will examine the relevant legislation with reference to basic human rights and to normalisation theory.

Normalisation theory

According to normalisation theory, the person with mental impairment should be aided to achieve a valued role in society, and be encouraged and supported in his or her efforts to live as normal a life as possible.

Normalisation has been defined as:

The utilisation of culturally normative means (familiar, valued techniques, tools, methods), in order to enable persons life conditions (income, housing, health services etc) which are at least as good as that of average citizens, and to as much as possible, enhance or

support their behaviour (skills, competencies, etc), appearances (clothes, grooming, etc), experiences (adjustment, feelings etc) and status and reputation (labels, attitudes of others etc) (Wolfensberger, 1980, p. 80).

This formulation included the notion that people with disabilities should be shaped and changed, through their image and competencies, to be more acceptable to the community, and as such, it signalled a move away from an initial rights orientation and placed more emphasis on the roles of services and professionals in preparing people for community living (Chenoweth, 2000). Because of concerns that it was greatly misunderstood, misinterpreted and misused, Wolfensberger (1983) later reconceptualised normalisation as social role valorisation (SRV). He defined SRV as “the creation, maintenance and defence of valued social roles for people, particularly those at value risk, by the use, as much as possible, of culturally valued means” (Wolfensberger, 1983, p. 234).

In Australia in the 1980s, normalisation and later SRV were quickly embraced by the Commonwealth and State Labor governments as part of their social justice agenda. These policies provided the theoretical base for the *Commonwealth Disability Services Act 1986*. Its principles and objectives were heavily oriented towards community integration and a policy of deinstitutionalisation (Chenoweth, 2000).

Because the person's adult peers without disability are free, within some limits, to express their sexuality, normalisation theory would suggest that adults with mental impairment should also be free to express their sexuality unless such expression put them at risk of being unacceptably exploited or harmed in any other manner.

Human rights

According to the human rights perspective, it is commonly said that two competing rights exist: a right to protection and a right to sexual expression (see, for example, Carmody, 1990, 1991; Hayes, 1993; Kennedy, 1999; Kennedy & Niederbuhl, 2000; Sundram & Stavis, 1994). These statements are usually accepted without question, and this might well be appropriate in some jurisdictions. However, its acceptance in Australian jurisdictions is a matter I would like to examine here.

UN Declarations. Australia does not have a Bill of Rights. However, two UN declarations ratified by Australia contain the rights of persons with impairment. The *Declaration on the Rights of Disabled Persons* states that persons with disabilities have "the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible" (Article 3), and that they have "the same fundamental rights and civil and political rights as other human beings" (Article 4). The *Declaration on the Rights of Mentally Retarded Persons* states that "the mentally retarded person has, to the maximum degree of

feasibility the same rights as other human beings” (Article 1). Article 5 states: “The mentally retarded person has a right to a qualified guardian when this is required to protect his personal well-being and interests.”

A third UN document. A third UN document, the *Convention on the Rights of Persons with Disabilities*, has been signed but not yet ratified by Australia. In it, Article 16 (1) states that “states parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.” Article 22 states: “No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation. Persons with disabilities have the right to the protection of the law against such interference or attacks.” According to Article 25 (a), states parties must “provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes”. Finally, in Article 28, states parties “recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability...”.

As Australia is a signatory to all three documents, it appears that Australia has indicated its willingness to abide by the rights set out therein. It appears that, when the rights have been drafted into domestic law, persons with disabilities have the same rights as other citizens and that their rights may be limited only where justification is provided. The right of persons with mental impairment to protection is specifically enunciated.

The right to sexual expression. The right to sexual expression has been enunciated in the *Human Rights (Sexual Conduct) Act 1994 (Cth)*. Section 4 (1) reads: "Sexual conduct involving only consenting adults acting in private is not to be subject, by or under any law of the Commonwealth, a State or a Territory, to any arbitrary interference with privacy within the meaning of Article 17 of the International Covenant on Civil and Political Rights."

The position adopted in this thesis. In this thesis I will adopt the position that both the right to sexual expression and the right to protection do in fact exist. The ideal is to achieve a balance between these competing rights. If a high standard of knowledge is demanded in order that the person with mental impairment is deemed capable of consent to sexual expression, the number of individuals who are able to achieve capacity will be diminished. The advantage of this position is that more persons will then be afforded whatever protection the law can provide. The cost associated with this approach is that it restricts freedom of sexual expression. Yet if the right to sexual expression is prioritised, the protection that can be given to

vulnerable people is undermined. The challenge is to set a legislated standard so that those persons who require protection are given it, and those who are capable are allowed the freedom to express their sexuality by avoiding unnecessarily paternalistic interference from the law. This thesis will focus upon these questions: How well does existing law fulfill the function of protecting persons with mental impairment from harm? How well does it support the right to sexual expression? What changes could be implemented in law to support both rights concurrently?

A note on the interface between psychology and law

Before concluding this introduction I would like to comment on the interface between the disciplines of psychology and law. There are quite significant problems where these two sit together. Psychology works in multifactorial space, using continuous variables. In other words, psychology takes account of the whole range of human experience. It does this by looking at a person's position on each variable, and it examines their position on many variables. With regard to establishing each person's capacity to consent to sexual acts, some of the variables psychology would be interested in are the person's sexual knowledge, interest and desire; emotional volatility; self control; their ability to avoid danger; decision making ability; assertiveness, socialisation for compliance; life experience and intelligence. It is not possible to say that persons whose IQ (intelligence quotient) is less than a certain figure are automatically incapable of consent.

According to psychology, a person's capacity to consent depends on their understanding of the many aspects of life, including the variables mentioned above, and their IQ alone is not a determining factor in their capacity to consent. Intelligence must be considered against a background made up of other variables. In contrast, the law has to make a decision on capacity within its framework of dichotomous variables. At the heart of the matter is the determination of guilt or innocence, or the capacity or incapacity of the complainant. In general, in law a person is either guilty or not guilty, has capacity or does not have capacity. There are usually no half measures or shades of grey. Discrimination between degrees of guilt is not possible until the process of sentencing.

Format of the thesis. The format of the thesis is as follows. In Chapter 2, contextual and background information on the types of mental impairment that make suspect a person's capacity to give consent to sexual acts, with special focus on intellectual disability, is given. I also examine the definitions of mental impairment drawn from the law and other sources. Moreover, I identify the Australian laws that pertain to capacity to consent. The aim of this section is to present a framework within which to situate the thesis.

A history of intellectual disability and the law, from the earliest descriptions of mental illness and intellectual impairment, including the era of popularity enjoyed by the "science" of eugenics, the political policies that developed from that and the outcome of those policies, followed by the

present day laws and social strategies including the development of normalisation theory is presented in Chapter 3. In this section the changes in public and government attitudes over time and between nations are examined.

Following this I begin an examination of existing Australian law in terms of its content. I have found three types of legislative provision: those that proscribe the sexual exploitation of persons with mental impairment, those that set out a standard of knowledge that the person with mental impairment must have in order to be deemed capable of consenting to a sexual act, and those that ban sexual relations between the person with mental impairment and persons who provide them with services or who are in a position of authority over them.

Chapter 4 is a multi-authored published paper which examines the value (or lack of it) of using the term “sexual exploitation” in the law. My co-authors and I also discuss at length laws that ban sexual relations between carers and those in their care and those that set out a standard of knowledge that the person must have in order to be deemed capable of giving consent to a sexual act. We examine the validity of drafting law that applies only to a subsection of the population, asking whether such law is discriminatory or paternalistic.

Chapter 5, a second multi-authored published paper, examines the laws that set out a standard of necessary knowledge. It questions whether consent that is based on only knowledge of the nature and character of the

act, but specifically not the consequences of the act, as widely required by current law, can result in valid consent. Again, the contrast is made between the law as it applies to the general population and a subsection of it.

Chapter 6 further examines the validity of consent not underpinned by knowledge of the consequences of the act, positing that such a decision does not allow the person to make a decision in their own best interests. In it I argue that the current standard of sexual knowledge is too low to ensure that any person, not necessarily a person with mental impairment, is able to make a real choice in their own best interests.

Chapter 7 looks at two major discrepancies between the law that applies to the general population and that which applies only to the population with mental impairment. The first is the fact that marriage is allowed as a defence to charges under the relevant legislation. It is common knowledge that the marriage defence to charges of rape or sexual assault by a married person against their husband or wife has been removed from Australian law applying to the mainstream population.

The second discrepancy between provisions of the general law and that which applies to persons with mental impairment is that in some jurisdictions, the penalties that apply to an offence against a mentally impaired person are substantially less severe than those for an offence against a member of the general population. It is my position that this inequity reflects an attitude that offences against those with mental

impairment are less serious than those against a member of the general population. This type of law can be argued to be discriminatory.

Chapter 8 reviews the arguments made in Chapters 4 to 7 and extrapolates from them proposed amendments to existing law with the view to reducing discrepancies between the general law of sexual offences and those that apply only to offences committed against persons with mental impairment. The recommended legislative changes must deal with difficulties surrounding the notions of “relationship”, “exploitation”, “consent” and “protection”, terms that even a legal draftsman would find difficult to deal with. I have advanced definitions of these terms based in part on existing legal definitions and on definitions drawn from other areas such as ethics.

Finally, Chapter 9 summarises and presents the conclusions I have derived from my work.

Existing literature. As I commence, I would like to note that because there is only a comparatively small body of legal literature on the topic of capacity to consent and sexuality, some citations appear repeatedly in this thesis. Second, there is some repetition of background information because chapters were written as stand alone papers and it was necessary to provide a context in which to situate each set of arguments. In addition, I have drawn on literature from the fields of disability studies; psychology; philosophy, especially ethics; human rights; and women’s studies. The inclusion of work that falls within these disciplines is useful, I believe, in that it provides a broad framework in which to place the thesis. It also arguably provides a

more contemporary context than that provided by the law alone, given the law's self-referential discourse.

Chapter 2: Context and background

The difficulties of defining intellectual disability

It has long been recognised that there are different degrees of cognitive impairment, and levels of impairment have been named (and renamed in more politically correct ways). With regard to cutoff points for each level of impairment, the reason that I will use approximations is that different sources contain small differences in cutoff points for mild, moderate, severe and profound classifications. Furthermore, a low IQ score alone is not taken to be necessarily indicative of intellectual disability, though it should be reason for further assessment. For example, the definition of intellectual disability offered by the American Association on Mental Retardation (AAMR) reads:

Mental retardation refers to substantial limitations in present functioning. It is characterised by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work. Mental retardation manifests before age 18 (AAMR, 1992, p. 1).

The AAMR designates the cutoff point for intellectual impairment as IQ scores of between 70 and 75. In a similar vein, the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV-TR, 1994, p. 46) defines mental retardation according to three major criteria:

- A. Significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly subaverage intellectual functioning).
- B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her cultural group) in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety.
- C. Onset is before age 18 years.

It can be seen that while there are commonalities between these definitions, namely the presence of significantly subaverage IQ, deficits in life skills and onset before age 18, there is controversy over the point at which IQ scores should be recognised as indicators of serious deficits in intellectual function when combined with other adaptive deficits. For the purpose of this thesis, cutoff points are probably moot, since most people whose IQ is approximately 70 would usually be capable of consent (O'Callaghan & Murphy, 2002), unless education in sexual matters had been withheld. People with IQ scores around 70 are usually able meet some Australian jurisdiction's current criteria for capacity to consent, meaning that they are aware of the nature of sexual relations, are usually able to protect

themselves against exploitation and in many cases are aware of the consequences of sexual activity. The intellectual functioning of a complainant who was alleged to be incapable of consent would be assessed on a case-by-case basis by an expert on intellectual disability (McSherry, 1998a). Of course, the assessment process must be conducted using a set of criteria; it is the validity of the criteria that are being used to establish whether or not the individual is capable that is central to this thesis. According to Davis (1996), the courts are likely to examine the chronological and mental ages of the person, their IQ, their adaptive skills, school attendance, knowledge not only of the sexual act but also of pregnancy and STDs, ability to resist coercion, and understanding of the moral dimensions of sex.

Incidence

The incidence of persons with intellectual disability is estimated to be between 2 and 3 percent of the population (McSherry, 1999; Wen, 1997). Most intellectual disability is classified as mild, which means that the person has an IQ score between approximately 50 and 70, where 100 is the population mean (Irish Law Reform Commission, 1990; Oltmanns & Emery, 2001). IQ scores between approximately 35 and 49 signify moderate impairment, those between 20 and 34 are categorised as severe impairment, and persons whose IQ score is less than 20 are classified as having profound impairment. These classifications are listed in descending

order of prevalence; mild levels of disability are much more common than profound disability, which is least likely to occur. Individuals with a mild level of disability are usually able to live relatively independently (Wen, 1997). Of all gradations of intellectual disability, these individuals would be the most likely to be deemed capable of consenting to sexual acts according to current law, assuming that they had received education in sexual matters.

Description of the relevant laws

There are differences in the mental conditions that render a prosecution possible under legislation that defines sexual offences against persons with mental impairment. In the past, the *Criminal Code (WA)* contained statutory sexual offences against women with mental impairment. In *R v Lindsay* (1984), it was stated: "For the purposes of ss 188 and 189 of the *Criminal Code (WA)* an imbecile is a person in whose case there exists mental defectiveness, which though not amounting to idiocy, (as defined in the *Mental Deficiency Act 1927 (Imp)*), is yet so pronounced that she is incapable of managing herself or her affairs, such incapacity extending to and including an incapacity to make a reasoned judgment as to whether she should or should not consent to an act of a sexual nature proposed in relation to her."

Under contemporary law, Western Australia's *Criminal Code* s 330 defines offences that may under some circumstances be committed against persons who are mentally impaired. The term "mental impairment" is defined

in the *Criminal Code* (WA) s 1 as intellectual disability, mental illness, brain damage or senility. “Mental illness” is defined under the same section as an underlying pathological infirmity of the mind, whether of short or long duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to extraordinary stimuli. Intellectual disability is left undefined.

The precise contemporary definition of incapacity to consent, initiated into the WA *Criminal Code* by the *Acts Amendment (Sexual Offences) Act* of 1992, is specified in the new section, which states:

In this section a reference to an incapable person is a reference to a person who is so mentally impaired as to be incapable —

- (a) of understanding the nature of the act the subject of the charge against the accused person; or
- (b) of guarding himself or herself against sexual exploitation.

The remaining subsections define specific offences, penalties and defences available to charges under this section.

In the ACT, no precise definition is given in the *Crimes Act 1900* (ACT) of the underlying reason for mental incapacity that vitiates consent. Section 67 simply states that consent is negated by mental incapacity to understand the nature of the act in relation to which the consent is given.

The legislation of South Australia and New South Wales prohibits sexual offences with incapable persons where the incapacity is caused by

intellectual disability. In South Australia, no definition is given of the term “intellectual disability”. The New South Wales *Crimes Act* 1900 s 61H (1A) defines intellectual disability as appreciably below average general intellectual function that results in the person requiring supervision or social habilitation in connection with daily life activities.

Sexual offences against “intellectually impaired persons” are defined in the *Criminal Code* (Qld) s216. Under s 229F, "intellectually impaired persons" are persons who have a disability attributable to an intellectual, psychiatric, cognitive or neurological impairment or a combination of these that results in a substantial reduction of the person's capacity for communication, social interaction or learning and the person needing support.

In Tasmania, the term mental impairment covers senility, intellectual disability, mental illness and brain damage (Tasmanian *Criminal Code Act of 1924* s 126). The Northern Territory *Criminal Code* s130 defines offences against persons with mental illness or handicap. However, these terms are not defined in the *Criminal Code*.

The *Crimes Act* 1958 (Vic) s 50 defines offences against persons with “cognitive impairment”. Section 50 states that the impairment may result from mental illness, intellectual disability, dementia or brain injury. Intellectual disability, in relation to a person over the age of 5 years, means the concurrent existence of significant sub-average general intellectual

functioning, and significant deficits in adaptive behaviour, each of which became manifest before the age of 18 years.

The *Criminal Law Consolidation Act 1935 (SA)* s 49 (6) applies only in respect of intellectually disabled persons who do not understand the nature or consequences of the sexual act, and so where the victim describes his or her own understanding in terms that are sufficient there cannot be a conviction unless expert or other evidence clearly shows that this apparent understanding was not real (*R v Richardson*, 1990, SCSA). In cases of sexual offences against a person whose lack of knowledge vitiates consent, intellectual disability need only be a substantial contributing cause of the victim's lack of understanding and not the sole cause (*R v Beattie*, 1981, SCSA).

The *Commonwealth Criminal Code Act 1995 (Cth)* s 7.3 (8) defines mental impairment as including senility, intellectual disability, mental illness, brain damage and severe personality disorder.

Evaluation of definitions of intellectual disability found in Australian law. It seems that the definition of cognitive impairment found in Victorian law is the most similar to the definition found in DSM-IV-TR. The law of the other Australian jurisdictions is consistent with sound psychological understandings of domain-specific IQ and decision-making capacity.

Types of legislative provisions. Statutes defining sexual offences against persons with mental impairment have been enacted in all Australian states and territories. These statutes may be categorised by the physical or

external element relating to the victim. The first type of statute adopted in Australian jurisdictions criminalises the sexual exploitation of persons with mental impairment. This category of law has been adopted by New South Wales (*Crimes Act 1900* s 66F) and Western Australia (*Criminal Code* s 330). Conversely, Queensland allows a defence if the prosecution is unable to prove that the act was exploitative (*Criminal Code* s 216). The major problem with prohibiting exploitation is that this term is impossible to define with any precision, and therefore judgments must be made on a case by case basis. The benefit of leaving exploitation undefined is that it does not limit the kind of case that can be tried. Although the normal practice of the criminal law is to judge each case according to its peculiar facts, it is usual to have guidelines according to precedent and statute that provide direction to judges and juries as to the placement of this particular case among others of the same general type. In the case of sexual exploitation, however, no guidance from statute is available, and there is very little case law on which to rely.

A second form of provision is to set out a standard of knowledge that the person must have before they are deemed capable of consent. In Western Australia (*Criminal Code* s 330) and the Australian Capital Territory (*Crimes Act 1900* s 67), the person with mental impairment must understand the physical and sexual nature of the act to which they are consenting. South Australia is unique among Australian jurisdictions in requiring not only

capacity to understand the nature of the act, but also the consequences of the act (*Criminal Law Consolidation Act 1935 s 49*).

The final category of statute is that which prohibits sexual relations between a person with mental impairment and persons involved in their care. Victoria (*Crimes Act 1958 ss 51 & 52*), New South Wales (*Crimes Act 1900 s 66F*), Tasmania (*Criminal Code Act 1924 s 126*) and the Northern Territory (*Criminal Code s 130*) have adopted this approach. The vulnerability of an impaired person to overt or covert coercion by a person on whom they are dependent for care is immediately apparent. The disadvantage of these statutes is that they restrict an already limited number of potential sexual partners to people who are not in a position of responsibility

Differences in the victim's mental condition. There are differences in the mental conditions of the victim that render a prosecution possible under legislation that defines sexual offences against persons with mental impairment. Western Australia's *Criminal Code s 330* defines offences. The term "mental impairment" is defined in the *Criminal Code (WA) s 1* as intellectual disability, mental illness, brain damage or senility. "Mental illness" is defined under the same section as an underlying pathological infirmity of the mind, whether of short or long duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to extraordinary stimuli. Intellectual disability is left undefined.

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Intellectual disability, in relation to a person over the age of 5 years, means the concurrent existence of significant sub-average general intellectual functioning, and significant deficits in adaptive behaviour, each of which became manifest before the age of 18 years.

The *Criminal Law Consolidation Act 1935* (SA) s 49 (6) applies only in respect of intellectually disabled persons who do not understand the nature or consequences of the sexual act, and so where the victim describes his or her own understanding in terms that are sufficient there cannot be a conviction unless expert or other evidence clearly shows that this apparent understanding was not real (*R v Richardson*, 1990, SCSA). In cases of sexual offences against a person whose lack of knowledge vitiates consent, intellectual disability need only be a substantial contributing cause of the victim’s lack of understanding and not the sole cause (*R v Beattie*, 1981, SCSA).

In all jurisdictions, the intellectual disability of the victim that interferes with understanding the nature of the sexual act provides sufficient cause to make charges under the special sections of legislation that define offences of incapacity, although in NSW no charges may be laid without prior referral

to the Attorney General.¹ In this thesis, sustained attention is given to the application of the law in cases where persons with intellectual disability are involved, because catering to the needs of these persons presents complex and unique issues not found when dealing with other forms of mental impairment. Persons with intellectual disability are perhaps the most challenging subpopulation in terms of drafting legislation that is protective without being unnecessarily restrictive of sexual freedom. I explore this topic in depth when discussing sexual exploitation in Chapter 4.

Without consent. A key concept is to distinguish between acts that are apparently consensual and those that are definitely non-consensual. Although in law a sexual act that occurs without consent due to the fact that one person is incapable of giving consent is the equivalent of an act that is against the person's will, it is non-consensual acts which are due to incapacity which are the focus of this thesis. Just as acts committed without consent because the victim is unconscious or asleep can form the subject of criminal charges, so too can sexual acts with an apparently acquiescent person who cannot give consent because they are incapable.²

A person who is incapable by definition cannot consent to sex. But they may still refuse to engage in a proposed act. In other words, being incapable of giving consent does not mean that the individual is incapable of withholding consent. Although an incapable person cannot legally say "yes" to a sexual act, they can say "no" to the same act. An incapable person may

¹ *Crimes Act 1900 s 66F (6).*

² See *Banditt v R* (2005) 224 CLR 262.

be quite able to indicate that they definitely do not want to participate, although of course there does not have to be overt resistance for the act to constitute sexual assault. According to the Victorian *Crimes Act 1958* s 37AAA (d): “that the fact that a person did not say or do anything to indicate free agreement to a sexual act at the time at which the act took place is enough to show that the act took place without that person's free agreement”. Similarly, s 61HA(3) (c) (d) and (e) of the *Crimes Act 1900* (NSW) state: “A person who has sexual intercourse with another person without the consent of the other person knows that the other person does not consent to the sexual intercourse if: (c) the person has no reasonable grounds for believing that the other person consents to the sexual intercourse. For the purpose of making any such finding, the trier of fact must have regard to all the circumstances of the case: (d) including any steps taken by the person to ascertain whether the other person consents to the sexual intercourse, but (e) not including any self-induced intoxication of the person.” Statements with similar meanings are to be found in the laws of other Australian jurisdictions.³

I will examine the relevant law of all Australian jurisdictions, but Western Australian law forms the major focus of this thesis. The first reason for this is that Western Australia has, on a number of occasions, developed social policies that are at the forefront of thinking in this area. One example is the use of a scheme to grade hostel residents according to their life skills, and to allow those who acquired more sophisticated skills to graduate to a

³ For example: SA *Criminal Code Consolidation Act 1935* s 48; WA *Criminal Code* s 319.

more skilled hostel and so on until their eventual move into the community. Another is the introduction of a policy of sex education of persons with intellectual disability who had been recently deinstitutionalised. The course included in matters such as sexuality, sexual exploitation and human relations. The second reason for my choice of a Western Australian setting for this thesis is the historical treatment of persons with intellectual disability in Western Australia, which has in many respects typified that of many other jurisdictions. Thus Western Australia provides an enlightened framework in which to place the thesis.

I will not review the literature on consent in contexts other than sexual offences, such as tort or contract law. The meaning of consent varies according to the area of law under consideration (Young, 1986). Even in one context, determination of capacity to consent may be extremely difficult: a person may possess capacity to consent to some activities but not to others, or they may have possessed capacity at one time but have lost it through permanent or temporary mental impairment. In the latter situation capacity may be regained, though evaluation of the presence or absence of capacity may be difficult, especially when understanding of the act, its positive and negative consequences, and alternative courses of action, which underpins informed consent, is not legally required. This is the case with matters of sexuality.

Returning to capacity to consent to sexual acts in Australian law, in the Victorian case *R v Morgan* (1970) VR 337 at 341, it was held 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.” This precedent has never been overturned, so it would be likely to be relied upon in the common law jurisdictions except South Australia, where it is an offence to knowingly have sexual intercourse with a person who is by reason of intellectual disability unable to understand the nature or consequences of the act (*SA Criminal Law Consolidation Act 1935 s 49*).

Legal advances in the determination of informed consent may have been driven by legal obligations to obtain informed consent, especially in relation to capacity to consent to medical procedures and to participation in research. There is wide acceptance of, and adherence to, the following principles among bodies that regulate such activities: the person must be given the relevant information regarding risks, harms, benefits, and alternatives to the proposed course of action; they must have the capacity to comprehend that information; they must understand it; they must actually make a decision; and that decision must be voluntary and free of coercion (Dharmananda, 1992). In the case of a medical procedure, it may be a relatively simple matter to establish whether the person has the required level of understanding. Indeed, questions of capacity tend to be forgotten if the person makes a decision that is consistent with the opinion of the

medical practitioner. It is decisions that are incongruent with those of the clinician that sometimes raise questions of capacity (Eastman & Dahr, 2000).

In theory, competence is judged according to a person's cognitive capacity, and not on the basis of the exercise of this *per se*, and therefore, not on the basis of the content of the decision the person reaches. In practice, these latter features often play a role in the determination of competence, because they can be used as evidence indicating a lack of the necessary cognitive capacity (Somerville, 1994, p. 192).

**Chapter 3: A history of intellectual disability, sexuality, and
the developing law**

Academic aptitude was less necessary to successful living in earlier, agrarian societies than it is in our modern, technological world. Thus many people seen as having mild mental retardation today would not have been viewed as having notable problems in the past. Even today, mental retardation is defined differently in more industrialized countries than in less industrialized ones because of the educational and technological requirements for work in the industrialized countries (Oltmanns & Emery, 2001, p. 516).

Although academic achievement was less important in earlier times, and individuals with mild mental impairment would have blended more easily into society than they do today, there is evidence that intellectual impairment was in actual fact not as common in archaic society as it is in contemporary society. The incidence of Down syndrome, which in modern society is the most common cause of intellectual disability, occurring in 0.11% of persons, is positively correlated to maternal age. The probability of having a baby with the syndrome increases as the mother ages. Women over 35 are particularly at risk of having a child with Down syndrome. In ancient times, however, life expectancy was only 20 to 30 years. Women had children at earlier ages, and therefore it might be expected that the incidence of Down syndrome would be much lower than it is today. An examination of European graveyard remains dating from 3200BC to 800AD for the cranio-facial features indicative of Down syndrome revealed that of 7063 bodies, only 1

showed the facial bone structure typical of the condition. This reflects an incidence of Down syndrome approximately one tenth of the modern rate (Czarnetzki, Blin & Pusch, 2003).

Bragg (1997) is also of the opinion that disabilities were both less common and less limiting than they are in modern society. He reported evidence that in early societies, the killing of infants born with congenital abnormalities was common practice. This he attributed to the fact that a community that depended on the contribution of each individual for its survival could not support a person who required lifelong care. In the Middle Ages, however, people with acquired disability (as opposed to congenital abnormality) were often chosen for important roles such as mystic, shaman, or priest. These persons were not in any sense marginalised, but rather were respected members of the community. Indeed, some conditions that would be called disabilities today were valued in early societies. It was thought that such persons had traded ordinary sensation such as sight for the extraordinary ability to see the future. Behaviour that would be identified as psychotic in modern society was regarded as evidence of connection with divine entities (Bragg, 1997).

A special connection to God was sometimes also attributed to persons with intellectual disabilities, although Martin Luther promoted a converse belief that people with intellectual disability had no souls and should be killed (Megahey, 2000). Thus, throughout history persons with mental impairment or illness have been the subjects of polarised opinion and

treatment, depending on the era and society in which they found themselves.

Mental illness and intellectual disability. Although it is often said that the concept of intellectual disability did not emerge as distinct from mental illness until the end of the seventeenth century, the distinction was made in thirteenth century English law, where the “natural fool” was described as witless from birth, in contrast to the lunatic who had lost the use of his reason through a variety of causes (Megahey, 2000). Under the thirteenth century Statute of Prerogatives in the Common Law, intellectually impaired individuals were stripped of their right of inheritance (Davis, 1996). Thus those with intellectual disability were sometimes recognised and were the victims of discrimination.

A trio of physicians who lived between the end of the fifteenth and the mid seventeenth centuries, namely Paracelsus, Platter and Willis, are commonly credited with early descriptions of intellectual disability (Goodey, 2004; Megahey, 2000). Goodey argued that these physicians use of the terms *stultitia*, *fatuitas*, or *stupiditas*, signifying “foolishness” was so broad and imprecise that they could not be equated with any modern definition of intellectual impairment. Yet Goodey’s criticism may be due to his underestimation of the difficulty of defining intellectual disability. Indeed, as noted earlier, the criteria for intellectual disability are still disputed today.

Labelling and categorisation. Nevertheless, the labelling (stemming from the recognition) of people with obvious deficits in intellectual ability as

“idiots” dates back to at least the Middle Ages (Megahey, 2000). These unfortunates were likely to find themselves cast out on the streets, living in poorhouses, or confined to institutions or asylums for the mentally ill (Oltmanns & Emery, 2001). By the nineteenth century, categories such as “imbecile” and “moron” emerged to denote gradations in the severity of disability (Megahey, 2000). The term “feeble-minded” was coined in 1866 by P. Martin Duncan and William Millard in their publication *A Manual for the Classification, Training and Education of the Feeble-minded, Imbecile, and Idiotic*, and was applied to persons with mild intellectual disability who had not been institutionalised but who were deficient in academic or social achievement (Jackson, 2003).

Incurable or not? Most eighteenth and nineteenth century writers regarded intellectual disability that warranted institutionalisation as incurable, due to their belief in biological determinism. An exception was Itard, director of the Institute for Deaf Mutes in Paris, who believed that changes in environment would impact upon achievement. He was able to test his idea when he was brought a child who had been discovered running wild in the forest. “The Wild Boy of Aveyron”, called Victor by Itard, was given basic socialisation training. After five years, he was able to understand speech, recognise objects, and had acquired some social skills. But Victor did not learn to speak, which Itard interpreted as evidence of his failure as a teacher rather than evidence of the intractable nature of intellectual impairment (Megahey, 2000).

Itard's protégé Seguin undertook the education of a number of children with intellectual disabilities and in 1846 published a book on training and treatment. He immigrated to the United States where a number of residential schools that operated on his methods were opened. The results produced in these schools demonstrated that intellectual disability was not always immutable. Indeed, many techniques in use today are based on Seguin's work (Megahey, 2000).

So successful was Seguin's training that it gave rise to the belief that given sufficient intervention, all persons with intellectual disability could eventually return to the community (Mesibov, 1976). This of course was not the case, and with this discovery came disillusionment, especially when the numbers of people with intellectual disability appeared to be increasing as the nineteenth century progressed (Ryan & Thomas, 1987). It is not clear whether this increase was real or illusory, and, real or not, what might have brought it to attention, but it resulted in a return to the custodial model and a swing away from the educational approach (Megahey, 2000).

Western Australia

In the early Western Australian colony the educational approach had never been implemented. Megahey (2000) attributed this adherence to the custodial model to the early struggle of the colonial population for survival. In times of privation, no public resources were available to provide food or shelter for persons with mental impairment. From the time of first settlement in 1829 until the Fremantle Asylum was built in 1857, persons with mental

illness and intellectual impairment who could not be cared for by family were sent either to gaol or to the Colonial Hospital. The fate of such persons rested with the Governor, rather than with medical authority. Although few records remain of this era, it seems clear that little medical or psychological expertise was available locally, and in any case there were no facilities for the treatment of persons with mental impairment. As a result, inmates with mental illness or mental impairment were viewed by authorities as a nuisance or worse. They were isolated from other inmates and restraint was commonly used to ensure compliance (Megahey, 2000).

Ellis (1984) noted an increase in the numbers of reports of “criminal lunatics” in the years following the introduction of convicts to Western Australia in 1850. This increase led to the establishment of the Fremantle Asylum in 1857. According to Megahey (2000), over the next several decades, Western Australian medical personnel showed a puzzling inability to discriminate between mental illness and intellectual disability, despite the well-established distinction made between these conditions in Europe. In law, Western Australia followed an outdated 1845 British model when enacting the *Lunacy Act* 1871, which stated: “Lunacy shall mean and include every person of unsound mind and every person being an idiot.” In 1903 a new *Lunacy Act* was passed, which retained this definition, though “lunatic” was replaced with “insane person”. As a result, many persons with intellectual disability were incarcerated with persons with mental illness in the Fremantle Asylum. Similarly, people perceived as economic or moral

threats were sent to the Asylum by doctors even in the absence of any evidence of mental impairment. Paupers were routinely incarcerated, as was a woman whose grief over the death of her child was interpreted as mental illness. Even intellectually impaired children as young as 9 were sent to the Asylum. Not surprisingly, the 45-bed facility became overcrowded; by 1896 it accommodated 190 people (Megahey, 2000).

In 1900, conditions in the Fremantle Asylum were brought to public attention by the press (Gillgren, 2000). The government-appointed Vosper Inquiry recommended a new institution be built and a new superintendent be appointed to replace the incumbent who devoted little time and attention to the Asylum (Megahey, 2000). These recommendations were followed: the new institution was Claremont Hospital for the Insane and the new superintendent was Dr Montgomery. Montgomery was instrumental in the enactment of the 1903 Lunacy Act. It introduced the requirement that insanity be medically certified by two doctors, and it prohibited doctors from treating persons they had committed. But it still failed to discriminate between mental illness and intellectual impairment. The widespread belief in Europe and America that the incidence of the latter condition was rising was echoed in Australia (Gillgren, 2000). This perceived rise in the incidence of intellectual deficit may have been a contributory factor to the enthusiastic and widespread reception of eugenic ideals. Eugenics emerged at a time that was curiously suited to it in terms of political, social and economic attitudes. Whether the new “science” was a product of such attitudes or

whether it helped to shape popular opinion is a moot point. Eugenics quickly became one of the most influential social policies of the early twentieth century.

The eugenic era

UNFIT HUMAN TRAITS such as feeble-mindedness, epilepsy, criminality, insanity, alcoholism, pauperism and many others, run in families and are inherited in exactly the same way as color in guinea pigs. If ALL MARRIAGES WERE EUGENIC we could BREED OUT most of this unfitness in THREE GENERATIONS (Wording of a poster that was shown at American state fairs in the 1930s; Kevles, 1999, p. 436).

The term eugenics was first used in 1883 by Francis Galton to indicate the improvement of the human species through selective breeding (Engs, 2005). By 1900 eugenics had gained popularity due to the reemergence of Mendel's theory of genetic inheritance and its application to human heredity (Kevles, 1999). It was widely believed that feeble-mindedness was inherited, that it was linked to crime, prostitution, poverty and a variety of other social problems (Kevles, 1999; Williams, 2000), and that the feeble-minded were prolific breeders (Williams, 2000).

In Australia, as elsewhere, there were fears that the “lower classes” would proliferate at a rate that would swamp the “upper classes”; this concern led to a series of surveys to establish the incidence of feeble-mindedness. The first report of 1902 has not survived, but the Australasian Medical Congress committee report of 1914 stated that 4% of schoolchildren were definitely feeble-minded and a further 12% were dull and required special training (Williams, 2000). Although Williams noted that a large amount of data was missing from the report, the reason for these high figures is not clear. It may be that standardised testing was not used, or it may be that cut-off points for determining intellectual disability were high (at one time the United States cut-off was one standard deviation below the mean intelligence quotient with the result that almost 15% of the population were classified as mentally defective: Oltmanns & Emery, 2001). Whatever its cause, such figures lent credence to eugenic claims.

In 1904, Galton addressed a meeting of the Sociological Society: “The aim of eugenics is to bring as many influences as can be reasonably employed, to cause the useful classes in the community to contribute *more* than their proportion to the next generation” (italics in original, p. 3). Galton advocated “education” of the public on the laws of heredity. He recommended that research be conducted into the reasons behind the rise and fall of civilisation, which he believed was attributable to a lack of fertility amongst the upper classes. He also advocated investigation into the circumstances that produced “thriving families”, which he defined as those

with at least three adult male children who had risen socially above others of their class and who therefore could be regarded as a success; the social disapproval of eugenically unsuitable marriages; and introduction of eugenics “into the national conscience, like a new religion” (Galton, 1904, p. 5).

Positive and negative measures were advocated by Galton and his fellow eugenicists to bring about the improvement of the quality of the human race. Positive eugenic acts were aimed at manipulating human heredity or breeding, or both, to produce superior people; the goal of negative eugenics was to eliminate or exclude biologically inferior people from the population (Kevles, 1999). By the end of the nineteenth century, it had been recognised that mildly feeble-minded women were vulnerable to exploitation and were therefore thought to be legitimate targets for paternalistic intervention. This intervention took the form of segregation in homes, schools, or agricultural colonies, where close supervision would not only limit reproduction, but would allow both male and female inmates to be taught to work and so contribute to their own upkeep (Jackson, 2003).

That the institutionalised feeble-minded should contribute to their own upkeep was an appealing concept to wealthy conservatives. Moreover, adoption of a policy of eugenics would restrict the reproduction of the lowest income groups, and consequently would reduce the cost of caring for their offspring. To conservatives, the primary benefit of eugenic policy was in terms of savings in government expenditure (Kevles, 1999). Eugenics was

very much based on the principle of efficiency: a simple and cost-effective sterilisation prevented the cost of care of “deficient” offspring in the future (Allen, 1997). In the 1870s, a eugenicist named Dugdale claimed to have traced the family of one Ada Jukes, a “degenerate” American woman who lived in the early 1700s. Among her descendants were “64 mentally diseased, 174 sex perverts, 196 illegitimates, 142 paupers, and 77 criminals and murderers” (Allen, 1997, p. 82), who had cost the state of New York over \$1.3 million (Kuhl, 1994). Eugenicists claimed that her sterilisation would have saved the state all but \$150 of that amount (Allen, 1997).

The “efficiency” of eugenics appealed not only to political conservatives, but also to progressives. Progressives believed that through the application of scientific discoveries, society could be improved. There was widespread belief in eugenic claims that social problems were attributable to genes (or to use the terminology of the day, “germ plasm”), and that inherited conditions might be remedied by selective breeding (Kevles, 1999). The result was that progressives, as well as conservatives, were attracted by eugenicist solutions to perceived social problems.

Eugenic beliefs were translated into practice through the establishment, in the early years of the twentieth century, of institutes the aim of which was to determine the links between phenotype and genotype. Information was publicly disseminated on the undesirability of “defective” persons reproducing. The recent development of standardised intelligence testing by Binet in 1904, accompanied by introduction of the concept of

mental age by his colleague Simon, heightened interest in the application of science for the betterment of mankind (Kevles, 1995).

Binet and Simon's test was introduced to the United States in 1908 by Henry Goddard, who was director of the Training School for Feeble-minded Girls and Boys at Vineland, New Jersey (Engs, 2005; Kevles, 1995). Goddard tested Vineland children and members of their families, and researched their family history. In 1912 he published *The Kallikak Family*, which traced the family history of one pupil. Kallikak was a pseudonym derived from the Greek *kalos* (good) and *kakos* (bad) (Kevles, 1995). The "bad" Kallikaks were descended from offspring conceived by an affair between a Revolutionary War soldier named Martin and a nameless feeble-minded girl. Goddard traced 480 of these descendants and considered that only 46 of them were normal. Martin later married an "upstanding woman". Four hundred and ninety-six descendants were traced, and almost all were respectable citizens, property owners and professionals (Elks, 2005; Engs, 2005; Kevles, 1995). Goddard claimed that the Kallikaks were living proof of the heritability of feeble-mindedness and his work was widely publicised in popular magazines as well as in academic circles (Elks, 2005). Family histories such as the Kallikaks and the Jukes were used by eugenicists to support their calls for the introduction of compulsory sterilisation law (Kuhl, 1994). The eugenic social action program of research and public education begun by Galton was so successful that institutionalisation and segregation by gender became mandated by law in

many countries throughout the world (Allen, 1997; Jaeger & Bowman, 2005; Kevles, 1999).

In Britain, the 1913 enactment of the *Mental Deficiency Act* meant that institutionalisation of feeble-minded children and adults could be legally enforced (Jackson, 2003; Searle, 1976). In Australia, lunacy laws such as the *Lunacy Act* 1898 (NSW) and the previously mentioned *Lunacy Act* 1903 (WA) provided the legal basis for similar institutionalisation of persons with mental illness or intellectual impairment. In New South Wales, the policy of institutionalisation continued well into the twentieth century. But in Western Australia, humane concern over the treatment of the “insane” led to the Royal Commission on Lunacy of 1922. The Commission report improved the lot of incarcerated people by acknowledging degrees of mental impairment, and by recommending the separation of treatable cases and incurables. It also led to enactment of the *Mental Treatment Act* 1927. Unfortunately, under that Act persons with intellectual impairment were still viewed as incurable (Gillgren, 2000).

Despite being thought incurable, in Australia persons with intellectual disability were never subjected to routine sterilisation. Although a sterilisation law was debated in Australia throughout the 1920s and 1930s (Wyndham, 2003), it was never enacted (Williams, 2000; Wyndham, 2003). It was also debated without result in Britain (Engs, 2005). Law enabling voluntary sterilisation was passed in British Columbia in 1933 (Wyndham, 2003). Involuntary sterilisation was legalised in 24 American states, beginning with

Indiana in 1907; some of these laws still exist though they are rarely enforced. A similar law was passed in the Canadian province of Alberta, where discharge from institutions of psychiatric or intellectually impaired persons became conditional upon agreement to undergo sterilisation (Wyndham, 2003). Involuntary sterilisation was also legalised in all the Scandinavian countries and, of course, in National Socialist Germany (Engs, 2005).

For years before the Nazi ascent to power, eugenicists of the United States and Germany had provided mutual support to each other, each using successes in the other country as an example to overcome opposition in their own country. The first International Congress devoted to eugenics was held in London in 1912. Americans were particularly well received; they had already succeeded in influencing legislation restricting marriage of the unfit, and in enabling involuntary sterilisation in six states. German eugenicists viewed the United States as the world leader in bringing Galton's dreams to life, but despite concerted lobbying, they did not succeed at this stage in mandating sterilisation of the unfit in their own country. World War I intervened, and afterward, German delegates were either ostracised from or refused invitations to further international gatherings of eugenicists (Kuhl, 1994).

By 1925, relations were restored. Americans such as Charles Davenport, director of the Eugenics Record Office at Cold Spring Harbour, New York and Germans such as Fritz Lenz, co-editor of the major racial

hygiene journal, provided links between the two countries for the dissemination of information, visits and exchanges. The first American eugenic restrictions were placed on immigration in 1924; these were primarily based on ethnic origin, with applicants of non-Anglo Saxon heritage being deemed undesirable (Allen, 1997). In 1927, the Supreme Court upheld Virginian sterilisation law in *Buck v Bell*.⁴ Giving the majority decision, Oliver Wendell Holmes stated: "It is better for everybody if society, instead of waiting until it has to execute degenerate offspring or leave them to starve because of feeble-mindedness, can prevent obviously inferior individuals from propagating their own kind... Three generations of imbeciles is enough" (p. 1159).

By the end of the 1920s, there was enormous interest in the effect of sterilisation and restrictions on marriage and immigration as they were applied in the United States (Kuhl, 1994). Germans saw that American racial eugenic policy, which was directed particularly against Blacks (Reilly, 1983), was an excellent model for parallel policies that would be directed against Jews and eastern European immigrants (Kuhl, 1994). This was the climate into which Adolf Hitler was elected as leader of the German people in 1933.

The "efficiency" of eugenics was particularly appealing to the Nazi regime. Efficiency was the watchword of the German nation of this era. The country had suffered deprivations under the Treaty of Versailles and was in dire economic straits due to rampant inflation during the 1920s and early 30s. Every citizen was expected to be productive. People who could not

⁴ 274 U.S. 200 (1927).

support themselves were viewed as a burden on a society that was engaged in a struggle for survival (Weiss, 1990).

In 1933, six months after the Nazi Party came to power, the German Reichstag passed the “Law on the Prevention of Hereditary Diseases in Future Generations”. This law provided for the involuntary sterilisation, by force if necessary, of any person 10 years and over who had one of eight hereditary diseases. These were: inborn mental deficiency, schizophrenia, circular insanity (bipolar disorder), hereditary falling sickness (epilepsy), hereditary St. Vitus’ dance (Huntington’s disease), hereditary blindness, hereditary deafness, and severe physical malformation. Medical personnel were obliged to report the results of every medical examination to a secret records office; from there evidence was passed to hereditary health courts to determine if sterilisation was warranted. As a result of this law, an estimated 350,000 persons were sterilised throughout the Reich. Three percent of Hamburg residents were ordered to be sterilised; over 24,000 people were actually operated upon (Pfafflin, 1986).

Of course, eugenic measures in Nazi Germany did not end with sterilisation. Support for eugenic policy based on economics became part of everyday life, even extending to the Reich’s “New approach to arithmetic” which was taught to schoolchildren. An example of this policy read as follows: “Of (all) mentally deranged persons, 868 are shut up for at least 10 years, 260 for at least 20 years, 112 for at least 25 years, 54 for at least 30 years, 32 for at least 35 years and 6 for at least 40 years. How many

Reichsmarks at least have these mentally deranged persons cost the state of Baden if 18 Reichsmarks have to be spent monthly on each one? How many healthy families with an annual income of 3,000 Reichsmarks could live for 10 years from this amount?" (Source not cited; Pfafflin, 1986, p. 3). This type of reasoning formed the basis for the first legalised murders of psychiatric patients, alcoholics and children with mental impairment, who were characterised as "useless eaters".

In 1938, a woman petitioned Hitler to allow the "mercy killing" of her badly deformed grandchild. He acceded to her request, authorised similar killings, and introduced mandatory reporting to the records office of a number of conditions including "severe idiocy", mongolism, microcephaly, hydrocephaly, and deformity. Each record was assessed by three members of the Reich Committee for Scientific Research into Serious Illness of Hereditary and Constitutional Origins. If all three marked a plus sign on the record, the child was taken to a "special children's ward" where the diagnosis was confirmed and the child was killed (Pfafflin, 1986).

With regard to adult citizens, over 70,000 psychiatric patients were put to death in the gas chambers between 1940 and 1941. It was reported that as a result, over 88 million Reichsmarks would be saved annually. After 1941 authorisation for "euthanasia" was not required: death by poisoning and starvation became part of the practice of psychiatry in the Third Reich. The killing of patients in hospitals and asylums in captured territories by Einsatzgruppen (killing squads) was also undertaken because these persons

were unproductive and so were regarded as deserving of elimination. The killing of concentration camp prisoners for racial and eugenic reasons need scarcely be mentioned as it is so well known. Millions were put to death; it is not known exactly how many persons were killed due to mental impairment but estimates number in the hundreds of thousands (Pfafflin, 1986).

Post WWII: Human rights, normalization and deinstitutionalization

As knowledge of the mass murders of disabled people and the racist-inspired systematic killings of Jews and Gypsies emerged, many members of the United Nations formed the opinion that existing documents such as the *United Nations Charter* did not sufficiently articulate human rights. This attitude provided the inspiration for adoption of the *Universal Declaration of Human Rights* in December, 1948. More than thirty rights and freedoms are documented. The most important are considered to be the right to life, liberty and security of the person; the right to education; the right to participate fully in cultural life; freedom from torture or cruel, inhumane treatment or punishment; freedom of thought, conscience and religion; and freedom of expression and opinion (United Nations, 2006).

The lives of people with disabilities, however, were not greatly affected by this Declaration. Until the latter decades of the twentieth century, the majority of people with disabilities were institutionalised (Ryan & Thomas, 1987). In many cases, the only alternative to institutionalisation

was for parents to care for their disabled children at home without government support or services (Chenoweth, 2000). In two separate Western Australian cases, the strain of caring for severely disabled children resulted in their murder (Gillgren, 2000). In both cases, institutionalisation in Claremont Hospital for the Insane had been rejected by the parents as being no choice at all.

Although some progressives lobbied for the removal of children with intellectual impairment from institutions such as Claremont Hospital, government officials resisted such moves, claiming the cost was prohibitive (Gillgren, 2000). They also pointed out that in many other countries, institutions were overcrowded and were shared with the mentally ill (Chenoweth, 2000; Williams, 2000). Instances occurred where residents with intellectual impairment were exposed to persons who had been found not guilty of murder on the grounds of insanity (Gillgren, 2000). Individual treatment or therapy was unknown; all inmates were treated alike regardless of the nature or severity of their impairments (Chenoweth, 2000). According to Wolfensberger (1975), segregation by gender continued to be the strategy of choice for the prevention of the reproduction of people with intellectual disability until the policy of deinstitutionalisation was implemented.

In 1952, the first example of a Western Australian move away from state care in a large institution occurred. Following a philanthropic donation, fifty children with intellectual disabilities were relocated from Claremont Hospital to normal housing and provided with special education in the Perth

suburb of Guildford. Parents formed the Slow Learning Children's Group which soon became a major service provider funded by the government. The evidence suggests that most Western Australian progress in social policy on the treatment of people with intellectual impairment during the early and middle years of the twentieth century was due to private pressure rather than to government action. But the majority of persons with intellectual disability were still incarcerated in Claremont, where conditions of overcrowding were worse than ever (Gillgren, 2000).

Political debate over mental health treatment policy surrounded the drafting of the *WA Mental Health Act 1962* which repealed the *Lunacy Act 1903*. Little attention was given to intellectual disability, which was still not differentiated from mental illness, despite the fact that several politicians had raised the issue and advocated the differential treatment of persons with these conditions. In an effort to reduce overcrowding at Claremont Hospital provision was made for construction of residential facilities to house persons with intellectual disabilities, but the planned residences were still based on the institutional model (Gillgren, 2000).

Due to the widespread belief in the incurable nature of intellectual disability, by the 1960s the living conditions of many institutionalised persons in Western Australia had changed little since the days of the Fremantle Asylum. In the latter part of the decade, however, the appointment of mental health officials who recognised the educational needs and potential of children with intellectual impairment, accompanied by recognition that

disabled persons had rights, provided a catalyst for changes to their living conditions.

In the social climate of the late 1960s, placement of mildly intellectually disabled people in institutions began to be seen as a violation of their human rights (Chenoweth, 2000). The rights of people with disability were clearly stated in the United Nations *Declaration on the Rights of Mentally Retarded Persons* and the United Nations *Declaration on the Rights of Disabled Persons*, which Australia signed in 1971 and 1975 respectively. The latter document states that “disabled persons have the same fundamental rights as their fellow citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible” (Article 3), and that “disabled persons have the same civil and political rights as other human beings” (Article 4). The *Declaration on the Rights of Mentally Retarded Persons* states that “The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings” (Article 1) and that “the mentally retarded person has a right to... such education, training, rehabilitation and guidance as will enable him to develop his maximum ability and potential” (Article 2). As previously mentioned, the *Convention on the Rights of Persons with Disabilities* enunciates the rights to protection from exploitation, to privacy, to access to sexual and reproductive health services and to social protection.

At the end of the 1960s the standard of living of persons with disabilities was as poor as it had been in the late 1940s, when a Western

Australian reporter named Turner had gained access to the environments in which disabled people lived by obtaining a position as an attendant at Claremont Hospital. Each of his reports contained accounts of the regular verbal and physical abuse of residents by staff (Gillgren, 2003; Ryan & Thomas, 1987). There were also reports of widespread sexual abuse (see, for example, Carmody, 1990; McCarthy, 1999), and of a very low standard of hygiene (Ryan & Thomas, 1987). In the United States and England, there were separate reports that living conditions had not improved and that persons with disabilities were still subject to regular abuse (Chenoweth, 2000; Ryan & Thomas, 1987). These statements could equally be applied to conditions at Claremont Hospital (Gillgren, 2003).

An outcome of these reports was that in the late 1960s in the US, a government-appointed advisory committee was established, out of which emerged new ideas about the principle of normalisation. One of the committee members was Wolfensberger, whose policy of normalisation was instrumental in bringing about the deinstitutionalisation of a large number of people with disabilities. A description of normalisation theory and the role it took in the formulation of social policy within Australia is available in Chapter 1.

In Western Australia, the goal of moving all persons with intellectual impairment from Claremont Hospital to hostel accommodation was accomplished by 1984. Although the hostel was another form of institution, the Division for the Intellectually Handicapped had developed a grading

scheme, whereby residents who acquired and improved their living skills could graduate to a more skilled hostel, and eventually move into the community. Several hundred persons completed this transition. However, deficits in social skills became apparent as people moved into the community. Common problem areas were decision making, human relations, and sexuality (Stella, 2000).

Parents were concerned about the issues of sexuality in general and about sexual exploitation in particular. These concerns were addressed through meetings and discussion between stakeholder groups including parent groups and government officials, and resulted in the development of a policy for education in human relations and sexual matters. This was the first Australian policy on this subject, and became the model for other states. The pragmatic outcome was the development of courses for newly deinstitutionalised people and those about to move into the community (Stella, 2000).

Normalisation is based on the precept that persons with disabilities should be afforded the opportunity to live as normal a life as possible. Life in the community inevitably led to sexual experimentation. It became accepted among stakeholders that while sexual expression should not be unnecessarily restricted, there was also a need for protection of persons with mental impairment. However, there remained the possibility that the rights of persons with disability may have to be limited in some circumstances, such as when the person was being exposed to danger. Article 1 of the

Declaration on the Rights of Mentally Retarded Persons (1971) states: “The mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings”. An ethical approach to caregiving dictates that any limitation of the rights of disabled persons must be clearly justified (McSherry & Somerville, 1998; Somerville, 1994).

The law has never sought to draw clearcut boundaries across the chart, so as to create categories similar to the age-groups of children. There are no generalized “packages” of law which apply to any particular range of disability. The law does not generalize to any great extent. It will define whether a particular individual has legal capacity for one particular purpose, at one particular time, and in one particular set of circumstances. It will define whether one particular form of legal intervention is or is not appropriate (Ward, 1984, p. 6).

Use of current statute

Law governing sexual acts involving persons with mental impairment is a neglected area in the practice of law and in academic discussion. In Victoria only 17 prosecutions under the relevant sections took place over the eight year period 1996 to 2004 (McSherry & Naylor, 2004). Similarly, authors of legal textbooks generally have dedicated minimal space to the topic. I do not intend the following as criticism, but rather as evidence that this area of law is underused and this in part may be because it has lacked critique. In their 56-page chapter on sexual offence law, Whitney, Flynn & Moyle (2000) devoted only 9 lines to Western Australian provisions and 15 lines to

Queensland provisions. Waller and Williams' (1993) discussion of sexual offences against persons with mental impairment was contained in a 17-line paragraph of their 942-page treatise on criminal law. A comparatively longer section was dedicated to these types of offences by Bronitt and McSherry (2001). They devoted 2 pages of their 879 page first edition to these offences. A similar section is devoted in their second edition (Bronitt & McSherry, 2005). An 8-page discussion of sexual offences against persons with mental impairment is to be found in McSherry & Naylor (2004), which may be a reflection of the interest of these authors in this topic and an increasing general interest that has been generated by the few authors who have examined this area of law. To date it appears that little research has been done on this area of law. Prior to the publication of the articles contained in this thesis, the status quo in the literature was as described above.

In 2005, the Victorian Law Reform Commission conducted an inquiry into the law defining sexual offences. The Commission published the results of their inquiry including a large section on offences committed against incapable persons. This appears to be the most detailed and comprehensive examination of these offences defined by Australian law that is available. The Commission recommended that the existing prohibition of sexual acts between workers at residential facilities and residents contained in the existing s 52 of the *Crimes Act 1958* (Victoria) would be extended "to cover any person working at a facility or program that provides services to people

with cognitive impairment, rather than just workers at residential facilities” (VLRC, 2005, p. 337). Section 52 would apply to paid and voluntary workers. Thus, consensual sexual acts involving a person with mental impairment and a worker who provides only indirect services to residents might become illegal if this recommendation was strictly interpreted. Not only medical, therapeutic and supervisory staff but also administrative staff, cooks, gardeners and the like would be proscribed from entering into sexual relations this recommendation was to be implemented and enforced.

The use of the criminal law to restrict the consensual sexual expression of anyone who is capable of consent is, of course, not tenable under the UN Conventions outlines in preceding sections. It is also doubtful that it was ever the intention of lawmakers in the various jurisdictions. If the person is not harmed the law should not be used to prevent their consent. However, the law does not approve of affronts to human dignity (Laster & Erez, 2000). Difficulties arise in situations where the person is an eager participant, or at least wishes to continue the relationship, but where others believe that the person is being exploited or unfairly dealt with.

The previous three chapters have attempted to situate the topic in its legal and historical background. As previously mentioned, in order to discuss Australian legislation in a coherent manner, I have categorised the legislation of the various jurisdictions according to their content and aim. I have identified three categories into which such legislation can be divided: those that aim to penalise sexual exploitation, those that set a minimum standard of knowledge that the person with mental impairment must have to be deemed capable of consent, and those that ban sexual acts between the person with mental impairment and staff who provide services to that person. In Chapter 4, a discussion of the concept of sexual exploitation and its application in the law of sexual offences against persons with mental impairment is presented. In it my coauthors and I examine the notion of sexual exploitation, the extent to which such a notion can function as an enforceable concept, and whether it is essentially a paternalistic restriction on the sexual freedom of persons with intellectual disability.

**Chapter 4: The concept of sexual exploitation in legislation
relating to persons with intellectual disability⁵**

⁵ Published paper:
Graydon, C., Hall, G., & O'Brien-Malone, A. (2006). The concept of sexual exploitation in
legislation relating to persons with intellectual disability. *Murdoch University
Electronic Journal of Law*, 13, 150 – 174.

Abstract

The focus of this paper is on the use of the concept of sexual exploitation in legislation concerning sexual expression by persons with mental impairment, with particular emphasis on persons with intellectual disability. Two main statutory approaches have been adopted in Australian jurisdictions. The first is prohibition of sexual acts between a person with intellectual disability and others who, by virtue of their employment, are in a position of ascendancy over that person. The second is the prohibition of sexually exploitative acts by any person towards a person with an intellectual disability. The major aim in this article is to critically examine these approaches and evaluate them according to the standards of being non-discriminatory, minimally restrictive of rights, and enforceable. It is argued that comprehensively cataloguing sexually exploitative acts is untenable, with the result that prohibition of all sexual exploitation is unenforceable. The alternative, namely legislation that prohibits sexual relations with any person employed to render any kind of service to the intellectually disabled person, would further restrict an already limited number of potential sexual partners. We suggest that a more useful approach would be to prohibit sexual activity in one-on-one relationships whose scope is commonly understood to exclude such acts, while allowing relations between workers or caregivers and the persons to whom they do not directly render services. This mechanism would have to be narrowly defined to have the desired effect of affording protection to vulnerable persons while preserving their right to sexual expression.

The concept of exploitation is central to the law regarding sexual offences against persons with mental impairment.⁶ All Australian states and territories and many overseas jurisdictions, including Canada and England, have enacted legislation that, under certain circumstances, criminalizes sexual activity with a person with impaired mental functioning, over and above offences that may be committed against members of the general population. Although details differ between jurisdictions, the common theme underlying the legislation is the protection of vulnerable persons against their being taken advantage of — that is, against sexual exploitation.

The diversity of approaches and provisions enacted in these various jurisdictions indicates the difficulty involved in balancing the right to sexual expression of persons with mental impairment, while meeting their need for protection from exploitation. Our major aim in this article is to examine what legislative protections with regard to sexual exploitation should be in place for persons with mental impairment. In the absence of legal guidance, either by statute or by precedent, as to the meaning of sexual exploitation, we have drawn on definitions and concepts from disciplines such as philosophy and psychology to underpin our discussion.

The complexity of framing legislation in this area is reflected in the fact that the categories of persons protected by legislation differ between

⁶ Although the Victorian Law Reform Commission (2005) rejects use of the term “mental impairment” in favour of “cognitive impairment” which they see as less stigmatising, we have chosen to retain mental impairment because it is the term used in Australian legislation. In addition, over time, any initially inoffensive term chosen to denote disability gains pejorative status; attitudinal change rather than a change of terminology is required to alter this (Jaeger & Bowman, 2005).

jurisdictions. In some states, for example Tasmania, the term mental impairment covers senility, intellectual disability, mental illness and brain damage (Tasmanian *Criminal Code Act* of 1924 s 126). The New South Wales *Crimes Act* 1900 s 66F, however, pertains only to persons with intellectual disability, defined as persons who have appreciably below average general intellectual function and who require supervision or social habilitation in connection with the activities of daily life.

In this paper we will focus solely on sexual acts where the apparent willingness of the person with mental impairment may have been exploited. In addition, we focus on the law as it relates to persons with intellectual disability, rather than on the broader class of persons with other forms of mental impairment. One of the characteristics of intellectual disability is that it is stable and lifelong, and persons with intellectual disability may have a continuing inability to consent to sex. In contrast, other conditions of mental impairment are frequently temporary, so that a person suffering a psychotic episode, for example, may temporarily lack the capacity to consent to sex, but will very likely regain it when the episode ends. Persons whose degree of intellectual disability is such that it is questionable whether they have ever possessed the capacity to consent to sex are perhaps the most challenging class of individuals to be catered for by legislation, because intellectual disability carries with it characteristics that are not present in other forms of mental impairment, and which may increase vulnerability to exploitation. These characteristics are briefly reviewed below.

Part I: A Population in Need of Protection?

Effects of Intellectual Disability

Socialised to acquiesce. People with intellectual disability are less free to make choices about their lives than other people. When children, their lives are more highly supervised and controlled than their same aged peers (Clarke, Olympia, Jensen, Heathfield, & Jensen, 2004). When adults, they have fewer employment options, fewer places of residence from which to choose (Rourke, Grey, Fuller, & McClean, 2004), fewer recreational opportunities, and so on, than other people. Although ethical caregivers will promote decision-making opportunities at all stages of life, people with intellectual disability are, of necessity, much more likely to have decisions made for them than are other people (Rourke et al., 2004). As a result, individuals with intellectual disability become accustomed to following instructions without question. Some people with intellectual disability have a great desire to please and they become particularly adept at discerning what response is wanted by another person. These factors, separately or in combination, lead to an increased risk that, in sexual matters, persons with intellectual disability may be more compliant with instructions from others than would be their same-aged peers.

Limited decision making ability. A related issue is that people with intellectual disability exhibit limited ability to make a considered choice. This is almost certainly because their limited intellectual abilities result in their

having difficulty envisaging consequences, goals, and alternative courses of action and the advantages and disadvantages of these (Jenkinson & Nelms, 1994). It may also be that their inexperience in decision-making contributes to their difficulties in making considered choices. Jenkinson and Nelms investigated decision-making style by presenting their participants with a series of vignettes, five of which represented major decisions with long-term consequences, and five of which were minor decisions. Twenty-five adults with intellectual disability and 14 non-disabled adult university students participated. Results showed that, in comparison with the students, participants with intellectual disability tended either to try to avoid making a decision at all, or rushed into one alternative without considering its advantages and disadvantages. Significantly, rushing into one alternative was more common with vignettes that depicted some kind of threat to the person and which required assertive action for a successful resolution. It is interesting that participants displayed stress, even though the choices did not truly affect their lives. It seems reasonable to infer that when authentic decisions are faced, the reactions and strategies found in this study would, if anything, be amplified.

Easily manipulated. People with intellectual disability may lack the ability to resist a tempting offer. One tactic for gaining the consent of a person with intellectual disability is to offer them a reward for having sex (Thompson, 2001). The offer of a desired object such as a toy, as occurred in the case of *R v Beattie* (1981), or a packet of cigarettes, money, or a soft

drink may be successful in obtaining sex with people with intellectual disability because the person with intellectual disability may not see the transaction as an unequal exchange. Such an offer may be enticing because they may have no other means of obtaining the desired object.

Persons with intellectual disability can also be easily manipulated because they may lack the ability to identify situations of risk. Therefore, they are more likely than other adults to engage in dangerous behaviours, such as entering a stranger's car. Once in such a situation, they are less able to extricate themselves from the unwanted encounter (Kempton & Gochros, in Furey, 1994).

Issues of Dependency

A person with intellectual disability is dependent on others in a variety of ways. Because of this, they are vulnerable to sexual exploitation especially when approached by a person who renders them services. If they resist an advance, they risk the withdrawal of those services — services which may be essential to their health and wellbeing. They also risk retaliation in more subtle ways, for example by being made to wait unnecessarily for services to be performed. They may be unable to complain about such treatment, either because of they are unaware of complaint channels or because they lack the necessary verbal ability (Rosser, 1990).

Issues Stemming from Limited Knowledge

Lack of knowledge about sex. Completion of sex education courses is less frequent in people with intellectual disability than in the general population. An English study (O'Callaghan & Murphy, 2002) found that just over 50% of adults with intellectual disability reported that they had received sex education, compared to 98% of non-disabled English 16-year-olds. Similarly, an Australian study (McCabe, 1999) revealed that only about half the adult participants with intellectual disability reported they had received sex education. Williams (1991) suggested that the lower rate of sex education in the population of persons with intellectual disability may reflect the attitudes of caregivers who either think that sex education is irrelevant for the person in their care, or wish to keep the person "innocent". The aversion of carers to the involvement of people with intellectual disability in a discussion of sexual matters is reflected in the difficulty O'Callaghan and Murphy and McCabe had in obtaining participants for their studies.

In relation to overall sexual knowledge, McCabe (1999) found that people with mild intellectual disability had less experience of, and less knowledge about, sex than people with physical disability, who in turn had less experience and knowledge than non-disabled individuals. This finding was consistent with that of O'Callaghan and Murphy (2002), who found that, in comparison with 16-year-olds, adults with intellectual disability had significantly less knowledge of sex and its consequences. In the O'Callaghan and Murphy study, some items were mnemonically demanding,

or required the ability to interpret line drawings and to articulate answers, and some items and scoring were value laden. Nevertheless, these recent results are consistent with older research (see, for example, Gillies & McEwen, 1981). The apparent lack of knowledge about sex, even among those who have attended sex education classes, might be because delivery of factual information does not necessarily lead to understanding and retention of it (McCabe, 1999). Of course this latter point is true of all persons, not only those with intellectual disabilities. McCabe also suggested that persons with intellectual disability do not discuss what they have learnt in sex education classes with family or friends, so that material is not expanded upon or internalised. Most participants with disability revealed that their sole sources of information regarding sexuality were sex education classes and the media. In contrast, persons without disability also gained information from family and friends. McCabe suggested that because sexuality was not discussed openly with persons with disability, they experienced negative feelings about the topic as a whole, and especially about their own sexuality.

Thompson (2001) presented qualitative evidence gleaned from interviews conducted as part of a counselling service for sexually active men with intellectual disability. Thompson's analysis suggests that only the most able men had even a basic knowledge about women's bodies. The men whom Thompson interviewed generally had only one goal: their own orgasm. In addition, the men were insensitive to their male or female

partner's emotional and physical feelings, and very often did not realise that pregnancy or disease transmission were possible outcomes of intercourse. Overall, sex was conducted with little communication except that of resistance. Although the proportion of the sample that had received sex education was not mentioned by Thompson, these findings may be a reflection of a lack of sex education, an interpretation consistent with the low rate of participation reported above. A second explanation is that, when sex education is provided to this population, the focus is on the mechanical aspects of sex rather than on emotional experiences. Alternatively, Thompson suggested that the men's insensitivity may have been gender-related rather than an artefact of their intellectual function, as there is evidence that women with intellectual disability are skilled at interpreting verbal and non-verbal cues during sex (McCarthy, 1999).

Further, accurate assessment of how much persons with intellectual disability do know about sex is difficult, since persons with intellectual disability may display knowledge that is more apparent than real. That is, when questioned, they may echo what they have been taught, giving an impression of much greater understanding than is really the case. This problem is, of course, present in any attempt to assess genuine understanding by any person; however, the distinction between real and apparent knowledge sometimes demonstrated by persons with intellectual disability has been judicially acknowledged in *R v Richardson* (1990) when King CJ commented, "It is quite possible, of course, that a mentally deficient

person will use words indicating an apparent understanding which does not really exist.”

Little knowledge of rights and of the law. People with intellectual disability may not understand that they can refuse an unwanted sexual encounter. Johnson, Andrew, and Topp (1988) cited these words of a young woman with intellectual disability: “The taxi driver touched me [sexually]. I didn’t know if I could say no or not.” Similarly, expert evidence was presented in *R v Eastwood* (1998) that the complainant did not know that she could refuse intercourse if it was offered or requested by another person.

Moreover, the level of knowledge of the law relating to sexual matters among adult persons with intellectual disability is much lower than that of 16- and 17-year-olds (O’Callaghan & Murphy, 2002). The fact that behaviours such as genital exposure and masturbation, or even taboo behaviours such as sexually approaching a child, are sometimes publicly performed by persons with intellectual disability has been interpreted as evidence that these individuals do not know such behaviours are illegal (Cambridge & Mellan, 2000).

Finally, persons with intellectual disability may have difficulty distinguishing when consent to sexual activities has, or has not, been given. When shown line drawings depicting a range of sexual encounters, people with intellectual disability had difficulty discriminating between consensual and non-consensual acts (O’Callaghan & Murphy, 2002). For example, it

was common for participants to say that what were clearly consensual acts should be reported to staff, parents or police. This group did not appear to derive as much assistance as did a sample of teenagers from cues such as facial expression and postures. It is possible that difficulties with comprehension were symptomatic of difficulties interpreting the drawings. However, the addition of narratives to the presentation of line drawings produced no change in the performance of the group with intellectual disability. For every vignette, the group with intellectual disabilities performed at a lower level than did the teenagers when asked for factual information, such as what was happening. Their interpretations of the situations, such as imagining how each of the depicted persons felt, were also less plausible. The results indicated that even if the person with intellectual disability knows that sex without consent is illegal, they have difficulty judging whether or not consent has been given.

These results may, however, reflect difficulty viewing the scenes and narratives objectively. If a person with intellectual disability has been taught that it is wrong to engage in sexual contact and that they should report any such incident, they may label all sexual depictions as wrong. In other words, they may have evaluated the vignettes against their own moral values (or those of their caregivers) rather than against legal standards. If empirical support could be obtained for such an interpretation, it would emphasise the necessity of including instructions differentiating moral and legal standards in

sex education programs specifically designed for persons with intellectual disability.

Summary

A combination of the effects of intellectual disability, both on cognition and on lifestyle, issues of dependency, and a lack of knowledge of sexual matters, of rights and of the law, leads to greater vulnerability to sexual exploitation in persons with intellectual disability than is generally the case in the rest of the population. This list of contributory elements is best viewed as inclusive rather than exclusive, and is not exhaustive, nor are all aspects necessarily present in any particular person. It seems overwhelmingly clear, however, that the question of whether this population is in need of special protection in law must be answered in the affirmative.

Part II: Prohibition of Sexual Exploitation by Any Person

It appears likely that the increased vulnerability of persons with intellectual disability to sexual exploitation was one reason for the enactment of legal provisions aimed at preventing this occurrence. One of the principles of a liberal society is freedom of individual choice (Rawls, 1999), and most individuals are legally capable of making choices. If a capable person willingly consents to engage in what many would regard as their own exploitation, they are free to do so, at least within some limits. It is when doubt exists as to the person's mental functioning that the law sees fit to

intervene even within those limits. Under these circumstances, the law does not approve of exploitation, even if the person is willing to engage in it, and legislation has been set in place to protect persons who are unable to adequately guard their own interests in sexual transactions. The difficulty lies in framing provisions which afford the required protection, but do not unnecessarily restrict sexual choice.

On the face of it, the most straightforward approach is to assess capacity to consent to sex. Some authors have attempted to establish criteria by which capacity to consent might be assessed (see, for example, Kennedy & Niederbuhl, 2000; O'Callaghan & Murphy, 2002). The task has proved a difficult one. The Victorian Law Reform Commission (2005) rejected a number of submissions that relied on establishment of capacity to consent, indicating that this requirement would increase the difficulty of prosecuting offenders who sexually exploit persons with mental impairment. If, for example, expert testimony was entered that conflicted as to the complainant's capacity to consent, the conviction of an accused person who claimed they believed the complainant consented would be highly unlikely. Additional difficulties are that the nature of consent is by no means established in law (Leader-Elliott & Naffine, 2000), and agreement has not been reached on the prerequisites for capacity to consent, for example, what underlying knowledge is necessary for consent to be real. The Royal Australian and New Zealand College of Psychiatrists, in its submission to the Law Reform Commission of Victoria (1988, p.19), stated:

Consent to sexual intercourse must contain a full understanding of the consequences of pregnancy and child rearing and the ability to understand the effect of impaired mental functioning on the development of a child resulting from such intercourse.

However, in most States, the knowledge required for legal consent to a sexual act is only that the person understands the nature of that act.⁷

Another approach would be to assess whether a person is able, in a general sense, to give consent. However, an individual might be legally capable of decision-making in one area of life but not in another (Somerville, 1994), and thus this approach also does not yield a satisfactory solution. One method of avoiding questions of consent and of capacity to consent, which involve assessment of mental states and the competence of the *person*, is to frame legislation that is more reliant on assessment of circumstance and context — to ask in fact whether an *act* constitutes sexual exploitation. This is the basis for one of form of legislation adopted within Australian jurisdictions.

As noted earlier, some states have criminalised sexually exploitative acts committed by any member of the general population against a person with mental impairment or intellectual disability.⁸ The wording of these provisions differs from state to state but is broadly similar in aim, namely to

⁷ ACT Crimes Act 1900 s 67; NSW Crimes Act 1900 s 66F; NT Criminal Code s 130; Qld Criminal Code 1899 s 216; Tas Criminal Code Act 1924 s 126; Vic Crimes Act 1958 s 50; WA Criminal Code s 330. The sole exception is South Australia, where the nature and consequences of the act must be understood (Criminal Law Consolidation Act 1935 s 49).

⁸ NSW Crimes Act 1900 s 66F; WA Criminal Code s 330; Qld Criminal Code Act 1899 s 216).

deter any person from exploiting members of a vulnerable population. A number of issues are raised by this approach.

Categorising exploitation.

The problem of definition. There are emerging definitions of exploitation in the law but these mainly pertain to sexual slavery or servitude (see for example the *Commonwealth Criminal Code Act 1995* (Cth) s 270.4). No definition of the sexual exploitation of a person with intellectual disability appears to exist. This is likely to be because examples of exploitation are so varied as to necessitate assessment on a case-by-case basis. The fact that exploitation has not been judicially defined indicates that the term has no special legal meaning. Given the lack of legal status of the term, we have drawn on definitions taken from the disciplines of philosophy and politics. The entry under 'Exploitation' in *The Oxford Companion to Philosophy*, reads, in part:

[T]o exploit someone or something is to make use of him, her, or it for your own ends by playing on some weakness or vulnerability in the object of your exploitation. A manipulative friend, lover, or parent exploits someone's feelings of guilt or need for affection.... If we think it is wrong to exploit a person, that is only because we think that someone's vulnerability should not be used to bring his or her life or labour under another's control (Wood, 1995, ¶ 1, 3).

Reeves (2003, ¶ 1 in *The Concise Oxford Dictionary of Politics*) defines exploitation as "taking unfair advantage of persons, their characteristics, or their situations.... A particular problem is the identification of exploitative transactions within consensual exchanges." For the purposes of this article, let us expand the category of consensual exchanges to include exchanges which are not overtly non-consensual but which involve a person with an intellectual disability severe enough to instil doubt as to their capacity to consent.

On the rare occasions when the legislation pertaining to the sexual exploitation of persons with intellectual disability is invoked, one of the difficulties facing justice personnel lies in the identification of purportedly exploitative relations which are, nonetheless, apparently consensual. In reported Australian cases, judicial use of the term exploitation in a sexual context is uncommon. When it does occur it is used almost exclusively in relation to cases involving the sexual abuse of children (see, for example, *R v Howes* [2000]; *R v ADW* [1999]; *Ryan v The Queen* 1999; *R v Barnes & Purnell* [1998]; and *R v Dawson* [2000]). A literature search revealed only one Australian case, namely *R v Grech* (1999), in which both the person with intellectual disability and the alleged offender were adults, where specific mention was made of the term "sexual exploitation". This case involved a young man with intellectual disability and a staff member at his residence. With cases involving children, one feature is easily identified as exploitative — the fact that children who are unable to give legal consent have been

used by the stronger party, the adult, for sexual gratification. But cases in which an adult person with intellectual disability is involved pose greater difficulties. When is it appropriate for the law to intervene and override that person's decisions about their sexual activities? When is it paternalistic to do so? How is the concept of sexual exploitation to be put to practical use in the courtroom?

Pragmatic use of the term "exploitation". Attitudes within the community vary widely as to what is legally acceptable, what is morally acceptable, what is one but not the other, and what is never acceptable. For instance, it seems likely that a small number of people view heterosexual intercourse between a married couple for the sole purpose of procreation as the only acceptable form of sexual activity, whereas a small number of others might approve of any sexual act whatsoever. Most people's attitudes probably fall somewhere between these extremes, with the greatest number falling somewhere toward the "middle of the road". A similar distribution can be found in relation to a large number of variables. It seems reasonable to assume that community attitudes to what constitutes sexual exploitation is one of these variables. Because of this, precise definition of exploitation based on community norms is difficult. Indeed, submissions to law reform commissions working on sexuality and disability legislation have reflected just such a range of attitudes (see, for example, Law Reform Commission of Ireland, 1990; Law Reform Commission of Victoria, 1988).

It can be seen that categorisation of a behaviour as exploitative is necessarily based on personal opinion. This may be one reason so few cases are prosecuted under the current legislation. However, a further difficulty in employing this terminology is that anyone can feel they have been sexually exploited, a point which is discussed in the following section.

We are all vulnerable to sexual exploitation. Traditionally, exploitation has been viewed as occurring prior to the act, for example, through the use of deception or coercion to gain consent. Recently, however, the philosopher Klepper (1993) offered the opinion that this view neglected exploitative acts that occurred during or after consensual sex. Two examples he cited were: ignoring one's partner's needs and pleasure; and revealing intimate details of the act to a third party. It is reasonable to assume that consent would not be given to either of these behaviours, which treat the person as a sexual object. There is a tacit understanding that each person will treat the other as an end in themselves. We expect that our partner will attempt to please us as we do them. Likewise, Klepper argues, our societal norm is that we do not talk about intimate encounters and therefore we do not expect details of our sexual actions to be revealed to other persons. Behaviours that violate socially accepted standards such as these may be exploitative.

The value of Klepper's analysis lies in its exposure of the extent to which exploitation is possible when we trust another person to act in accordance with social and cultural expectations. It demonstrates the ease with which individuals without any particular vulnerability may be exploited.

Such general vulnerability may be compounded by the presence of intellectual disability. This may disadvantage its possessor in interactions with people who do not have that disability, or do not have it to the same degree. The South Australian *Criminal Law Consolidation Act* (1935, s 142) contains a section that addresses dishonest exploitation of a position of advantage. It applies to “the advantage that a person who has no disability or is not so severely disabled has over a person who is subject to a mental or physical disability.” If a person with intellectual disability is indeed at a disadvantage in all interchanges, one conclusion seems to be that any sexual act with such a person constitutes exploitation.

Is all sex necessarily exploitative? The view that all sexual acts that involve persons with intellectual disability are exploitative seems to be the basis of a submission published by the Law Reform Commission of Ireland (1990, p. 17):

In typical circumstances the girl is spotted and induced into sexual intercourse or other acts by a male who has no interest in her personally and who has no intention of offering her any attempt at a long term relationship or marriage. The essence of the wrong done is that, unlike a normal girl, the handicapped one cannot see clearly the intentions of the predatory male, is too weak willed to struggle against physical inclination and is not the personality equal of the male in any struggle for friendship or commitment. If a handicapped girl is

exploited in these circumstances, she may have unrealistic expectations which can be fuelled by a predatory male and be subjected to hurt or exploitation greater than a mentally able person (Law Reform Commission of Ireland, 1990, p.17).

If this view is accepted, it is difficult to see how a person with intellectual disability would be able to exercise the right to sexuality at all. Moreover, there is no evidence that “handicapped” persons are subject to greater emotional hurt than other people. Bruised feelings are not confined to persons with intellectual disability, nor are they confined to “girls”. Men, whether disabled or not, also suffer emotional hurt. And it is not only women with (or without) intellectual disability who may be deceived. The position shown in the quote is based on an assumption that a female must want commitment, and that a long term relationship or marriage is her only legitimate goal. Yet the females referred to may not have the capacity to understand what marriage involves and may not be legally allowed to marry. The commentator does not acknowledge that sex may be engaged in for simple physical relief and nothing more. There appears to be a belief that the woman should struggle against physical inclination, and in any encounter is destined to be a victim. In such a view, women with intellectual disability are the equivalent of children, and their male counterparts are not even recognised. Yet it appears that the Law Reform Commission of Ireland heeded this anecdotal submission, rejecting a more liberal approach and

recommending that it become an offence for *any* person to have sexual relations with a person incapable of protecting themselves against sexual exploitation. The Western Australian *Criminal Code* s 330 (1) contains a similar provision — in that legislation, a reference to an incapable person is to a person who is incapable of understanding the nature of the sexual act, or of protecting themselves against sexual exploitation. Any sexual act with such a person may be the subject of a charge under this legislation.

The Irish and Western Australian provisions are similar to the approach that has been taken in Queensland.⁹ There, the current statute prohibits any person from having unlawful carnal knowledge of an intellectually impaired person. However, a defence is available if the act did not in the circumstances constitute sexual exploitation of the intellectually impaired person. It is difficult to see how, in the absence of any legal definition of sexual exploitation, it can be proved that an act is not exploitative, any more than it can be proved that it is.

Adults with intellectual disability are subject to the same sexual desires as other adults. They may wish to express those feelings, possibly with a partner, as other adults do. However, if the law is framed in a manner which allows any sexual act with such a person potentially to be seen as exploitative, then it is difficult to see how adults with intellectual disability can fulfil their sexual needs. Although making an offence of sexually exploitative behaviour affords, in principle, the most protection to those in need, this

⁹ Qld *Criminal Code Act* 1899 s 216.

legislation is almost unenforceable. It also neglects the needs and rights of persons with intellectual disability for sexual expression.

In the next section, one alternative approach, which is in use in several Australian jurisdictions, is examined.

Part III: Banning Relationships with Persons in Authority

As previously noted, one alternative is to ban sexual acts between people with some form of mental impairment and those who hold a position of care, supervision, authority, or responsibility towards them.¹⁰ Perhaps the most cogent Australian example of this approach is Victorian legislation, which contains two relevant sections. Section 51 of the *Crimes Act 1958* prohibits sexual penetration of a person with mental impairment by a person who provides medical or therapeutic services to them, where the person with impaired mental functioning is not their spouse or de facto spouse. The services provided must be related to the impaired mental functioning. Section 52 of the *Crimes Act 1958* prohibits sexual relations between a worker at a residential facility and a resident who is not their spouse or de facto spouse. Consent is not a defence to charges under either section unless the accused believed on reasonable grounds that he or she was the spouse or de facto spouse of the person with intellectual disability.

¹⁰ This approach is taken in the following legislation: NSW *Crimes Act 1900* s 66F; Vic *Crimes Act 1958* ss 51 & 52; Tas *Criminal Code Act 1924* s 126; NT *Criminal Code* s 130.

In *R v Patterson* (1999), Mullaly J ruled that in order to secure a conviction under s 51 of the *Crimes Act* 1958 (Victoria), the prosecution must prove that: the complainant was a person with “impaired mental functioning”; the accused was providing medical or therapeutic services to the complainant; the services related to the complainant’s impairment; the act of sexual penetration occurred when the accused was providing services to the complainant, although not necessarily at the exact time of giving the service; the accused knew that the complainant was a person with impaired mental functioning; the accused knew that he or she was providing medical or therapeutic services to the complainant; the accused knew that the services related to the complainant’s impairment; and the acts were conscious, voluntary and deliberate.

According to the Victorian Law Reform Commission (VLRC; 2001), emphasis on the accused’s knowledge may make it difficult for this offence to be established and they recommended the offence be one of strict liability not reliant on the knowledge of the accused (VLRC, 2005). The VLRC (2001, 2005) appeared especially interested in making it easier to obtain convictions because although there is a high incidence of sexual assault against persons with mental impairment, the crime is underreported. They recommended that the existing s 52 of the *Crimes Act* 1958 (Victoria) be extended “to cover any person working at a facility or program that provides services to people with cognitive impairment, rather than just workers at

residential facilities” (VLRC, 2005, p. 337). Section 52 would apply to paid and voluntary workers.

However, we believe that any instance of sexual assault would and should be charged under the general law of sexual offences. Such offences occur in the absence of consent. There may be an overt lack of consent, consent may be vitiated by a number of factors including deception or coercion, or the person may be incapable of consent. In these cases, the result is sexual assault and should be charged as such, regardless of whether or not the accused provides services to the complainant. On the other hand, if the person is capable of consent and their consent was not vitiated for any reason including coercion, then no crime has occurred.

We suspect that there are a number of reasons that widening the range of persons who are prohibited from sexual relationships with persons with mental impairment will not reduce the incidence of sexual assault nor increase reporting rates. First, reporting rates are currently low, so it is difficult to see how prohibiting more sexual liaisons would alter that. Second, sexual offences in general are notoriously underreported (Easteal, 1998a) and sexual offence charges are defended in court more than any other type of crime (Wundersitz, 1996). The difficulties of testifying in court are amplified for persons with mental impairment (VLRC, 2005), and conviction may be more difficult to secure when the victim has a mental impairment (McSherry & Naylor, 2004), factors which discourage reporting and prosecution. Third, the VLRC (2001, 2005) states that some persons with

mental impairment are unaware of complaint channels; it is difficult to see how extension of s 52 would alter that situation.

Incorporation of the proposed extension to s 52 into law would effectively prohibit sexual relations between persons with mental impairment and workers who are not in any position of ascendancy and therefore could not use their employment as a coercive device. Most people find their partners through the circumstances of their life, for example, where they live and work. Extension of s 52 would mean that anyone who held any paid or voluntary position would be prohibited from engaging in sexual relations with a person with mental impairment. Workers not directly involved in the care of the person with mental impairment might well develop a genuine relationship with them but would be unable to legally engage in a sexual act. The effect of extension to s 52 would be to limit the sexual autonomy of persons with mental impairment who voluntarily wished to engage in a sexual relationship.

In the past, the rights of individuals in need of special care have often been curtailed on the basis of unjustified beliefs. In the context of freedom of sexual expression, it is most likely that these individuals' rights will be limited on the basis of their incapacity, a concept that should be applied in accordance with principles of human ethics and human rights. For example, while it is acceptable to limit the right to marry where an individual lacks the capacity to understand the nature of the marriage contract, it is not acceptable to assume that all

mentally ill or retarded persons lack such capacity. Likewise, the right to freedom of sexual expression may be curtailed if the individual lacks the capacity to consent to sexual intercourse, but there should be a presumption against limiting this right and clear justification for doing so would need to be provided. Such limitations are often justified by recourse to the notion of harm, but care must be taken that this is not used unethically. The main difficulty lies in drawing the line between true, justified prevention of harm to the individual and unjustified paternalism (McSherry & Somerville, 1998, p. 118).

Consider if the sexual choice of non-disabled people was to be restricted because of the high incidence of rape and underreporting of it. One might imagine that anyone who suggested such a thing would face a firestorm of criticism by the public and in the national media. Rather than further limiting the sexual choice of the victim, a more useful solution to the problem of sexual abuse of persons with mental impairment would be to provide them with education about who may not have sex with them, that consent is “free and voluntary agreement” (McSherry, 1998a & b; McSherry & Somerville, 1998) and what that means in pragmatic terms, about coercion, about the fact that they can say no, and about complaint channels. Education should also be provided to all workers to enable them to recognise the signs of sexual abuse, which have been comprehensively catalogued by Hayes (1993).

Nevertheless, there are negative effects associated with consensual sexual relationships in which one partner is in a position of ascendancy. In her examination of consensual sex in professional relationships where one party is subordinate to the other, Sanger (2004) discussed the arousing effects of power and influence and the flattering effect of capturing the attention and interest of an experienced, skilled and intelligent partner. She also examined the negative effects that can result from such relationships. First, there may be an appearance of, or indeed, real favouritism, which may have harmful effects on the colleagues of both parties and on overall morale within the organisation. Second, such relationships may compromise professionalism. Finally, initially benign power differentials may be misused if the relationship founders. These points are relevant to the relationships under consideration here. Staff may be reluctant to enforce rules on a resident who is having an affair with their colleague or superior, and other residents may feel neglected. The reputation of the whole organisation may be tarnished if the existence of a sexual relationship between a member of staff and a resident becomes common knowledge. Even if it does not, staff members who view such a relationship as unethical are likely to be uncomfortable with this situation. And as previously discussed, the person with disability may be punished in a variety of ways by the staff member if the relationship founders.

Although the coercive power of authority quickly comes to mind, not all authoritative influence is coercive, and a blanket prohibition of sex

between parties who hold positions of responsibility and those in their care does have several disadvantages. First, persons with intellectual disability often have a restricted range of potential sexual partners. There are three classes of persons with whom an attachment might be formed: people responsible for them, others with intellectual disability, and people without disability. O'Callaghan and Murphy (2002) found that with the exception of family, professionals and carers, adults with intellectual disability have a much smaller number of people in their social networks than do mainstream 16- and 17-year-olds, and of these, very few are not disabled themselves. Thus there is only a small chance of meeting and developing a relationship with a person without disability. Prohibition of sexual relationships with a large proportion of their social circle, namely people who hold a position of responsibility, may, therefore, effectively restrict an already limited number of possible partners to others who have some form of disability.

A second disadvantage of legislating against relationships between persons with intellectual disability and those in positions of responsibility is that the persons involved might have genuine feelings for each other. In the previously mentioned case *R v Grech* (1999) the defendant was a team leader at a home run by the New South Wales Department of Community Services. He was charged with having a homosexual relationship with a resident over a period of several years. Evidence was presented that the defendant's marriage had broken up as a result of this relationship, and both men asserted their love for each other and their wish to continue seeing

each other. It might be argued that an ethical person could resign their employment if they found themselves in such a position. However, it seems likely that even if Grech had resigned, the revelation of such a relationship would have provoked negative reactions from family members and staff (the precipitating factor in charging Grech was the resident's parents becoming aware of the relationship). One result of resignation and/or disclosure may be that fewer opportunities for contact are available to the couple and the person with mental impairment might suffer the loss of the comforting presence of a genuinely caring person. This may not seem an acceptable risk to take.

However, the *R v Grech* case was unusual. It is far more common to find references to non-consensual sexual acts committed against people with mental impairment, often by people close to them, than it is to find consensual ones (Carmody, 1990; Furey, 1994). Although statistical evidence citing abuse rates is difficult to obtain, the effect of socially legitimated authority on compliance is well recognised in the psychological literature (the classic study in this area is that of Milgram, 1963). According to the Model Criminal Code Officers Committee (1999, p.181):

Some way of distinguishing between, on the one hand, truly exploitative sexual contact between mentally impaired persons and their carers, and, on the other hand, sexual contact with a carer to which a person with some degree of mental impairment might

nevertheless freely and voluntarily consent, must be found.

Otherwise, the Code will arbitrarily restrict the sexual autonomy of mentally impaired persons when it comes to their carers.

McSherry and Naylor (2004, p. 244) express similar concerns:

The benefit of having specific provisions criminalising sexual acts with those with mental impairment is that they may very well lead to more convictions... The problem with such provisions is that they may go too far in preventing those with mental impairment exercising any right to sexual autonomy.

Recommendations made in the Model Criminal Code are that offences should be created only against persons directly responsible for the care of a person with mental impairment. A limited defence ought be available, however, if the person with impairment consented, and the giving of that consent was not unduly influenced by the fact that the person was responsible for the care of the person with mental impairment (Model Criminal Code, p. 180).

It is difficult to see how it could be proved that being in a position of dependency was not unduly influential on the giving of consent. To be legal, consent must be freely given. When one party is in a position of power over the other, an element of doubt necessarily exists as to whether the consent

of the subordinate to the superior's request was completely free. Because it would be so difficult for a defendant to avail themselves of the Model Criminal Code defence, it seems likely that if such legislation were enacted, only the most optimistic carers would risk sexual contact with those they care for.

Part IV: Is Protection Without Discrimination Feasible?

The Model Criminal Code recommendation has the merit of being non-discriminatory and would be useful if a test for exploitation could be developed. Without such a test, any judgment that exploitation has occurred is necessarily open to the criticism that such an opinion reflects the values of the observer. Indeed, our earlier criticism of the submission to the Irish Law Reform Commission was based on such an argument.

In that submission, acceptance of sexual contact as an end in itself is absent. The submission supported a position which was founded on particular moral values rather than on legal principles. Other moral values may be held by other members of the community. For instance, some might argue that there is nothing inherently exploitative about casual sex and that any adult, including a person with intellectual disability, may freely choose to have a casual liaison.

If the view that all casual liaisons or certain types of sexual acts are necessarily exploitative for persons with intellectual disability were enshrined in legislation, the outcome would be discriminatory — the result would be

that casual sex or those particular acts would be illegal for people with mental impairment but not for people without. Even as it stands, current law allows enormous scope for its interpretation to be coloured by the personal values of an observer. It also allows discrimination on the basis of disability. Persons with mental impairment may wish to engage in sexual acts but be prevented from doing so because of the moral values that others hold.

The problems inherent in current legislative approaches along with the dearth of case law in this area indicate the need for reform. Of course, sexual acts involving people with mental impairment are not uniquely subject to sanction. Children are also protected by law, and certain professional relationships are subject to ethical scrutiny by governing bodies. As these measures are designed to protect the more vulnerable party of a dyad, and are therefore relevant to this discussion, an examination of these relationships is the focus of the following section.

Part V: Relationships that might function as legislative models

Relations involving children. All relationships contain power imbalances. Some imbalances are so large that certain categories of sexual relations have been proscribed, the obvious example being acts involving children. Statutory laws against sexual activity with children were enacted because it is considered that a child is in such a subservient position relative to an adult that the child cannot consent in any circumstances. The power imbalance between a child and an adult is too great to allow for genuine

choice on the part of the child, even if power is not overtly exercised by the adult. Typically, children are easily manipulated by an unscrupulous adult, have limited ability to see alternatives, are easily threatened, lack knowledge of their rights and of the law, and have much to lose. Their position resembles that of persons with intellectual disability. It might be argued, therefore, that the law relating to sexual acts with children provides an acceptable model for provisions regarding adults with mental disability.

Acceptance of this model would certainly confer protection, but at the expense of the right to sexual expression. All sexual acts involving persons with intellectual disability would become illegal. Currently, supporters can be found to champion the priority of the right to protection over the right to sexuality, and vice versa. There are good arguments for both cases.

If we balance the need for protection and safety against the need for sexual expression with another person, we may find ourselves agreeing that the former should take precedence over the latter. Such a judgment is consistent with the theoretical ideas of the prominent humanist psychologist Maslow (1970), for whom safety and freedom from fear were secondary only to the most basic physiological requirements necessary to sustain life. The outcome of this line of reasoning is that the need to protect persons with intellectual disability is paramount, and the need for sexual expression is secondary.

But there are several problems with assigning priorities using such an approach. First, it is unnecessary to prioritise protection to such an extent

that the possibility of any sexual expression with a partner is eliminated. These rights and needs are not mutually exclusive. It is possible to find a middle ground that respects both. Such an approach is consistent with the United Nations *Declaration on the Rights of Mentally Retarded Persons* (1971, paragraph 1), which states that "the mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings". Although international law has no direct effect until it is incorporated into domestic law (Mason, 1998), which has not occurred in relation to this *Declaration*, the rights of the disabled will ideally be upheld even in the absence of legal obligation (McSherry & Somerville, 1998). In *R v Swaffield; Pavic v The Queen* (1998), Kirby J stated: "To the fullest extent possible, save where statute or established common law authority is clearly inconsistent with such rights, the common law of Australia, when it is being developed or re-expressed, should be formulated in a way that is compatible with such international and universal jurisprudence."

The rights of persons with mental impairment are not equivalent to the rights of a child with the same mental age. Mental age is based on the IQ test score of the average child. When a test is first designed, a large number of children of the same age are tested and the average number of correct answers is calculated. This score is known as the norm for that age. This procedure is repeated for a range of ages. When a person is tested, the number of correct answers they give is compared to the norms. Their mental age is the age of children who give the same number of correct answers.

Mental age is sometimes incorrectly used to infer that an adult with intellectual disability is in all respects the mental equivalent of a child of that age. This is not the case; such a person may have accumulated far more life experience than a child, and they are physiologically not children. In particular, they are sexually mature. Persons with intellectual disabilities are interested in sexuality, in its variants and in its consequences (McCabe, 1999). They wish to be allowed self determination and to have their decisions respected (Somerville, 1994). As a model for legislation, therefore, laws pertaining to the involvement of children in sexual acts are unsatisfactory.

Professional ethics. At this point we would like to conduct a more searching examination of sexuality in professional relationships. Our specific interest here is in sexual relationships between a professional and their client that are either prohibited by law or which contravene professional ethics. Leaving aside relations that are entered into because of coercion, deception, irrationality, ignorance or emotional vulnerability such as that occasioned by grief, there is a morally suspect class of consensual relationships that are, at least in part, entered into as a result of the power structure of the professional relationship itself. Archard (1994) condemned such relationships as unethical. His reasoning was that "A's giving of consent is attributable, wholly or in significant part, to the nature of the positions occupied by A and B within their relationship" (Archard, p.95). Consent would not have been given but for the existence of the professional

relationship; sex between doctor and patient, therapist and client, and professor and student fall into this category. The critical feature identified by Archard of this “exploited consent” is that the professional relationship has a certain scope, and that this scope is breached by sexual intimacy. The discovery of sexual acts between professional and client, when they involve only adults, generally does not lead to criminal prosecution; the skilled party is usually only subject to sanctions administered by the governing body of his or her profession.

Archard’s analysis, although confined to professional relations, is particularly applicable to relationships between persons with mental impairment and those who care for them. These relationships are established for a specific purpose, are commonly understood to have a specific scope, and they are peculiarly open to exploitation. The distinguishing feature of these relationships is that they are not overtly non-consensual but they do contain a power imbalance — one person is in a position of dependency and the other person holds the power to influence their life to a significant degree. It may be that consent would be extremely unlikely if the professional relationship did not exist. The category excludes relationships in which no professional connection exists between two people.

[T]here is nothing in our understanding of the everyday relationship between professional and non-professional that says sexual intimacy is inappropriate, that is outside its proper scope... we must be careful

not to condemn any consensual relation whose parties are not the equals of one another. If we do, we condemn too much (Archard, 1994, p. 99).

By this reading, an example of an unethical relationship is where consent is given by a student to her own teacher. It would not be unethical if she consented to a teacher because he was a teacher, as long as he was not *her* teacher. There is no professional relationship between the two: he cannot favour her when he grades her work, he cannot retaliate by marking her down if things go wrong. There is nothing in the relationship that is breached by sexual contact.

We advocate a legislative approach based on this principle. Relations would be allowed between persons with mental impairment and any person who does not hold a position of authority whose scope proscribed such contact. Positions of authority that would be excluded would be all those that incorporated ascendancy over the person being cared for; and from which, by virtue of that ascendancy, any coercive pressure could be exerted. This approach minimises the number of persons expressly excluded as potential sexual partners. For the same reasons it is minimally restrictive of rights. At the same time it is enforceable, and therefore is preferable to much of the current legislation.

Part VI: Conclusions and Recommendations

One weakness of basing legislation on a concept such as sexual exploitation is that concepts can best be used only when they are properly operationalised. When precise definition is neglected or when the concept is found to be so broad as to be impossible to precisely define, it opens significant debate as to whether or not the indicated concept has been observed. Has exploitation occurred in a particular case? In these circumstances, the law becomes unenforceable.

Much of the current law attempts to address the right of persons with intellectual disability to protection from sexual exploitation, but does so in a way which may result in undue interference with their right to sexual expression. The purpose of the law is not to prevent people with intellectual disability from making errors of judgment. Such a law would be paternalistic in that it would treat adults as children. It would also be discriminatory: people who may have a reduced capacity to foresee the consequences of their actions nevertheless have a right to have their decisions respected unless there is a very clearly justified reason for not doing so (Somerville, 1994). The purpose of legislation is to afford protection from the peculiar vulnerabilities that accompany intellectual disability or, more broadly, mental impairment. The goal is to achieve this protective function while avoiding unnecessary restriction, discrimination and paternalism.

Very often a passive, victimized role is ascribed to people with intellectual disability — it is assumed that, if anything, they will be taken advantage of. Such notions are in evidence in submissions to law reform

groups. However, it is difficult to argue that exploitation of a person with mental impairment has occurred based only on the presence of a sexual act. Even when acts occur that some would view as degrading, as, for example, in the case of *R v Eastwood* (1998), where a woman with intellectual disability was urinated upon, the same complexities arise. Some people without intellectual disability willingly engage in this practice, so a conviction based on this fact alone might be overturned. The difficulty in proving the existence of exploitation may be one of the reasons that very few charges of sexual offences against complainants with mental impairment come before the courts.

The prohibition of sexual acts between persons in a position of responsibility and those in their care is necessary because of the potential within such relationships for the abuse of power. The analysis of such relations by Archard underlined the pervasive influence of authority on compliance. Even in the absence of intentional use of power differentials, consent may be achieved in circumstances that are suspect. The law does have the legitimate role of providing protection by preventing the undue influence of persons with a particular susceptibility.

To that end we recommend the creation of criminal offences that prohibit sexual acts between persons in a relationship, either paid or voluntary, with a person with a mental impairment where the said relationship has a clearly defined and commonly understood scope which excludes sexual acts. This proposal redistributes criminal liability. It does not

disqualify people as potential sexual partners based on employment categories such as professional, residential worker or carer. Rather, it is based on the status of the relationship between the individuals involved. Persons who hold positions that are recognised as having a clearly defined scope which excludes sexual acts are only excluded from having sex with the particular person or persons with intellectual disability to whom their position applies. Under this proposal, criminal liability is extended to all persons who have been engaged, or who have volunteered, in a role that is understood to exclude sexual acts, but who would be liable under current legislation to conviction only if sexual exploitation could be proved.

A potential criticism of this recommendation is that it is discriminatory — those who hold a position that excludes sexual acts are not free to engage in casual sex with persons in their care. However, to afford such a freedom to those who hold what are in many ways positions of trust is to risk the exploitation of the persons in need of protection. Declarations of the rights of the disabled acknowledge that it may be necessary to curtail the rights of affected persons, a notion which is justified by reference to harm occurring, either to the person or to others (McSherry & Somerville, 1998). Our suggestion is in keeping with this principle.

A second point which may be seen as discriminatory is that there is no criminal liability for analogous acts that do not involve a person with mental impairment. A consensual sexual act between a professional and their adult client, patient or student is viewed as unethical but not criminal.

This might be because there are sanctions for professionals who breach ethical principles. Moreover, increased gravity in offences against persons with mental impairment is consistent with existing principles of aggravation. In the eyes of the law, any offence is aggravated when committed against a member of a vulnerable population, which includes people with disabilities (Walker & Padfield, 1996), and more severe penalties are available for such convictions. Giving criminal status to acts that would be viewed as merely unethical in other circumstances is consistent with this approach. It is difficult to see how it is possible to afford protection to persons with mental impairment unless there are some differences between legislation that applies to them and legislation that applies to the population as a whole. Adherence to general legal principles while increasing the severity of the offence and the sentence satisfies this protective requirement.

A weakness with existing legislation that bans all sexual acts between any worker at a residential facility and a resident is that relationships are prohibited with workers who do not provide services to that particular person. Examples are maintenance workers, gardeners, administrative staff and the like, who may be in a position to form genuine friendships with residents. People filling these roles are not ascendant in any significant respect over the person with mental impairment, and sexual acts do not contravene the scope of the relationship. The suggested policy minimises restrictions and is therefore consistent with the principle of maximisation of the human rights of persons with disabilities.

Thus this approach may be employed as a basis for legislation that approximates the criteria of being non-discriminatory, minimally restrictive, clearly defined and applicable. The emphasis is on approximation: we do not claim that our recommendation is ideal. Any specialised clauses that apply only to a subsection of the population are immediately suspect as discriminatory. Yet the right to protection can only be preserved by the enactment of such special provisions. Without them, people who are particularly vulnerable can claim only the protection afforded to the whole community. We have argued that such a position is unsatisfactory. It is not kind to pretend that people with disabilities do not have special needs when in fact they do; to that end we have attempted to formulate a legislative approach that meets those needs while at the same time most fully supports the exercise of their rights.¹¹

¹¹ In the interests of minimising duplication, the reference list for this paper has been consolidated into the reference list at the end of the thesis.

The previous chapter addressed the notion of sexual exploitation and its practical application in legislation. I have discussed the difficulties inherent in enacting legislation that applies only to a subsection of the community while at the same time providing protection to those with special needs. I will return to these issues in Chapter 8.

The focus of the following chapter is a second issue arising from current law, the issue of informed consent. We argue that the knowledge that a person is currently required to have, that is knowledge of the nature and character of the act proposed, in order to be deemed capable of giving consent to a sexual act is inadequate. I argue that this is especially so when compared to the standard of informed consent required for medical procedures.

Chapter 5: To what extent can consent be uninformed? The validity of consent to sexual acts by persons with intellectual disability¹²

¹² Published paper:

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Abstract

The aim of this paper is to examine the question of what knowledge a person should have to be deemed capable of consenting to sexual acts. Currently in all Australian states except South Australia, only the nature and character of the act needs to be known for consent to be legal. Knowledge of the consequences of the act is specifically not required. We argue that simple knowledge of the nature and character of the act is an inadequate basis for valid consent, and that consent to sexual acts should more closely resemble the informed consent required for medical treatment. Furthermore, although there is some variation in particulars, all Australian state legislations specify that a victim's lack of knowledge must be based in some form of mental impairment. We argue that such legislation is discriminatory. The question that should be asked is whether a person has sufficient understanding to consent; the presence or otherwise of mental impairment should be immaterial. Protection should be given to all persons who lack knowledge of the particular sexual act that is the subject of interest, regardless of the reason for that naiveté.

Consent to sexual activity is a topic that has received both academic and judicial attention in recent years. This attention has both been both a product of, and a driving force behind, legislative reforms of the law pertaining to sexual offences. Changes to the law, such as recognition of rape within marriage, have meant that in some respects, the concept of consent has narrowed. No longer does a husband have perpetual sexual access to his wife (at least legally, if not pragmatically; Eastal, 1998). Similarly, silence is no longer automatically accepted as evidence of consent. Theoretically, a more stringent standard of consent must now be proved than was the case before these changes, though judicial directions such as that “rougher than usual handling” was an acceptable method of overcoming resistance are still delivered (Bollen J in *R v Johns*, cited in Bronitt & McSherry, 2001, p. 604).

Within academic discourse, although authors such as Fisse (1990) and Williams (1983) cling tenaciously to outdated views on “seduction”, where the persistence of the male in the face of the female’s reluctance is seen as a legitimate ploy, close scrutiny of consent has led some commentators to reject less-than-wholehearted participation as true consent (see, for example, Leader-Elliott & Naffine, 2000). Other developments are: the recognition of consent as a continuum rather than a dichotomy composed of either consensual sex or rape (Kelly, 1987); advocacy of a positive consent standard (discussed by McSherry, 1998b); condemnation of judicial directions that support either overt or covert coercion of women (Moses, 1993); and rejection of the penetrative/coercive model of sexuality

in favour of one that features positive communication and mutuality (see, for example, Bronitt & McSherry, 2001, p. 607; McSherry, 1993; 1998b; and Pineau, 1989).

Despite this attention, it seems unlikely that many women would applaud the current laws of sexual offences. As Leader-Elliott and Naffine (2000) point out, in practice silence is still construed as consent; the traditional “no means yes” argument is still given weight in court; and there is still disagreement over the vitiation of consent by the use of deception. Leader-Elliott and Naffine reject outright the notion of consent: “The concept of consent in rape continues to give latitude to the liar and to tolerate those who resort to intimidation” (p. 72). Given the words of Bollen J above, the position adopted by Leader-Elliott and Naffine seems pertinent to a law that still affords protection to the sexually assaultive individual.

In an environment that in pragmatic terms still supports the male’s view of consent over that of the female’s, it is unsurprising that the female’s view of the act is viewed with suspicion (Henning & Bronitt, 1998; Kissane, 1993; Leader-Elliott & Naffine, 2000). It is also less than surprising that the law appears to support the male’s point of view, and to support a very low standard of knowledge that is required for an individual to be deemed capable of consent. The basic knowledge that is required is restricted only to an understanding of the nature and character of the act. In this paper we begin by examining judicial directions and other definitions of what needs to be known to give consent and the vitiation of consent by ignorance. This is

followed by a review of the research literature on the question of what should be known in order that a person is considered capable of consent, both to sexual acts and to medical procedures. We will argue that any persons, not only those with mental impairment, who do not understand what they are consenting to and what the commonly known consequences of that act are, are in need of the protection of the law. For the sake of convenience, throughout the discussion we refer to the accused person as “he” and to the complainant as “she”. This measure was taken with reluctance. We do, of course, acknowledge that not all accused persons are male and not all victims of sexual offences are female.

The law of sexual offences has its origin in the belief that it is easy to make an accusation of rape but difficult to disprove such an allegation (Williams, 1983). In law it is preferable to have a guilty rapist released, rather than have an innocent person convicted (Waller, 2000). In cases of sexual assault the law has generally taken the perpetrator’s — generally the male’s — perspective: it has often been enough for the accused to claim that “he thought” she consented for charges to be dismissed (Henning & Bronitt, 1998; McSherry, 1998b). Such an approach has led to what might be termed a minimalist approach to consent. Any sign (or lack of it) made by a victim, whether voluntary or involuntary, real or only imagined by the assailant, has sometimes been enough to secure an acquittal. An extreme example was mentioned by Kissane (1993) where the jury convicted a man for having badly beaten a woman with a wheelbrace, but acquitted him of raping her as

part of the attack. Apparently the jury believed that the woman, although bashed severely, consented to intercourse. In a second case, a US grand jury refused to indict for rape a burglar who admitted breaking into a woman's house and holding her at knife-point before having sex with her. The woman's plea to her attacker to wear a condom to protect her against possible AIDS infection was taken by the jury to mean that she consented (Kissane, 1993).

Consistent with this minimalist approach to consent, a very low level of knowledge about the act itself is required for a person to be considered capable of consent. In most Australian jurisdictions, only the nature and character of the sexual act must be known for a person to be considered capable of consent. Other factors may vitiate consent, such as deception, coercion, or mistake — but as far as factual knowledge about the actual act goes, there needs only be an understanding of the physical mechanics of the act and that its purpose is sexual rather than medical or hygienic (*R v Morgan*, 1970). The outcome is that almost any person, except one suffering from some severe form of mental impairment or one who is completely ignorant of sexual acts, is considered capable of consenting.

For the protection of persons with mental impairment, special legislation has been enacted that criminalises sexual acts involving them. Within Australian jurisdictions, there are variations in specific provisions. In some states, such as Tasmania, the term mental impairment covers senility, intellectual disability, mental illness and brain damage (Tas *Criminal Code*

Act 1924). Section 66F of the New South Wales *Crimes Act 1900*, however, pertains only to persons with intellectual disability, defined as persons who have appreciably below average general intellectual function and who require supervision or social habilitation in connection with the activities of daily life. In every Australian jurisdiction, provisions apply to persons with intellectual disability, and this group is the focus of much of the discussion that follows.

The aim of legislation regulating sexual acts involving persons with mental impairment should be to achieve a balance between the right to sexual expression and the right to protection. One approach, adopted in Victoria, New South Wales, Tasmania and the Northern Territory, is to prohibit sexual relations between a person with mental impairment and persons involved in their care except where the couple is married.¹³ A second approach, adopted by New South Wales and Western Australia, is to ban any sexual relations that exploit the person with mental impairment, and Queensland allows a defence if it can be shown that an act involving a person with intellectual disability was not exploitative. A third type of provision is to set a minimum standard of knowledge that must be present if the consent of the person with mental impairment is to be legal.

In those Australian jurisdictions in which the law contains a knowledge requirement, that is, South Australia, Western Australia, and the

¹³ This provision has its problems. In other areas of sexual assault law, marriage no longer carries with it an implied consent to intercourse: *R v L* (1991) 103 ALR 577; *R v R* (1991) 3 WLR 767.

Australian Capital Territory,¹⁴ the latter two require the person with mental impairment to understand only the nature and character of the act to which they are consenting. South Australia is unique in requiring not only capacity to understand the nature and character of the act, but also its consequences of the act. In this, the South Australian provisions bear some resemblance to the informed consent required for medical procedures.

To take a typical example of a statute¹⁵ that defines informed consent, the Qld *Mental Health Act 2000* s137 states: Before a person gives informed consent, a full explanation must be given to the person in a form and language able to be understood by the person about—

- (a) the purpose, method, likely duration and expected benefit of the treatment; and
- (b) possible pain, discomforts, risks and side effects associated with the treatment; and
- (c) alternative methods of treatment available to the person.

Defining consent

The meaning of consent differs according to the area of law to which it relates (Young, 1986). Our discussion of consent and its vitiating factors is

¹⁴ SA *Criminal Code Consolidation Act 1935* s 49(6); WA *Criminal Code* s 330 (1); ACT *Crimes Act 1900* s 67.

¹⁵ Other sections of statute that refer to informed consent are: ACT *Mental Health Act 1994* s54; NSW *Mental Health Act 1990* s155; Vic *Mental Health Act 1986* s53B; and WA *Mental Health Act 1996*, ss95, 96, & 97.

confined to consent to sexual acts. An examination of the history of cases in which consent has been judicially discussed reveals that modern law differs considerably from the law of, say, one hundred years ago. It is not our intention to extensively review that history here (for a detailed discussion, see criminal law treatises such as Bronitt & McSherry, 2001, 2005; or Fisse, 1990). We will, however, compare some older law with its modern counterpart to highlight some of the changes that have taken place in the law governing consent, using contemporary cases where it has been claimed that the complainant's ignorance of facts has vitiated her consent.

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 to and engaged in sex with him. After several days he deserted her and the facts came to light. The High Court held that because the complainant 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 only consented on the basis of a belief that she was legally married and that belief had been fraudulently induced by the defendant. As a result of *Papadimitropoulos*, the *Crimes Act* 1900 was amended so that s 61HA (5)(b) 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, does not 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 with 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 *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 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 at 21: “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.” On the basis of this ruling it appears that in cases of mistake regarding the facts surrounding the sexual act, criminal liability is not confined to cases in which a false belief has been actively induced by the defendant.

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). A different approach was taken 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: “A consent that is not based upon knowledge of the significant relevant factors is not a valid consent” (p. 127).

In all the cases mentioned above, there was no question that the parties were legally capable of consent. The issue was whether ignorance of some fact vitiated any alleged consent. Few cases have come before the

courts in which it was alleged that the complainant was incapable of consent due to a lack of knowledge caused by mental impairment. One such case was *R v Morgan* (1970). The County Court judge directed the jury 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). Interestingly, knowledge of the possibility of infection with a sexually transmitted disease was not mentioned in either the County or Supreme Court.

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.

In the South Australian case *R v Beattie* (1981) the defendant was charged with rape and with having unlawful sexual intercourse with a mentally deficient woman. He was acquitted of the first charge but convicted on the second. The woman was 23 years old at the time of the offence. She had a mental age of 10 years, had received no sex education and had no sexual experience. She and some companions attended a fair, where she spent a lot of time attempting to win a toy frog at a hoopla stall. She spoke to the attendant, Beattie, who asked her if she wanted to “make love”. He led her without resistance to a nearby caravan. He took with him the toy frog, which he subsequently gave to her. In the caravan, he had intercourse with her. Afterward, she returned to the fair. She made no complaint about the intercourse to her friends and spoke to the accused again. Later, another man enticed her into a truck with a toy panda. She had intercourse with him. Subsequently a third man attempted to have intercourse with her but she resisted and ran away. When her mother came to pick the woman up, she was distressed but would not say why. Later she revealed to her parents and the police what had occurred.

The *Criminal Law Consolidation Act 1935 (SA)* s 49 (6) reads: “A person who has, or attempts to have, sexual intercourse with another person knowing that other person to be so mentally deficient as not to understand the nature or consequences of the act shall be guilty of a misdemeanour and liable to be imprisoned for a term not exceeding seven years.” Beattie was found guilty but appealed to the Supreme Court. In delivering the judgment of the Supreme Court, White J laid emphasis on the woman's lack of resistance as a reason for acquittal on the rape charge. However, the appeal against the conviction for having unlawful sexual intercourse with a mentally deficient woman was dismissed on the grounds that the woman obviously did not possess any understanding of the consequences of the sexual act in which she had engaged. White J at 491 – 492 stated “it was clear that she did not understand the consequences of the sexual act, in particular the primary consequence of possible pregnancy. Her delight at learning where babies came from was quite evident during her cross-examination. From the way her face lit up, it was clear that the revelation occurred there and then.”

Whether conviction would have been made in the *Beattie* case had it occurred in a jurisdiction where only the nature and character of the act (rather than the nature, character and consequences of it) need to be known is open to doubt, as there was some evidence that the woman had had discussions about sexual matters with colleagues at her place of work in the days prior to the offence. The woman's evidence, demeanour and appearance were relied upon by the court as indices of her capacity to

consent. Were the trial to be heard today, it is likely that the court would take expert evidence on the woman's capacity to consent, though the difficulty inherent in accurate assessment of such capacity is well known (McSherry, 1998a).

The cases reviewed above suggest that consent must be based on knowledge; it is only the degree of knowledge that is in question. According to *The Oxford Companion to Philosophy* (1995, p. 153), consent "is morally binding only in so far as it is voluntary, undertaken with full knowledge, after deliberation". In case law, consent has been described as "a free and informed exercise of the will" (*R v PS Shaw*, 1995, p. 111).

A central question regarding consent is "What is it that was consented to?" Wittgenstein (cited in Leader-Elliott & Naffine, 2000) encapsulated the problem thus: A asks B to teach some children a game. A leaves the room. B teaches the children gaming with dice. When A returns and discovers this, he says, "I didn't mean that sort of game". Several questions arise: to what did A consent when he asked B to teach the children a game? Did A consent to the children being taught any sort of game? Should B have used his social knowledge to infer that A meant a children's game? Was A's consent vitiated by the type of game they were taught? What if, in B's culture, gaming with dice was commonly played by children? This example may be applied when accusations that any types of non-consensual acts are made, including sexual ones. Did B's act differ in such a way from A's expectations that criminal charges are appropriate? Wittgenstein's example shows the

difficulties that can arise from two people's differing understandings of consent. A number of feminist authors have examined the question of consent at length and usually find that in practice, B's (the male's) point of view is allowed to override A's (the female's) understanding (for an overview of the work of these authors, see Graycar & Morgan, 2002).

In the cases reviewed above, was consent given simply to the physical fact of the act itself? Was it sexual intercourse with a specific person as in *Pryor*? Was it sexual intercourse with a disease-free partner as in *Cuerrier*? Was it sexual intercourse with someone to whom the person is legally married as in *Papadimitropolous*? If one was to identify a trend in the law of consent, it would be that over time, the consent required by the court is consent to the details of the specific act that has taken place. Consent must be given to the particular circumstances that obtained at the time. Indeed, it seems that in cases where it is clear that the complainant would not have consented had she known the facts, such as the cases cited above, modern courts hold her consent to be vitiated.

Thus the trend over time is toward a standard that resembles informed consent. The difficulty is where to place the cutoff between real consent and vitiated consent. It would be unrealistic to set a standard where any unknown fact formed grounds for a rape charge. As an example, a person may not have consented to sex if they had known that their partner's sole motivation was lust and that they would end the relationship afterwards. But that is hardly grounds for sexual assault charges. Some jurisdictions

have attempted to address this issue by specifying that the lack of knowledge must be “fundamental” or some similar term. However, the inclusion of such terms does not solve the problem, since it is not clear what features define a lack of knowledge as fundamental.

When an ordinary type of decision is to be taken that does not involve anything more than common knowledge, a person who does not know such facts as are known to the majority of decision-makers is at a disadvantage akin to that experienced by an uninformed patient. A person who is unaware of the consequences of sexual acts is unable to make a considered decision because they are unaware of the risks, harms and benefits associated with the act. Like the uninformed patient, a sexually innocent person does not have the relevant information to allow them to make a decision that is in their own interest.

Given the developments in the law that resulted from *Papadimitropoulos*, *Mobilio*, *Cuerrier* and *Pryor*, it is arguable that statutes that do not demand knowledge of potential consequences as a prerequisite of capacity to consent are inconsistent with other standards of knowledge such as the informed consent required in medical law, where a practitioner may be charged with negligence if they fail to inform a patient of the risks associated with a proposed procedure. The proposal that the potential consequences of sexual acts should be known before consent can be given is not unique. The United Kingdom *Sexual Offences Act* 2003, Ch. 42, s 30 states:

(1) A person (A) commits an offence if—

- (a) he intentionally touches another person (B),
- (b) the touching is sexual,
- (c) B is unable to refuse because of or for a reason related to a mental disorder, and,
- (d) A knows or could reasonably be expected to know that B has a mental disorder and that because of it or for a reason related to it B is likely to be unable to refuse.

(2) B is unable to refuse if—

- (a) he lacks the capacity to choose whether to agree to the touching (whether because he lacks sufficient *understanding of the nature or reasonably foreseeable consequences of what is being done* or for any other reason), or
- (b) he is unable to communicate such a choice to A (emphasis added).

Current law in most American states also contains the provision that the person has knowledge of the nature of the act and of its consequences (Sundram & Stavis, 1994). Indeed, some jurisdictions require that persons with intellectual disability provide informed consent prior to sexual relations; there must be evidence of the ability to understand the nature and consequences of the sexual act, and additionally, the ability to exercise choice (Parker & Abramson, 1995). Some United States states go further

still, requiring an understanding not only of the nature and consequences of the act, but also an appreciation of the moral dimension of the act (Sundram & Stavis, 1994).

The small body of literature that relates to the sexual knowledge of persons with intellectual disability suggests that if appreciation of the moral dimensions of the act (or to use the terminology of the original *Morgan* direction in the County Court, an understanding that most people view sex as fundamentally different to other affectionate acts) was introduced as a criterion for capacity to consent, many persons might be unable to meet that standard.

With regard to the legal aspects of sex, O'Callaghan and Murphy (2002) found that people with intellectual disability knew significantly less about legal regulation of sexual acts than did a comparison group of mainstream 16-year-olds. It seems, therefore, that setting additional hurdles (such as knowledge about the legal aspects of sex) for a person to be deemed capable of consent would push capacity further out of reach for members of this population. We do not support the proposal that moral appreciation of the act be demonstrated because setting a standard of capacity that is too high infringes on the right to sexual expression. Furthermore, it is not a requirement that members of the general public, that is, those who do not have a mental impairment, must show an understanding of the legal and/or moral significance of the act and thus requiring such an understanding of a subsection of the population would be

discriminatory. On the other hand, current Australian law in which only the nature of the act must be known seems to afford little protection to those who need it. It is also at odds with the results of research that has been conducted in this area, which is reviewed in the following section.

What knowledge should be required before consent may be given?

Consent to sexual acts. The question of establishing criteria by which capacity to consent to sex might be assessed has been addressed by a number of researchers. This section contains a summary and critique of some studies that have been conducted in this field.

Kennedy and Niederbuhl (2000) sent questionnaires to 305 doctoral level members of the American Psychological Association, asking them to rate the importance of 56 items theoretically related to capacity to consent. Responses were grouped by content. Three major factors underpinning capacity to consent to sexual acts were identified: basic sexual knowledge, ability to protect oneself, and knowledge of the consequences of sexual behaviour. Among the highest scoring items were that they know that pregnancy is possible; they can make an informed choice; and they know that disease can result from sexual activity. This study would have been strengthened if the opinions of stakeholders had been sought, in addition to the opinions of a group of psychologists who may have had little knowledge of either intellectual disability or of the law. However, it is significant to our

discussion that knowledge of both pregnancy and disease were thought to be essential knowledge before consent may be given.

In earlier work, Kennedy (1999) had designed an assessment tool utilising items representative of sexual knowledge, protection and knowledge of consequences. The tool was named the Sexual Consent and Education Assessment (SCEA). It was administered to 69 persons with intellectual disability, among others. Each participant was deemed either capable or incapable of consent based on their SCEA score. This categorisation was then compared to a competence assessment by an independent team composed of family, staff, and professionals involved in each participant's care. For 91% of participants with intellectual disability, the SCEA and team's capacity determinations were identical. Twenty-nine persons were classified as competent and 34 persons were determined to lack the capacity to consent using both assessment methods. Two participants were deemed competent by the team but incompetent using the SCEA, and in four cases this result was reversed. The two knowledge items which best predicted capacity or incapacity to consent were that the individual demonstrated knowledge of sexual intercourse, and that they could identify the consequences of such activity.

This study was conducted in the United States and, as discussed above, in many jurisdictions in that country knowledge of the consequences of sexual acts is a prerequisite for legal competence¹⁶. This may be the

¹⁶ Note that in the United States, competence is the legal term used. This is the reverse of Australian jurisdictions, where capacity is the legal term.

reason that knowledge of the nature and consequences of sexual acts was predictive of capacity to consent. Due to the way US state laws are constructed, the assessment team may have weighted this criterion more highly in making their judgment. However, knowledge of consequences was not, at the time of publication, a judicial requirement in the state in which Kennedy conducted this research. An additional explanation is that it is probable that a person who does not know the consequences of sexual activity also lacks other traits found in capable persons.

Ames and Samowitz (1995) investigated what knowledge might be needed to give consent. These authors described two categories of persons to be assessed: those with command of verbal communication, and those without. These authors recommended that verbal persons should be assessed for capacity using indicators already mentioned, including understanding of the nature of the act and of its potential consequences. Additional indices which they recommended ought to be assessed were voluntariness, the ability to avoid harm, the ability to avoid exploitation, the ability to avoid abuse and to stop an interaction when it was no longer desired, and ability to choose an appropriate context for sexual activity.

Ames and Samowitz made one notable additional recommendation to be applied only to persons with verbal communication: they proposed that these persons should demonstrate a degree of knowledge that some sexual activities are illegal. In contrast, persons without verbal competence were to be assessed through their demonstration of “responsible interpersonal

behaviour” (Ames & Samowitz, 1995, p. 266). In making this recommendation, the authors advocated a double standard. A requirement that verbal persons should have to demonstrate basic legal knowledge but non-verbal persons should not results in the higher functioning group facing a more stringent assessment. Understanding of legal rights and options is difficult even for some caregivers (Morris, Niederbuhl & Mahr, 1993). A further weakness in Ames and Samowitz’s proposal is that the ability to verbalise is not synonymous with the ability to articulate relatively complex concepts. In other words, just because a person is able to speak does not mean that they will be able to express understanding of legal issues, such as consent, even if they have this understanding. We suggest that adoption of Ames and Samowitz’s (1995) proposal would impose an unnecessarily strict standard for determining capacity to consent. This would undermine the right to sexual expression of persons with intellectual disability.

A second problematic aspect of Ames and Samowitz’s recommendations is that “responsible” behaviour must be demonstrated. Exactly what constitutes responsible behaviour, and who is to judge, and what such a demonstration might consist of, are left undefined. Such terminology is ambiguous and judgments based upon it are bound to be value-laden. Moreover, numerous persons without disability engage in what many would consider to be less than responsible sexual behaviour. It would be discriminatory to insist upon a more responsible standard of behaviour from the intellectually disabled than from the rest of the community.

“People’s actual decision-making processes frequently fail to match the legal standards described... it is important to recognize that individuals with mental retardation should not be held to different standards than those commonly applied to individuals within the general population” (Morris et al., 1993, p. 264). Morris and colleagues also recognised that incapacity in one area does not necessarily imply incapacity in another area. Moreover, as Kennedy (1999) pointed out, if a lack of knowledge is the cause of incapacity to consent, capacity may be achieved through the provision of appropriate education.

O’Callaghan and Murphy (2002) conducted a wide-ranging study of the sexual knowledge, vulnerability, understanding of abuse and consent, and knowledge of the law possessed by 60 adults with intellectual disability. Participants had to be able to communicate with minimal assistance; their IQ scores ranged from 55 to 90¹⁷ with an average of 59.8. Their data were compared with the data obtained from 16-year-olds attending mainstream secondary schools. The results showed that in every area adults with intellectual disability had much less knowledge than did the teenagers.

O’ Callaghan and Murphy discussed several options for setting a minimum standard of knowledge that should be present for a person to be considered legally capable of consent. The lowest standard criterion they considered was that advocated in a Home Office proposal (Home Office, 2000) which stated that to be able to consent, the person should be able to

¹⁷ Persons whose IQ score is above approximately 70 are not usually considered to have an intellectual disability. In this study, 6 persons with scores above 70 participated.

differentiate sexual acts from personal care, and that they should understand that pregnancy and HIV/AIDS are potential outcomes of sexual activity. By this standard, 50% of the participants with intellectual disability in O'Callaghan and Murphy's study would have been unable to consent, though all the teenagers would have been capable. This result may indicate that requiring that the consequences of sexual activity be set as a prerequisite of consent is raising the standard of knowledge too high. However, our argument is that O'Callaghan and Murphy's results are indicative of the need for sex education programs that are tailored to the intellectually disabled community.

Consent to medical procedures. Given that few studies have focused on establishing capacity to consent to sexual acts, we have drawn on studies addressing capacity to consent to therapeutic treatment. Morris et al. (1993) created hypothetical vignettes in which a medical problem, a proposed treatment, other alternatives to this treatment, and risks and benefits were described. There were three groups of 15 participants: staff members who cared for persons with disability, persons with mild intellectual disability, and persons with moderate intellectual disability.¹⁸ Each participant was read a vignette and then questioned. The aim was to establish whether or not the participant understood the nature of the problem and its treatment, its risks, benefits and alternatives, and whether or not the participant was able to make a choice and justify it. Three independent

¹⁸ "Mild" and "moderate" classifications were made if IQ scores fell in the ranges 50-55 to approximately 70, and 35-40 to 50-55 respectively.

judges used the answers to determine the presence or absence of capacity to give informed consent.

Results showed that all staff members were deemed capable. Only six of those with mild intellectual disability were found capable, and all but one of the participants with moderate intellectual disability were determined to be incapable of giving informed consent. Competence was more readily achieved when vignettes reflected a situation that participants with intellectual disability had experienced in real life. Thus it may be that with education, competence may be achieved; it also suggests that appropriately designed and delivered education may lead to capacity to consent in sexual matters.

Guardianship. In some Australian states, a determination of (in)capacity to give informed consent to therapeutic procedures is made by a Guardianship Board. This board is also charged with the nomination of persons who may give valid consent on an incapable patient's behalf. Tustin and Bond (1991) compared assessments of capacity in 194 people with intellectual disability made by a Guardianship Board against determinations made using six alternative measures. The Guardianship Board based its rulings on an interview conducted by one of its members, as well as on information gleaned from professionals, staff and family of the person concerned. The comparative measures were a biographical information checklist, the residential manager's assessment, scores on the Adaptive Functioning Checklist (Marlett, in Tustin & Bond, 1991), the person's level of

independent living, the assessment of medical and dental officers, and a consent questionnaire devised by Tustin and Bond.

The consent questionnaire was based on a visit to the dentist. This scenario was chosen as most participants had personal experience of a dental examination. Elements assessed in the questionnaire were the person's understanding of the condition, the proposed treatment, the co-operative responses required of the patient, the main consequences, possible side effects, alternative treatments, and whether they understood that they had the choice to give or withhold permission for the treatment. In addition, each person was asked if they wished to claim or waive the right to decide whether to allow the treatment or not. Persons who chose not to make a decision were automatically classed as incapable.

In over 70% of cases the consent questionnaire correctly classified persons by Guardianship Board grouping. There was 100% agreement on persons deemed capable of consent by the Board, and on most persons deemed incapable. Disagreement arose over those participants who wavered on the cusp of capacity to give informed consent. This result may have been due to the hypothetical nature of the scenario used in the questionnaire, because some people may have had difficulty remembering the information given them during the experiment, they may have had difficulty imagining the scenario, or they may have been unable to recall previous dental visits.

Alternatively, a person deemed incapable by the Guardianship Board may have been rated as capable on the questionnaire because they were familiar with a dental visit, a possibility which would be consistent with Morris et al's finding that experience of related activities increased the number of ratings of ability to consent. Disagreement may also have been due to the fact that at the time of testing, a person was capable when assessed by one measure, but was not when subsequently assessed with the other. It seems likely, however, that disparate ratings may simply be a reflection of the difficulty in assessing persons who are on the borderline of capacity.

In summary, the research evidence indicates the importance of knowledge of the consequences of the act for valid consent to sexual acts. Yet under most existing Australian law, only the nature and character of the act must be known. A person who fulfils this criterion but does not realise the danger of having unprotected sex with an infected partner may have the legal capacity to consent,¹⁹ and there is no doubt that a person who does not understand that pregnancy may occur is deemed to be capable of consent to unprotected penetrative vaginal intercourse.

The standard of knowledge required for consent to medical procedures is much higher. Persons who are incapable of understanding the nature and consequences (and more) of a proposed procedure are not able to consent and another person must consent on their behalf (Somerville, 1994). We are not suggesting that another person might consent to sex on

¹⁹ There is doubt that a person who wishes to have unprotected sexual intercourse with a HIV-positive partner has "the legal capacity to consent to such serious harm" *R v Brown & Ors* [1994] 1 AC 212.

behalf of a willing but incapable person (although this possibility was mooted by Spiecker and Steutel, 2002, but was condemned by critics; see Greenspan, 2002, & Leicester & Cooke, 2002). What we are proposing is that until a person understands that disease and pregnancy are possible outcomes of some sexual acts, that person should be deemed legally incapable of consent because they do not possess sufficient knowledge to allow them to make a decision which is in their own best interests.

Furthermore, the requisite understanding for consent might come about through adequate and appropriately designed education; and such education as will most fully develop the capacity of each person should be provided to them. As there is evidence that information is sometimes not understood by the persons with intellectual disability (McCarthy, 1999), this information should be repeated as required. Given that in this population levels of knowledge are comparatively low even after sex education has been provided (McCabe, 1999), and information is likely to be forgotten or remembered incorrectly over time, especially by persons with intellectual disability (O'Callaghan & Murphy, 2002), repeated presentation of sex-related information is particularly important.

The education provided to persons with intellectual disability with respect to their sexuality might have to contain quite explicit directions regarding a number of issues. It is certainly necessary to ensure that the person knows that they can say no to anyone if they don't want to have sex with them. In addition, it might be necessary to actually tell the person the

names of people who, according to statute, are not allowed to ask them for sex and the names of people who are not allowed to have sex with them; who they should complain to if anything happens that they are uncomfortable with; and to ask them on a regular basis if anything has happened that they didn't like. Reassurance that they will not be punished for reporting an incident would possibly also be required. Given the evidence that the sex experienced by both men and women with intellectual disability is often grounded in personal gain (McCarthy, 1999; Thompson, 2001), there appears to be an additional need for education in more than the mere mechanics of sex, but also in basic social development, with specific emphasis on the communicative aspects of sex so that the partner may be recognised as more than simply a tool to be used to achieve orgasm or as a means of material gain but as a person with interests of their own. It may be thought that this is a double standard, because some people without mental impairment base their sexual interaction on how much money the other person has. However, if education in the communicative aspects of sex is provided, the person has a choice as to whether or not the education is used. Where any person, whether disabled or not, is given education, they are not obliged to use such knowledge. It is the person's own choice. But if they are never given education, they are of course unable to use it. For example, say education in arithmetic is given to a class of disabled and non-disabled students. All students are free to use or not use the information given in class. It may be that disabled persons choose not to use the

information for a number of reasons, such as they did not properly understand the information. But that does not mean that this education should be withheld from them. In fact, it may be seen as discriminatory not to provide education in many aspects of life, including the communicative aspects of sexuality to disabled persons.

Achievement of an understanding that their partner has their own feelings might be problematic for persons with intellectual disability because they sometimes lack understanding that their own experience is not identical to their partner's experience.

A possible reason why some men with learning disabilities may not respond more appropriately is that they find it difficult to comprehend that *their* experience is not *the* experience. In other words, as a person with learning disabilities, they may well have difficulty with abstract thinking and are unable to imagine that another person would be experiencing things differently from themselves. One indication of this was given by a woman who said: 'I told him it was hurting and he just said "it don't hurt"' (KS). In other words, because it was not hurting him, it was not hurting... Sex education work with men with learning disabilities has shown that it is, in fact, quite common for the men to be indifferent to their partner's quality of experience (McCarthy, 1999, p. 145 – 146).

In McCarthy's study, "the hospital-based women not only accepted payment but *expected* money, believing this was the right thing and that it was not fair if men did not pay them" (McCarthy, 1999, p. 151). The perception of unfairness may be that without payment, having sex is an unenjoyable chore (McCarthy, 1999). It might be argued that our proposal that education in the emotional aspects of sexuality is based on a belief that persons with disabilities should be shaped and changed so as to be more "acceptable" to the rest of the community, in keeping with the principles of normalisation. As with any education, the aim is to impart knowledge so as to allow each person to develop to their full potential. This should include the potential to enjoy sex as much as possible. In fact, it might be argued that withholding sex education from persons with intellectual impairment is not only discriminatory but smacks of a return to repression of sexual feelings in this subpopulation.

The cause of incapacity

Our final contention in this paper is that a lack of knowledge that gives rise to incapacity to consent should not necessarily be causally related to mental disability or illness. Current law in all Australian jurisdictions with the exception of the Australian Capital Territory limits the cause of incapacity to either some form of mental impairment²⁰ or, even more narrowly, to intellectual disability²¹. These provisions evolved as a protective measure for persons who, because of mental "differences" from the general population,

²⁰ WA *Criminal Code* s 330 (1); Vic *Crimes Act* 1958 s 50; Tas *Criminal Code Act* 1924 s 126; NT *Criminal Code* s 130.

²¹ NSW *Crimes Act* 1900 s 66F; Qld *Criminal Code* 1899 s 216.

were seen as particularly vulnerable to being imposed upon in sexual matters (Victorian Law Reform Commission, 2005). However, it is possible for adults to be innocent of sexual knowledge for reasons other than mental impairment; such reasons may include parental religious beliefs or cultural attitudes. To confine the protection afforded by legislation to persons with some form of mental impairment may constitute reverse discrimination against people without mental impairment who do not understand the nature and consequences of sexual acts. Under current law these persons are not protected.

It is interesting that Australian law defining incapacity applies only to persons whose ignorance of sexual acts has its origin in an irregularity of mental function. Those whose mental processes are judged as not conforming to the norm, as “not normal”, are seen as being in need of legislated safeguards. Matthews (1999) noted that, in contrast to persons with a physical illness whom we treat as equals and attempt to help, persons with mental illness are seen as being in need of protection, both from themselves and from others. This alleged need for protection was the origin of special legislation that applied only to those with mental conditions, such as modern day Mental Health Acts. Matthews’ argument against legislation that is applied only in cases of mental illness is based on two main points. First, he suggested that special legislation was originally a product of the old idea of “madness” — mad people were seen as being essentially different from the rest of the populace. Second, there are lingering overtones of the

Cartesian division of body and mind, in which mental disorder was seen as a corruption of the self; the actual *person* was changed or different to the “normal”. Even today, an individual with mental illness is suspected of irrationality, and therefore is likely to have their decisions overturned, although this is not the case for a person with a purely physical infirmity.

Matthews’ argument was directed against a dichotomous division of illness into physical or mental genres. He pointed out that many conditions described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 1994) have an organic basis. Depression, dementia and alcoholism are examples of disorders that have a physical component but which affect the mind. Given the physical component it is, therefore, difficult to sustain any argument that these conditions, or many others in the DSM-IV-TR, are mental illnesses *per se*. Matthews also opposed the restriction of rights made possible by mental health legislation. Such legislation is based on the rationale that only autonomous persons can exercise rights; therefore it is acceptable to restrict the rights of persons who lack autonomy due to mental illness. For example, it is possible to incarcerate persons against their will “for their own protection” (which also fulfills the function of protecting the public from them; Eastman & Dahr, 2000). The right to refuse treatment is also a right that may only be exercised by autonomous persons (Matthews, 1999).

As a cause of incapacity, the absence of autonomy is a confusing concept. Matthews pointed out that the concept of autonomy is based on the

Kantian ideal of moral worth; only a selfless impersonal decision was considered to be moral. But in the case of treatment decisions, Kantian autonomy is irrelevant. The person making that decision is not concerned with moral worth — they are concerned with their own wellbeing. Unless there is reason to suspect that the person does not or cannot understand what is in their own best interest, treatment decisions should be respected because the person is capable of making a decision in their own interest, whether or not that decision is approved of or thought “rational” by others.

Matthews’ argument can be applied to the issue of persons with intellectual disability and their capacity to consent to sexual acts. Whereas the mentally ill person is regarded as irrational or deluded, the person with intellectual disability is regarded as having only limited capacity to make judgments because of a lack of maturity and foresight. Persons with mental illness or intellectual disability are also thought to lack the logical ability to recognise which choices are in their own best interest. Only autonomous, or rational, persons are seen as capable of making decisions that go against the grain of “normal” thought (Matthews, 1999). In contrast, people with mental illness or with intellectual disability are seen as being in need of care and guidance. Decisions that are incongruent with the judgment of others are unlikely to be respected, more especially if that decision has grave consequences (Eastman & Dahr, 2000).

Persons who consent to sexual acts without knowledge of the potential consequences are in an equivalent moral position to the patient

who makes a decision regarding treatment without being informed of the associated risks. As we have seen, outside of South Australia the person who agrees to a sexual act without knowing its consequences is held to give valid consent. In contrast, the uninformed patient may charge their doctor with negligence and assault.

It might be argued that the situations are not analogous. In the medical scenario, there is a power imbalance between the doctor and patient. The doctor has specialised knowledge and is the “expert”. He or she is ethically bound to promote the best interest of the patient and to provide the relevant knowledge to the patient so that the patient can make an informed treatment choice. In contrast, the partner of a sexually naïve person is not considered to be an expert. It is reasonable for them to assume in the absence of evidence to the contrary that an adult person does possess the requisite sexual knowledge and is capable of giving consent. However, we suggest that if the knowledgeable party does at any stage realise or suspect that the other person is ignorant of the consequences of the act, any apparent consent should be vitiated. This proposal is consistent with current law. For example, in Western Australia, a person who engages in sexual behaviour with a person who they know or ought to know is an incapable person is guilty of a crime (*Criminal Code* s 330). South Australian statute provides that a person who knows that a person with intellectual disability is unable to understand the nature or consequences of sexual intercourse is guilty of an offence (*Criminal Law Consolidation Act* s 49).

In setting the standard of knowledge required for consent to be given, we suggest that both medical and sexual consent should be based on knowledge equivalent to that possessed by a properly informed person. In medical consent, that amounts to knowledge of the risks, benefits, alternatives and consequences of the proposed treatment. Our proposal is that in order to be deemed capable of sexual consent, a person should know what a properly informed person knows: that pregnancy and disease are possible consequences of sexual activity, in addition to other legal requirements such as realisation that there is a fundamental difference between sexual acts and other social interactions. If a person does not have that knowledge, they should be deemed incapable of consenting, regardless of the reason for that lack of knowledge.

Conclusion

The role of the law regulating the sexual expression of persons who fall near the borderline of capacity to consent is to find a balance between their need of protection and their need for sexual expression. Those persons with intellectual disability who wish to engage in sexual acts should be provided with such education as will promote achievement of capacity to consent, as should any other person who wants but has been denied sex education. There will, however, always be some persons who cannot achieve that capacity due to some form of mental impairment, and there may be some who do not wish to receive the requisite knowledge. These persons

are in need of the protection of the law. To allow the required standard of knowledge for consent to remain at its current minimal level does not afford that protection. It is our argument that one cannot consent if one does not know the potential consequences of one's action, because one cannot protect one's own interests in the same way that a person with knowledge of the consequences may. Our view — that to be capable one must understand the consequences of one's action — is a view found throughout the research literature, and indeed, in the law of other countries including the United Kingdom. Furthermore, the origin of a lack of knowledge that results in the person being deemed incapable of consent should not be confined to mental impairment; all who lack, for whatever reason, understanding of the nature and consequences of sexual acts should be afforded the protection of the law.²²

²² In the interests of minimising duplication, the reference list for this paper has been consolidated into the reference list at the end of the thesis.

Chapter 5 discussed the issue of the knowledge basis on which consent to sexual acts is based. In it we have argued that the current low standard of required knowledge is insufficient to protect some persons with intellectual disability, despite the fact that Australia, by signing three United Nations Conventions, has indicated a willingness to abide by the rights of disabled persons outlined within them, including the right to protection. I will return to this argument in Chapter 8, where suggestions for the reform of existing law are made.

The focus of the following chapter is again the issue of informed consent, this time in relation to the person being possessed of sufficient understanding of the consequences of their action to protect their own interests. Alteration of the law to require knowledge of the nature, character and consequences of the sexual act is evaluated for its effect on persons whose levels of intellectual impairment vary from mild to profound.

Chapter 6: Can consent be uninformed? Suggested reform of sexual offences against persons with intellectual disability²³

²³ Published paper:
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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.

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 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, 1991; 1992; 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 61HA (5) (b) 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 does not 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 (see Graydon, 2007), 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, 1998a). 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 (Australian Bureau of Statistics, 2004a) 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 & Schreck, 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.²⁴

²⁴ In the interests of minimising duplication, the reference list for this paper has been consolidated into the reference list at the end of the thesis.

In Chapter 6 I discussed the effect of raising the standard of knowledge to include understanding of the consequences of the sexual act. I also advocated a focus on supplemented and repeated sexual education for those persons who wished to receive it. The projected result would be that their consent, if given, would be more truly authentic than that which they currently are able to give, and would promote their own interests in the decision making process. I will return to these issues in Chapter 8.

The following chapter focuses on two issues: first, that differences exist between the maximum sentences available for sexual offences against members of the general population and offences against persons with mental impairment. In some states sentences are more severe for offences against members of the general population, which seems to indicate that offences committed against persons with mental impairment are viewed less seriously than equivalent offences against members of the general population. Second, I examine the fact that marriage is an available defence to charges of sexual offences committed against persons with mental impairment, although this defence has been abolished where the offence is committed against a member of the general population.

Chapter 7: Sexuality, the incapable person and the law:

Some issues²⁵

²⁵ Published paper:
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1st World Congress for Sexual Health, Darling Harbour, Sydney. Available:
<http://www.wasvisual.com/lecture.html?lecture=95>

Abstract

Persons with intellectual disability who wish to participate in sexual acts present a unique challenge to legislators. Although it has been argued that they have a right to sexual expression, it is widely accepted that these persons also have a right to protection from those who might take advantage of them. Finding a balance between these two rights has proved so difficult that, rather than enacting uniform legislation throughout the states, a range of approaches have been adopted within Australian jurisdictions. In this paper I will discuss two issues arising from current legislation and associated case law. First, I explore the perceived seriousness of these offences in comparison to sexual offences committed against the general population. Second, I examine the compatibility of the marriage defence which is allowed to charges under these sections of statute with other parts of the criminal law. In addition to advocating a positive consent standard, I suggest reforms that would have the effect of reducing discrimination and promoting consistency between different sections of sexual assault law.

Persons with intellectual disability have in the past had their rights to reproduction and sexual expression severely curtailed. The policy of eugenics, which entailed the so-called “improvement” of the human race through selective breeding, provided the rationale for unethical measures such as the forced sterilisation of persons with “undesirable” traits. Such traits included intellectual and physical disabilities, laziness, violent temperament, shiftlessness, abusive drinking and even epilepsy (McCarthy, 1999; Smith, 1995). Prevention of reproduction by people with these traits was thought to be necessary because it was believed that such traits were heritable (Smith, 1995) and as such, posed a threat to the “stock of the nation” (McCarthy, 1999).

The attitudes held by many powerful members of society were encapsulated in the majority judgment in *Buck v Bell* (1927, p. 1159, per Wendell Holmes J): “It is better for everybody if society, instead of waiting until it has to execute degenerate offspring or leave them to starve because of feeble-mindedness, can prevent obviously inferior individuals from propagating their own kind... Three generations of imbeciles is enough.” Laws upholding sterilisation, and institutionalisation reinforced by subsequent gender segregation were passed in the United States and many European countries (Jaeger & Bowman, 2005). An estimated 60,000 Swedish people, mainly women, were eugenically sterilised between 1930 and 1970 (Kevles, 1999), and 70,000 people were sterilised in the United States (Bates, 1987). Early twentieth century Californian sterilisation laws

formed the model on which Nazi laws were based (Jaeger & Bowman, 2005). Eugenic policies and associated measures were prevalent during the late nineteenth and early twentieth centuries and received enthusiastic support from the scientific community. Indeed, the well-known journal *Science* published an editorial supporting eugenic policy in 1933 (Jaeger & Bowman, 2005).

During the second half of the twentieth century, societal attitudes toward the sexuality of the disabled have undergone a reversal, at least superficially. In *Secretary, Department of Health and Community Services v JWB & SMB (1992, commonly known as Marion's Case)*, the High Court of Australia held that giving consent to the sterilisation of persons with intellectual disability is beyond parental authority. Prior court authorisation of proposed sterilisation or any other serious irreversible treatment is required in contemporary Australia (Jones & Basser Marks, 2000). Such approval will not be forthcoming if the sterilisation is to be performed for eugenic reasons, for contraception, to disguise abuse, or for anticipated menstrual difficulties (O'Neill, 1996). In *Marion's Case*, the majority of the High Court of Australia held sterilisation to be a treatment of last resort. Brennan J at 267 remarked: "Sterilisation of an intellectually disabled child requires justification of a compelling kind, for involuntary sterilisation is a serious invasion of that

child's personal integrity and a grave impairment of that child's human dignity."²⁶

McCarthy (1999) attributed the swing from eugenic policy to a policy of upholding sexual rights to changes in attitudes toward sexuality generally, and to adoption of the policy of normalisation. She also made a valuable contribution to the literature by suggesting that during the 1970s, the new availability of the contraceptive pill was influential in the relaxation of attitudes toward the sexual expression of the disabled. "Given the great fears about people with learning disabilities reproducing and the draconian lengths society and professionals were prepared to go to prevent this, one cannot but fail to see how important a role contraception has played in effecting change" (McCarthy, 1999, p. 57).

The existence of a right to freedom of sexual expression has been convincingly argued by McSherry and Somerville (1998 p. 108): "Apart from the legal viewpoint, it is probably fair to say that many, if not most, people in democratic societies would now agree that because consensual sexual intercourse is a personal and private activity, a right to freedom of sexual expression if it does not exist, should exist." Indeed, the bulk of the literature on the topic of sexuality and intellectual disability indicates that persons with intellectual disability are thought to have a right to sexual expression. However, some persons, due to the nature of their disability, may be at risk of being harmed in sexual encounters. Some people with intellectual

²⁶ There is evidence that unauthorised sterilisation does take place. An average of 27 vasectomies and 83 bilateral orchidectomies were performed annually in Australia from 1988 – 1994 on men younger than 20 years of age (Carlson, Taylor & Wilson, 2000).

disability tend to be particularly in need of protection due to their limited knowledge of their rights and the law, their socialisation to be acquiescent, or difficulty in refusing requests because of their dependence on others (Graydon, Hall, & O'Brien-Malone, 2006). The challenge for legislators is to find a balance between provision of the necessary protection and preservation of the right to sexual expression:

The law must balance two competing interests — protecting people with impaired mental functioning from sexual exploitation, and giving maximum recognition to their sexual rights. The difficulty for the legal system in striking an appropriate balance between these interests is compounded by the considerable diversity of people with mental impairment in terms of extent of impairment, living circumstances, and sexual interest and knowledge (Law Reform Commission of Victoria, 1988, p. 3).

Prior to the liberalisation of attitudes toward the disabled which began in the 1960s and 70s, all Australian jurisdictions had enacted legislation defining specific sexual offences against persons with mental impairment. These provisions are, sometimes in amended form, still part of law. However, each state has adopted different provisions or has combined two or more types of statute in an attempt to provide protection while concurrently avoiding

unnecessary restrictions on the rights of persons with disabilities. These approaches are outlined below.

Three types of statutes can be classified by the fault element they contain. One type of statute adopted in Australian jurisdictions criminalises the sexual exploitation of persons with mental impairment. It has been adopted by New South Wales (*Crimes Act 1900 s 66F*) and Western Australia (*Criminal Code s 330*), while Queensland allows a defence if it can be shown that an act involving a person with intellectual disability was not exploitative (*Criminal Code s 216*). I do not propose to comment here on statutes that prohibit exploitation as I have done so with others at length elsewhere (see Graydon, Hall, & O'Brien-Malone, 2006).

A second form of provision is to set out a standard of knowledge that the person must have before they are deemed capable of consent. In Western Australia (*Criminal Code s 330*) and the Australian Capital Territory (*Crimes Act 1900 s 67*), the person with mental impairment must understand the physical nature of the act to which they are consenting. South Australia is unique in requiring not only capacity to understand the nature of the act, but also the consequences of the act (*Criminal Law Consolidation Act 1935 s 49*). A critique of knowledge provisions is available (see Chapter 5).

The final category of statute is to prohibit sexual relations between a person with mental impairment and persons involved in their care. Victoria (*Crimes Act 1958 ss 51 & 52*), New South Wales (*Crimes Act 1900 s 66F*), Tasmania (*Criminal Code Act 1924 s 126*) and the Northern Territory

(*Criminal Code* s 130) have adopted this tactic, which we have also discussed at length elsewhere (Graydon, Hall, & O'Brien-Malone, 2006).

My foci in this paper are two further issues arising from the statutes. There are features of legislation that apply to sexual offences against persons with mental impairment which are difficult to reconcile with other statutory provisions that apply to the general population. The first issue I examine is the perceived seriousness of this type of offence. In this section I explore how myths that surround sexual offences generally might impact on the degree of harm that is perceived to result from these particular offences. I examine how this perception might provide the reason for differences between sentencing provisions that apply when the complainant has a mental impairment and when they do not. In the second section I discuss the fact that a defence is allowed if the accused is married to the person with mental impairment. As I begin, I would like to point out that I refer to the accused person as "he" and to the complainant as "she". This measure was taken for convenience. Although the large majority of victims of sexual offences are female and persons accused of the crimes are almost all male, I do acknowledge that there are exceptions to these rules.

How serious is having sex with an incapable person?

When a sexual offence against a person with mental impairment becomes known to authorities, the accused may be initially charged with rape, or with an alternative charge under the relevant sections of committing

a sexual offence against an incapable person. These two different charges were laid in *R v Beattie* (1981). In that case, which occurred in South Australia, a woman of 23 with a mental age of approximately 11 years was induced to have sex with a man named Beattie whom she had met only that day. Later she also was persuaded by another man whom she did not know to have intercourse, and later still a third man also attempted to have sex with her. In court, it was found that she had no understanding of pregnancy and thus she lacked the capacity to consent under South Australian statute. The defendant was convicted of having intercourse with a mentally deficient woman. Yet as the woman was found to be incapable of consent, it follows that any sexual act with her would constitute sex without consent. A sexual act that is done without consent would usually lead to charges of sexual assault or rape, depending on the jurisdiction in which the act took place. Indeed, as the offence has been committed against a member of a vulnerable population, which is an aggravating circumstance (Walker & Padfield, 1996), it follows that under existing law the accused should be charged with aggravated sexual assault. But in cases where the complainant has a mental impairment, and there is no evidence of resistance to the act or distress after the incident, the offence does not seem to be thought of as sexual assault at all.

This attitude might be attributable to myths about how the victim of a sexual offence should react to the crime. If the person, due to their impaired cognition, does not seem to be distressed by the act, it might be thought not

as serious as where the victim is fully cognizant of what has been done. In acquitting *Beattie* on the charge of rape, the fact that the complainant was not distressed after sexual intercourse was mentioned no less than three times in the judgment. The implication seems to be that as she was not distressed, no great harm was done.

This was a view that has also been adopted in the past in cases where the victim was intoxicated or unconscious during the act and as a result, was unaware of what was being done. However, contemporary courts have held that intoxication or unconsciousness on the part of the victim are circumstances of aggravation, not mitigation (for a review of cases, see Warner, 1998). The fact that the victim was not aware of what was being done is held to be a breach of trust, deserving of greater rather than lesser penalty. I do not suggest that mental impairment is the functional equivalent of intoxication or unconsciousness. The parallel I wish to draw is that, rather than lacking awareness of the act *per se*, the victim with mental impairment may lack awareness of the significance of the act and consequently manifest little emotional distress. That is, however, no reason for the accused to be shown leniency.

Some offences are considered to be harmful to society in general, are considered to be “an affront to our newly acquired consciousness of ‘human dignity’” (Laster & Erez, 2000, p. 242). This is true of offences committed against a person with a mental impairment. That impairment may negate their capacity to give consent and may impede their understanding of the

exploitative aspects of an interaction. In fact, a lack of distress may almost be thought of as a hallmark of cases prosecuted under mental impairment legislation: the victim is not averse to the sexual act, and but for the mental impairment that precludes consent, there would be no offence (Hall & Mizzi, 1996). However, the fact that the person is incapable of consent means that an offence has occurred, regardless of their apparent willingness.

It is enlightening to compare the maximum penalties for sexual offences against a member of the general population against equivalent offences against persons with mental impairment.²⁷ In Western Australia, the maximum penalty for the general offence of sexual penetration without consent is 14 years²⁸ and aggravated sexual penetration without consent is 20 years.²⁹ These penalties are the same as those provided for sexual penetration of an incapable person (14 years or 20 years where the incapable person is under the care, supervision or authority of the offender).³⁰ It seems that in Western Australia the offences are viewed as equally serious in terms of the sentences available. That the offences bear different names is an issue I will return to later in this paper.

The view that both crimes are equally serious does not appear to prevail in Victoria. There the maximum penalty for rape is 25 years.³¹ In contrast, the maximum penalty for sexual penetration of a person with

²⁷ Sentences quoted are the maximum available for the most serious type of sexual offence committed (a) against persons with mental impairment and (b) against a member of the general population.

²⁸ *Criminal Code* s 325.

²⁹ *Criminal Code* s 326.

³⁰ *WA Criminal Code* s 330.

³¹ *Vic Crimes Act 1958* s 38.

impaired mental functioning by a person who provides therapeutic or medical services to that person³² or who is a worker at a residential facility³³ is 10 years. It is difficult to understand why the penalty for sexual assault committed by a person in a position of responsibility and trust is less than half that available for a convicted rapist, because committing an offence against a person for whom one is responsible usually carries a more severe penalty (Walker & Padfield, 1996) because a fiduciary duty exists.

Queensland statute provides that the maximum penalty for rape is life imprisonment.³⁴ This is also the penalty where an offender is the guardian of the intellectually impaired person or has the person temporarily under their care. In Queensland, therefore, misuse of a position of trust is viewed very seriously. The penalty for “abuse of intellectually impaired persons” where there are no aggravating circumstances is 14 years.³⁵

The penalty for rape is life imprisonment in South Australia.³⁶ The maximum sentence for having unlawful sexual intercourse with a mentally deficient woman is 7 years, which was the sentence handed down in *Beattie*. It is notable that no allowance is made for longer sentences for offences committed by a person in a position of responsibility. This may be an area in need of reform.

In New South Wales, under s 61 of the *Crimes Act 1900*, sexual intercourse without consent carries a maximum penalty of 14 years, or in

³² Vic *Crimes Act* 1958 s 51.

³³ Vic *Crimes Act* 1958 s 52.

³⁴ Qld *Criminal Code* s 349.

³⁵ Qld *Criminal Code* s 216.

³⁶ SA *Criminal Law Consolidation Act* 1935 s 48.

aggravated circumstances including the victim having a serious physical or intellectual disability, the penalty is increased to 20 years. On the other hand, under s 66F sexual intercourse with a person with intellectual disability with the intention of taking advantage of that person's vulnerability to sexual exploitation carries a penalty of only 8 years. Where the person with disability is under the authority of the offender, the maximum penalty is 10 years. Thus penalties under s 66F are substantially less than those that apply when the victim is a member of the general population, or where a person with mental impairment withholds consent.³⁷ The apparent acquiescence to a sexual act by a woman with intellectual disability might be a reason that charges are made under s 66F rather than under s 61. The belief that charges of sexual assault are unfounded unless the victim resists is still held by a sizable proportion of the community and within the criminal justice system (Easteal, 1998a; Heath, 1998; McSherry, 1998b). Yet if a person is incapable of consent then any sexual act involving them must fulfill the fault elements in s 61: the sexual act is committed without consent.

I speculated that if a victim did not resist but was incapable of consent, charges would be made under s 66F rather than under s 61J. To examine this hypothesis, I made a search of case law. No cases were found where expert evidence was given that the victim was incapable of consent. The only case that bears some resemblance to these criteria is *R v Parsons* (1990). An 18-year-old woman whose mental age was 10 years was

³⁷ Note that a person with mental impairment who is incapable of consent is still capable of withholding consent.

bicycling near the country town where she lived, when she encountered the defendant. He was aware of her intellectual disability. During the afternoon, he had sexual intercourse with her on two occasions. When she returned home that evening, due to certain undisclosed features of her appearance, the woman was questioned by her family. The events of the afternoon emerged and police were contacted. When questioned, the accused immediately admitted what had occurred. He was charged under s 66F with having had sexual intercourse with a person with intellectual disability with the intention of taking advantage of that person's vulnerability to sexual exploitation.³⁸

Why he was not charged under s 61J with aggravated sexual assault is unclear. It may have been because the level of the woman's mental impairment was not considered to be a serious intellectual disability, but if that was the case and the woman was willing, it is difficult to see why charges were laid at all. The presence of intellectual disability should not preclude all mutual sexual expression, unless the person is incapable of consent.

If they are incapable of consent, the physical element of sexual assault is present because any sexual act involving them would amount to sex without consent. Admittedly, no evidence was given on the woman's capacity to consent, and New South Wales legislation does not contain any guidance on capacity. It may be that the effect of the New South Wales

³⁸ The defendant pleaded guilty and was sentenced to 4 years imprisonment, which was reduced to 3 years on appeal.

legislation is that a person with intellectual disability must not only be capable of consent,³⁹ but also, of somehow proving that they are capable of protecting themselves against sexual exploitation. This has been discussed in Chapter 4.

Sexual offences against incapable persons might be considered less serious than common sexual assault because instead of being against the will of the victim, these crimes are committed in the absence of will. As demonstrated in the cases already mentioned, the victim is often acquiescent during the act and not distressed afterward. There is nothing to distinguish it from its consensual equivalent — apart from the inability of the victim to consent. Under these circumstances it is easy to assume that not much harm has been done. This type of act appears to be as far removed as is possible from violent rape by a stranger, thought by many to be the worst possible sexual crime (Warner, 1998). It is understandable that those who infer the degree of harm from the degree of distress of the victim would view the offence as rather benign. Such thinking is incongruent with the role of the law, which is to protect the rights of every citizen, but in particular the rights of the most vulnerable members of the population. Indeed, it can be argued that the whole of society is harmed because the crime is a violation of our norms (Laster & Erez, 2000). It may be that it is easier to convict a defendant of committing a sexual act with a person with intellectual disability than it is to convict them of aggravated sexual assault. This appeared to be

³⁹ It is very likely that expert assessment of capacity would be called if the case was to be heard today.

the case in *Beattie*, where the defendant was cleared of rape charges but was convicted of having sexual intercourse with a mentally deficient woman.

Nomenclature is important. The fact that the crimes have different names suggests that they are, in fact, different crimes. Yet both rape and sexual assault are acts committed without consent. Naming the offence “sexual intercourse with a person with mental impairment”,⁴⁰ or similar is to make a simple statement of fact. There is nothing about the phrase that conveys that wrong has been done. Even in jurisdictions where the offence is named so there can be no mistake that it is a crime, the separation of crimes into different sections of the legislation seems discriminatory. Differential use of language reinforces the attitude that the sexual assault of persons with mental impairment is dissimilar to the sexual assault of anyone else; and perhaps even that it is not really sexual assault at all. Such thinking perpetuates the differential (and shoddy) treatment of people with disabilities. These distinctions between the general population and the disabled extend not only to naming and sentencing provisions but also to the fact that marriage is an available defence, a fact on which I focus in the following section.

⁴⁰ Tas *Criminal Code Act* 1924 s 126.

The marriage defence.

Under the law of general sexual offences, marriage no longer carries with it an implied consent to intercourse (*R v L*, 1991; *R v R*, 1991). Indeed, for the general population, sex without consent is a crime under any circumstances. In contrast, it appears that under mental impairment statutes, consent is viewed as part and parcel of the marriage contract, and cannot be retracted. A defence is allowed if the defendant is married to or is in a de facto relationship with the person with mental impairment.⁴¹ Hence, a sexual act between married persons where one person is experiencing a period of mental impairment so severe that they lose capacity to consent will be very unlikely to result in charges, unless some obvious and significant harm occurs. Palpable incongruence exists between this and other areas of sexual assault law.

It might be argued that the person with mental impairment has only to manifest some form of protest if they do not consent. Again, this is at odds with sexual assault law. Under the general provisions, it is not necessary for the complainant to say or do anything indicative of dissent (*R v Proctor*, 1998). In any case, persons with some forms of mental impairment may not know that they have the right to refuse sexual contact (Rosser, 1990), or they may be unable to indicate their dissent. Some types of brain damage, conditions such as schizophrenia and other psychotic disorders, and cognitive disorders such as delirium or dementia might render a married person incapable of consent. Consider, for example, a person with Dementia

⁴¹ WA *Criminal Code* s 330; Vic *Crimes Act* 1958 ss 51 & 52; Tas *Criminal Code Act* 1924 s 126.

of the Alzheimer's Type. The majority of people with this condition would have been fully capable of consenting to sex and to marriage prior to onset of the dementia. Toward the end of their life, however, they may well be incapable of consent and of communicating dissent. They may not even recognise their spouse. At this point the patient is very likely to be incapable of consent according to current mandates, which specify that a person must understand the nature of the act, or have the ability to protect themselves against exploitation. Yet it is not an offence for their spouse to have sex with them.

The divergent treatment of offences against married persons with and without disability may be based upon erroneous beliefs. First, there is the previously discussed perception that a sexual act that is not actively against the will of the victim is not a serious matter. Second, "[t]here is a mythology which describes marital rape as less damaging or injurious than other types of rape" (Easteal, 1998b, p. 109). Myth and law combine to ensure two powerful buffers against prosecution of the husband who takes advantage of his wife's incapacity. In the first place, the passivity of the wife will probably mean that the act will not be thought of as rape. In the second, he is her husband. Because such an act is physically identical to consensual marital sex, it is highly unlikely that charges would be laid.

The marriage defence may have been retained because of the belief that the law should not become involved in private matters. It is thought that legal interference may put marriage at risk by disrupting harmony (Easteal,

1998b), though the degree of harmony in a marriage in which rape has occurred is questionable. Although incursion of the law into marriage has become more accepted, as evidenced by the abolition of marital immunity to rape charges, there remains a general reluctance to interfere in the sanctity of marriage. This view is not confined to men, as some women's groups objected to the repeal of marital immunity laws (Scutt, 1977). Still, some authors (see, for example, Jeffreys, 1993; Scutt, 1998; and Young, 1998) have argued that sexual assault law was made by men for the benefit of men. In this view, the marriage defence is seen as an instance of the law's protection of men at the expense of women.

The continued existence of a "woman as chattel" attitude within the legal system has been widely documented (see, for example, Leader-Elliott & Naffine, 2000; Mack, 1998; Naffine, 1992; and Young, 1998). However, recent developments in case law suggest that the judiciary is beginning to view sexual crimes committed by persons in a close relationship with the victim as just as serious, if not more serious, than offences committed by a stranger. "In a number of cases... it has been suggested that the type of relationship may be of such a nature to suggest that the offence involved a gross breach of trust which the victim had placed in the applicant" (Warner, 1998, p. 176). One can hardly imagine circumstances more aptly described as a gross breach of trust than those in which an incapable woman is subjected to sex without consent by her husband. However, the fact that the marriage defence is still in place in the sections of law under consideration

here may simply indicate that this specific part of law has not yet been tested.

Is the concept of consent inherently flawed? A growing number of writers have pointed out flaws associated with current understandings of consent. Kelly (1987) identified consent as a continuum of experience, which ranges from free choice through pressure and coercion to physical force. Leader-Elliott and Naffine (2000) expanded upon this theme, arguing that a woman's rejection of intimacy is still construed in the courts as consent if the defendant claims he "thought" she consented. In other words, the court views the crime through the subjective lens of the defendant's (alleged) belief. The unfairness of this subjective liability led Leader-Elliott and Naffine to suggest an alternative classification of consent as real or apparent. Real consent was identified as an inner agreement, a wholehearted accord with a proposed course of action. Anything less was identified as apparent consent.

Real and apparent consent accords well with a positive standard of consent that is advocated by a number of writers including Bronitt (1994) and McSherry (1998b). A positive consent standard is based on communication. "Instead of focusing on whether or not the complainant resisted or whether or not she was in a fearful or intimidated state of mind, the way is now open for the prosecution to concentrate on what actions the accused took to ensure that there was free agreement to sexual penetration" (McSherry, 1998b, p. 33). Indeed, this standard has been passed as law in Canada (Wright, 2001).

According to Wright (2001), the application of a positive consent standard removes the burden of communicating dissent from the victim and places responsibility on the accused for ensuring that there is free agreement. Free agreement need not be communicated in words, but might be conveyed by touch or gesture, so verbal communication is not a prerequisite of positive consent. If such communication was legally required, it would reduce the occurrence of miscommunication between sexual partners, including persons with mental impairment. It would remove the reason for allowing the marriage defence to stand, since a person incapable of communicating consent to their spouse would be unlikely to possess the capacity to consent. The introduction of a positive consent standard would ease the task of the prosecution, since there would be an onus on the defendant to show that he obtained free agreement. At the same time, it would be easier for a defendant who did take such steps to demonstrate his innocence. For incapable persons, protection from predatory sexual partners would be strengthened. On the other hand, the sexual partners of capable but vulnerable persons with mental impairment would be less open to accusations of sexual exploitation if they could show that they obtained free agreement. The introduction of a positive consent standard would therefore appear to have advantages for both the female (including those with mental impairment) and the defendant.

Continuing discrimination.

This analysis of sexual crime against incapable persons reveals that the law, in common with many other spheres of life, continues to devalue persons with disability and mental impairment. Only when sexual acts committed in the absence of consent are treated identically to those committed without consent will discrimination cease. To achieve this outcome, amendments would need to be made to the law so that offences against incapable persons were defined under the same sections as rape and allied offences, rather than retaining the separate sections and innocuous names that currently exist.

The fact that these crimes appear to be less harmful than other types of crime may explain why so few cases have been brought to trial. There are numerous barriers to the progression of such a case through the criminal justice system. To begin with, the crime has to become known to a third person, and it is quite possible that an incapable victim might lack the ability to report it. If it does come to light, each step of the legal process involves overcoming the judgments of the officials involved, such as carers, police, prosecutors and, in New South Wales, the Attorney General's department.⁴² Any of these people may decide not to proceed with a complaint. If the case does eventually come to trial, the victim might be assessed as incapable of consent. Paradoxically, they may also be classed as not competent to give evidence. The result of research suggests that sexual offences against

⁴² The NSW *Crimes Act* 1900 s 66F (6) states that no prosecution shall be commenced without the prior approval of the Attorney General.

incapable persons are quite common, but due to a high attrition rate, very few cases come before the courts (Victorian Law Reform Commission, 2005). There is some support for this notion:

A non-verbal woman with profound mental retardation, living in a state institution, was found in a stairwell with a verbal, relatively “street-wise” and sexually active man. She was naked, while he was fully clothed. When found, he was observed stuffing her panties behind a large pipe near the stairwell door. Many other pairs of underwear were found there belonging to several other female residents. Three of these other residents were determined to be incapable of consenting to sexual activity. After initially denying that anything had happened, the man told a physician that he had had sexual relations with this woman that day and on many previous occasions. However, there was no physical evidence found upon a medical exam to corroborate this statement. Although the facility concluded that the woman lacked the capacity to consent to sexual activity, its staff concluded that because sexual intercourse had most likely not been completed, there was no sexual abuse and therefore no “incident” requiring a report. Some staff also considered her to be capable of protecting herself from unwanted sexual advances and this, together with their reported concern for her privacy, were offered as an alternative justification for the failure to report the incident. There was no follow-up regarding the other underwear found, and no special precautions were taken to

protect any of the women, who were determined to lack capacity to consent, from further incidents of this nature (Sundram & Stavis, 1994, p. 257).

Admittedly, this case occurred more than a decade ago. But the law of sexual offences against persons with mental impairment in all Australian jurisdictions remains unchanged since that time. There is no reason to believe that crimes against incapable persons are viewed any more seriously now than they were ten years ago.

In summary, the law that defines sexual offences against persons with mental impairment differs from that which defines sexual offences against members of the general public in quite significant ways. In some states, sentences for equivalent crimes are much shorter when committed against a person with intellectual disability. Marriage is allowed as a defence to charges under the sections of the criminal law that define offences against persons with mental impairment. Overall it appears that in some jurisdictions an offence committed against an incapable person is viewed as being less serious than one committed against a person without impairment. The fact that such crimes are differentiated from equivalent offences where in both cases the fault element is that the acts are committed without consent seems discriminatory. Reform is required if the law is to uphold the rights of

the disabled, who remain among the most disadvantaged groups in contemporary Australia.⁴³

⁴³ In the interests of minimising duplication, the reference list for this paper has been consolidated into the reference list at the end of the thesis.

The focus of Chapter 7 was discrepancies between aspects of the law that apply to the general population and those which apply to the subpopulation with mental impairment. The conclusions drawn support the recommendations I make for law reform in the next chapter.

Chapter 8: Reform proposal

Currently the law in all Australian jurisdictions, the United Kingdom, the United States, Canada and other jurisdictions contains legislative provisions that define sexual offences against persons with mental impairment. The aim of these existing laws is to provide protection against sexual exploitation to members of an especially vulnerable population. The challenge legislators face is to frame laws that fulfill this protective function while concurrently avoiding unnecessarily paternalistic restriction of the right to sexual expression. I have argued in Chapters 4, 5 and 6 that existing laws do not provide sufficient protection against sexual offences, nor do they uphold the right to sexual expression. Indeed, it is my contention that the fundamental right to sexual expression is being unreasonably restricted by this legislation, while on the other hand, the incidence of sexual assault causes concern because although many sexual offences are reportedly committed (Johnson, Andrew & Topp, 1988), very few offences are actually prosecuted (McSherry & Naylor, 2004; Victorian Law Reform Commission, 2001, 2005). Current Australian law is neither upholding the right to sexual expression, nor creating a deterrent to sexual offences against persons with mental impairment.

Current law and issues that arise from it

The fact that sections of sexual assault laws that pertain only to persons with intellectual disability exist means that a subsection of the population is treated differently to the rest of the community. Persons who are labelled as having a mental condition such as intellectual disability,

dementia, mental illness or brain damage⁴⁴ may be limited by this legislation in their ability to legally exercise their right to sexual expression. Such a limitation is not applied to the rest of the community, and as such, these sections of legislation may be viewed as overly protective and discriminatory.

Nevertheless, the fact remains that this type of legislation does exist in all Australian jurisdictions. Within current law that defines sexual offences against persons with intellectual impairment, I have identified three broad types of legislative provisions: those that set out a standard of knowledge that the individual must meet in order to be deemed legally capable of consenting to sexual acts; those that proscribe persons in a position of authority or responsibility from having sexual relations with persons in their care; and those that proscribe the sexual exploitation of persons with mental impairment by any person.

Legislative provisions that define a benchmark of knowledge. The sections of statute that set out a standard of knowledge that the person must meet in order to be deemed capable of consent all require that, as a minimum, the person understands the nature of the act. As discussed in Chapter 5, there are legislative provisions in Western Australia and the Australian Capital Territory. Under both laws, the knowledge required for

⁴⁴ The specific conditions that render prosecution possible under the sections of legislation under consideration here vary between jurisdictions. One consistency between Australian jurisdictions is that in every case, persons who have sexual relations with a person with intellectual disability are liable to charges. Conditions such as dementia, brain damage and mental illness are not always considered to be grounds for charges under these sections.

capacity is confined to understanding the nature of the act, or in other words, understanding the physical action that is to be done. In addition, some further knowledge regarding the character of the act may be required according to the judgment of *R v Morgan* (1970), which was discussed in earlier chapters. The *SA Criminal Law Consolidation Act 1935* is unique in Australian legislation in that it requires knowledge not only of the nature of the act but also of its consequences.

My argument is that capacity should be based on knowledge not only of the nature of the sexual act and its character, as set down in *Morgan*, but also on knowledge of the foreseeable consequences of the act. Consent that is based only on knowledge of the nature of the act does not allow a person to make a decision that is in their own best interest. This position would have the added advantage of bringing Australian statute into line with United Kingdom law, which states in the *Sexual Offences Act 2003* Ch 42, s40:

- (1) A person (A) commits an offence if--
 - (a) he intentionally touches another person (B),
 - (b) the touching is sexual,
 - (c) B is unable to refuse because of or for a reason related to the mental disorder, and
 - (d) A knows or could reasonably be expected to know that B has a mental disorder and that because of it or for another reason related to it B is likely to be unable to refuse.
- (2) B is unable to refuse if—

- (a) he lacks the capacity to choose whether to agree to the touching (whether because he lacks sufficient understanding of the *nature or reasonably foreseeable consequences of what is being done*, or for any other reason), or
- (b) he is unable to communicate such a choice to A (Emphasis added).

By contrast, it appears that, under Australian law, a woman who has no knowledge of either pregnancy or sexually transmitted diseases, under the law of all states except South Australia, is considered capable of giving consent to unprotected heterosexual penetrative intercourse. In the case of penetrative heterosexual intercourse, both persons should be aware that pregnancy and sexually transmitted diseases including HIV/AIDS are possible outcomes of the act. Persons engaging in anal intercourse should be aware of the possibility and the heightened risk of contracting HIV/AIDS that is associated with this form of intercourse.

Knowledge about the consequences of the act is not useful unless it is accompanied by knowledge of how to prevent those outcomes and the ability to obtain protection if so wished, that is, the person must understand the use and purpose of condoms and have access to them. But there is a difficulty in the pragmatic application of this recommendation. It is likely that persons other than the person with intellectual impairment are able to control access to condoms and other forms of contraception, and indeed, to control

access to information. Many caregivers have quite negative attitudes toward the sexuality of persons in their care. It might be useful to provide caregivers with education regarding the sexuality of those they care for. It should be made clear in this education that sexual expression is to be expected and that it is healthy. It should also be emphasised that where education in sexual matters is withheld from the person themselves, there is a heightened risk of them becoming the victim of sexual offences.

Knowledge of the consequences of sexual acts allows each individual to make decisions that are consistent with his or her best interest. If the person knowingly decides to take part in unprotected sex that is a different matter than if they naively take part in it and are ignorant of the risks to which they are exposing themselves. Moreover, the informed person is able to seek and use whatever prophylactic measures are available after the act, such as the “morning after” pill. In contrast, the uninformed individual is unable to avail themselves of such measures because they know nothing about either the possible consequences of the act or of their remedy.

Legislative provisions that ban workers from having sex with those in their care. This type of legislation is intended to prevent persons who are in a position of authority over persons with mental impairment from using their authority in a coercive manner to obtain consent. Examples are the NSW *Crimes Act 1900* s 66F(2)(b), Vic *Crimes Act 1958* ss 51 and 52, ACT *Crimes Act 1900* s 67(1)(h), NT *Criminal Code* s 130(2), and the Tas

Criminal Code Act 1924 s 126(1). In New South Wales, the Northern Territory and the Australian Capital Territory, proscription of sexual acts involving a person in a position of power and a person in their care is absolute. In Tasmania, however, proscription is not absolute and a defence is allowed if it can be shown that “the giving of that consent was not unduly influenced by the fact that the person was responsible for the care of the person with mental impairment” (*Tas Criminal Code Act 1924 s 126(2)(a)(ii)*). But if such a case came to court, it is difficult to see how it could be proved that a *lack* of influence existed. It would be difficult for the person to put such influence aside when deciding whether or not to consent to sex. This is especially so where persons with intellectual disability are involved because they are socialised to be acquiescent to the demands of others (Graydon, Hall & O’Brien-Malone, 2006).

Victoria proscribes all sexual acts between providers of medical or therapeutic services and persons to whom they provide services (*Crimes Act 1958 s 51*) and between workers at residential facilities and residents (*Crimes Act 1958 s 52*). The term “worker” means a person who provides services to residents at a residential facility (whether as an employee or as a voluntary worker or in any other capacity) but does not include a person who also receives services for impaired mental functioning [*Crimes Act 1958 s 50(1)*].

The difficulty with banning all sexual relationships between workers and those in their care is that persons with mental impairment, especially

those with intellectual disability, have a small pool of potential sexual partners. Potential partners may be divided into three categories: paid or voluntary workers, other persons with intellectual impairment, and outside persons. The number of persons in this latter category tends to be small. O'Callaghan and Murphy (2002) did not specifically ask how many outsiders were known, but they found that the average total number of people known, including neighbours, people known at clubs and people known at places gone to, was approximately 2.5. In the same study, the mean number of professionals and other workers known was 5.5. If the choices of sexual partner are limited only to other persons with intellectual disability or to unrelated outsiders, and service providers are eliminated from becoming involved in a sexual relationship with the person, the effect is a rather serious restriction on the right to sexual expression.

My proposal is to proscribe only those occupations where professional ethics would dictate that there can be no sexual relationships with persons who are service recipients. The adoption of this proposal would mean that providers of medical or therapeutic services would be restricted by professional ethics from entering into such relationships, while workers such as gardeners, kitchen workers, receptionists and so forth would remain as potential sexual partners to persons with intellectual disability, in addition to other persons with intellectual disability and outsiders.

Law that bans sexual exploitation. This type of legislation is intended to proscribe all sexually exploitative acts regardless of the status of the perpetrator, in other words, any person having sexually exploitative relations (not necessarily a worker), is liable to be charged under this law. As discussed in Chapter 4, there are legislative provisions in Western Australia and New South Wales that set out that any exploitation is against the law. Queensland allows a defence where it can be proved “that the doing of the act...which constitutes the offence did not in the circumstances constitute sexual exploitation of the intellectually impaired person” (Qld *Criminal Code* s 216(4)(b)).

There is little case law on which to rely in deciding whether or not an act constitutes sexual exploitation, nor have legislators seen fit to define sexual exploitation, as they would not wish to limit the type of case that could be tried under these statutes. The problem with this type of legislation is that the question of whether or not an act is exploitative is largely left up to individual jurors and courts to judge. This may lead to inconsistencies.

Second, such law is arguably discriminatory. There is no equivalent statute prohibiting exploitation that applies to persons without disabilities. This may mean that persons with mental impairment are held to higher standards of behaviour than are the rest of the community. Persons with intellectual disabilities who are capable of consent should not be censored for making a “mistake” in their choice of sexual partner, nor in the sexual acts in which they engage. Conversely, if an incapable person was involved

in an exploitative sexual act, the accused should be charged with rape or sexual assault because they have engaged in sex without consent, as an incapable person by definition cannot consent to sex.

In any case, everyone is vulnerable to exploitation because we can all be mistaken about facts regarding the sexual act, such as our partner's motivation for engaging in the act. There are circumstances which, if known at the outset, would make a difference to the decision to engage in that particular sexual act. For example, if A had known that B was going to talk to his friends about the details of their sexual encounter, she may well have changed her mind about engaging in the sexual act. It has been argued by Archard (1994) and Klepper (1993) that the violation of expectations based on social norms constitutes sexual exploitation. As we are all vulnerable to this type of exploitation the law that proscribes only the sexual exploitation of persons with intellectual disability can be seen as discriminatory.

Further issues

There are a number of further issues that I would like to raise, the first being that in some jurisdictions, marriage can be used as a defence to charges under the relevant sections, the second being charges of aggravation are automatic where the victim has a mental impairment, and the third being that in some states the sentencing provisions for an offence against a person with mental impairment are less severe than those for an equivalent offence against a member of the general population.

The marriage defence

In some states, the existence of a marriage between the alleged perpetrator and the complainant may be used as a defence to charges of committing a sexual assault against a person with mental impairment. As discussed in Chapter 7, Western Australia, South Australia, Victoria and Tasmania have this type of legislative provision. The wording of the Western Australian provisions is as follows: "It is a defence to a charge under this section to prove the accused person was lawfully married to the incapable person". I have argued that this defense is inconsistent with other sections of sexual offence law, where marriage has been abolished as a defence to charges of rape or sexual assault (see Chapter 7). Prior to the introduction of law allowing a wife to charge her husband with rape, the husband had, in effect, a licence to rape his wife (Easteal, 1998b). This position stemmed from the legal tradition that whatever occurred in marriage was private and therefore outside the reach of the law (Graycar & Morgan, 2002). Largely due to the reform efforts of feminist groups, the shield that marriage provided to husbands who raped their wives has been removed (Easteal, 1998b). In contrast, current law regarding incapacity means that an incapable wife might be faced with the marriage defense if her husband had sexual relations with her. The Victorian provision is even wider than that of WA: "Consent is not a defence to a charge under this section unless at the time of the alleged offence the accused believed on reasonable grounds that he or she was the spouse or the defacto spouse of the other person" [*Crimes*

Act 1958 s 51(3) and s 52(3)]. The inclusion of the phrase “believed on reasonable grounds” seems to imply that if the defendant alleges that he believed in the existence of a marriage, there is an onus upon the prosecution to prove that such a belief was not reasonable. This is a more extreme version of a defendant relying on his mistaken belief, where a perpetrator may admit that a sexual act took place but claim that he believed that the woman consented. If such an argument is successful the defendant will be acquitted. Consistent with the argument advanced by Leader-Elliott and Naffine (2000), the woman’s experience of sex without consent can be trumped by the perpetrator’s alleged belief in consent. Retention of a legislative provision that relies on the defendant’s belief allows the defendant to override the experience of the victim.

Charges

At present, in cases of sexual assault where the victim has a mental impairment, the charges would automatically be aggravated sexual assault, because the victim is a member of a group thought to be especially vulnerable. However, this automatic categorisation of the case as aggravated is discriminatory. The presence of mental impairment should not automatically mean that the charge is aggravated sexual assault. Instead, where an accused is proven to have sexually assaulted a person with mental impairment, the presence of the mental impairment should be regarded as a possible factor in aggravation. In contrast to current law, this is a non-discriminatory manner of sentencing.

Available sentences

In some Australian jurisdictions the sentences available for successful prosecutions of sexual acts involving persons with mental impairment are less severe than the sentences for equivalent acts that do not involve a person with mental impairment. Sexual acts that involve an incapable person are necessarily acts that are committed without consent,⁴⁵ because the person is not capable of giving consent. Therefore the fault element for charges of rape or sexual assault is fulfilled, and yet the available sentence is significantly less than that available for proven charges of rape or sexual assault.

As already set out in Chapter 7, there is a substantial difference in the penalties for rape and sexual offences against those with mental impairment except in Western Australia and Queensland.

A Model Law

At this point I would like to propose a model law pertaining to sexual offences against incapable persons, which avoids as much as possible the weaknesses outlined above. Relevant definitions, the proposed statute and sentencing provisions are outlined below.

⁴⁵ The provision that rape or sexual assault has to be committed against the will, as opposed to without consent, has been abolished in all Australian jurisdictions. This change was to provide for circumstances where the person was seriously intoxicated, unconscious, asleep or otherwise unable to give or withhold consent.

Definitions

“Consent” means free and voluntary agreement. Circumstances in which a person does not freely and voluntarily agree to an act include the following-

- (a) the person submits because of force or the fear of force to that person or someone else;
- (b) the person submits because of the fear of harm of any type to that person or someone else;
- (c) the person submits because she or he is unlawfully detained;
- (d) the person is asleep, unconscious, or so affected by alcohol or another drug as to be incapable of freely and voluntarily agreeing.

The fact that a person did not say or do anything to indicate free agreement to a sexual act is normally enough to show that the act took place without that person's free agreement; a person is not to be regarded as having freely agreed to a sexual act just because she or he did not protest or physically resist; or she or he did not sustain physical injury. The onus is upon the accused to show the steps that he took to ensure that there was, on the victim's part, free agreement.

“Incapable persons” means those persons who do not, at the time of the offence, understand the nature, character and reasonably foreseeable consequences of the sexual act that is the subject of the charge. This lack of understanding need not necessarily be due to mental impairment.

“Mental impairment” includes but is not restricted to intellectual disability, mental illness, dementia and brain damage.

“Professional relationship” is one in which the professional ethics of the body that regulates said profession proscribes sexual acts between the professional and those to whom he or she renders professional services.

Proposed law

1. Any person who engages in a sexual act with a person who is incapable of consent is deemed to have committed a sexual act without consent.

2. Any person who is in a professional relationship with a person with mental impairment where that relationship has been clearly defined as excluding sexual acts who commits such an act is deemed to have committed an offence.

Sentencing

1. The presence of mental impairment in the victim is to be regarded as a factor in aggravation when deliberating on the sentence to be handed down.

2. Persons convicted of having sexual relations with an incapable person are liable to the same sentences as persons convicted of having sexual relations without consent.

Conclusions

In this paper I have made a number of recommendations with the aim of eliminating a number of weaknesses in current law. These weaknesses include the difficulty in establishing that sexual exploitation has occurred, as exploitation cannot be defined with any precision. Second, I have argued that to ban all sexual relationships between any person in a position of authority and those subject to that authority is discriminatory and overly paternalistic. Instead, I have advocated that only such relationships as would be banned by professional ethics should be proscribed. Third, I have argued that for a person to be deemed capable of consent they should understand both the nature and consequences of the act, as well as understand that it is a sexual act rather than one performed for medical or hygienic purposes. If these proposals were adopted, there would be greater consistency between the law as it applies to persons with mental impairment and the general law of sexual offences. It would also result in less discrimination against persons with mental impairment. In addition, the proposed changes would have the effect of bringing Australian law into line with other jurisdictions, most notably with the United Kingdom. The criminal law should not be used to regulate the sexual expression of persons with mental impairment. The reduction of discrimination due to mental impairment is achievable. Indeed, it should be the legitimate goal of any proposed changes to sexual offence law.

In Chapter 8 I reviewed the conclusions that have been made in earlier chapters and proposed some reforms to existing law. In the final chapter I use available statistics to review the current effect of law that pertains to the sexual assault of persons with mental impairment.

Chapter 9: Conclusion

How effectively does the existing law of sexual offences against persons with intellectual disability achieve a balance between providing protection while concurrently preserving the right to sexual expression?

Not very effectively at all, if one equates efficacy with the number of prosecutions for the sexual assault of disabled people. Over an eight year period, only 17 prosecutions took place in Victoria, or an average of 2 per calendar year (McSherry & Naylor, 2004), even though evidence suggests that the incidence of sexual assault against persons with mental impairment is much higher than it is against members of the general population (Carmody, 1991, 1992; Hayes, 1993; McCarthy, 1999; McSherry, 1998a). This number can be contrasted against the number of sexual assault victims from the general population over a single calendar year. The Australian Bureau of Statistics (2004b) showed that there were approximately 18,000 sexual assaults of mainstream women in the whole of Australia reported to police during 2003. Forty three percent of cases⁴⁶ were cleared by police by way of apprehension of the offender (Wundersitz, 1996).

In measuring the incidence of sexual offences against persons with intellectual disability, there is the problem that, very often, it is either not noticed or not recorded that the victim has a cognitive impairment. Given that the presence of mental impairment is the basis of some types of sexual offences, it is difficult to see why it has been overlooked. To overcome this anomaly, 19 Victorian agencies agreed to monitor cases of alleged crime against persons with intellectual disability over a three month period. The

⁴⁶ This percentage is that reported for the state of South Australia.

result was reported by Johnson, Andrew and Topp (1988). It was found that, of 144 alleged crimes committed against people with an intellectual disability, 130 were sexual crimes. If that number were extrapolated from, it would translate into hundreds of prosecutions per annum if every case was followed through. Thus, if one is to measure the effectiveness of the law by the number of successful prosecutions, one would have to conclude that it was less than useful. Similarly, if one takes the attitude espoused by the Victorian Law Reform Commission (2001, 2005) that effective law can be measured by its deterrent effect, then current law appears to be ineffective given the large number of alleged offences.

It is my view that the reason that so few cases come to trial may be due to an amalgam of the following circumstances: (i) there are numerous barriers to the initial entry of the case into the criminal justice system, (ii) if the case does enter the system it may be dropped at any point by any one of a number of stakeholders including police and prosecutors, and (iii) a complainant who lacks capacity to consent to sex may also be ruled to be incapable of giving evidence if the case does come to court. It may be thought by those in a position of authority that pursuing charges will be unproductive and that it would be better for everyone concerned to forget the incident as soon as possible.

The existence of separate sections of legislation that define sexual offences against persons with mental impairment or intellectual disability might be attributed to the need for a fall-back position where a charge of

rape might fail (recall that *Beattie* was primarily charged with rape and alternatively with having sexual intercourse with a mentally deficient woman). It also seems likely that these charges might be easier to prove than charges of rape, especially where the incapable person manifested apparent willingness (McSherry, 1998a). The preservation of alternative charges could therefore be viewed as advantageous, and yet it echoes the old differentiation between “real rape” where the victim resists and offences where there was no resistance and which, according to Eastal (1998a), a fair proportion of men still regard as not being rape at all.

I have argued in Chapter 4 that society should not countenance the use of the criminal law as a method of regulating the sexual expression of capable persons with mental impairment. If it can be demonstrated that the capable person is being harmed by an encounter, and that bringing the relationship to an end would be less harmful to the person than allowing it to continue (Somerville, 1994), that might provide the necessary justification for invoking legislation to intercede in the relationship.

The overall trend found in my analysis of sexual assault cases is that, in recent years, the general law of sexual offences has undergone considerable change with regard to the vitiation of consent by ignorance, mistake or fraud. It seems, in theory at least, that consent must now more than ever be based upon full knowledge of the act which subsequently occurs. Significant deviation from the act that the woman believes is going to occur might vitiate her consent. Just what constitutes significant deviation

has been tested in contemporary courts. Some well-known cases which turned on the vitiation of consent due to ignorance on the part of the victim such as *Papadimitropoulis* and *Mobilio* were discussed in Chapters 5 and 6. The overall trend found in the cases reviewed is that acts that deviate from the expectations of the victim, whether by mistake as to the purpose, identity or health status of the offender are viewed as cause for criminal prosecution. This trend in the courts echoes changes in other parts of the criminal law. In some respects, the general law of sexual offences has become more intrusive into areas of life formerly considered to be private and thus beyond the reach of legal intervention, for example, the recognition of rape within marriage. On the other hand, the law has become less intrusive in respect to some consensual sexual acts performed in private by adults, such as homosexual intercourse.

What changes should be made to sexual assault law?

In this thesis I have advanced four unique modifications which, were they to be made, would improve existing law. I have advanced the argument that the concept of sexual exploitation is fundamentally flawed, and that liability should be redistributed to persons whose paid or voluntary position is commonly understood to exclude sexual acts. My proposal has the advantage of allowing sexual relationships with persons whose positions currently exclude them as potential partners, but who do not provide care to the person with mental impairment. Under this proposal, cooks, garden staff, receptionists and so on would be allowed to pursue relationships with

residents at a facility, while professional ethics would proscribe professional staff from such a course.

Second, it is my contention that, contrary to current law, knowledge of the consequences of sex in addition to understanding the nature of the act is necessary for consent to be valid. Consent that is not supported by knowledge that allows the person to protect their own interests may be meaningless.

Third, lesser penalties are available for sexual assault involving a person who is incapable of consent than the same act involving a person who withholds consent. My argument is that both are sexual acts without consent and should be subject to the same penalties. Current legislation in several states is discriminatory and tends to reflect that belief that sexual assault of an incapable person is less serious than the sexual assault of a non-consenting person.

Finally, it is my contention that retention of marriage as a defence is discriminatory and is at odds with the rest of sexual assault law, where marriage as a defence has been abolished.

Conclusion

It has never been my aim in this thesis to develop a set of barriers which the disabled person must negotiate in order to be deemed capable of consenting to sex. In a case where the question of capacity is raised, there ought to be a framework to assist the expert whose task it is to establish

capacity or incapacity. This is what I have attempted to provide. Under the current system, assessment of capacity is left up to the individual expert. Although this method has the advantage of flexibility, it does allow room for error and for personal feeling to intrude into the assessment. If the system was changed so that the person had to demonstrate a certain standard of knowledge, this could increase the reliability and validity of such assessments.⁴⁷ Determination of capacity is difficult, even for experts. It is my hope that the suggestions contained in this thesis will allow the process to be easier and will allow persons with intellectual disability to have their voices heard.

⁴⁷ Aspects of the testing conditions which impact on the person's ability to express their knowledge also have an impact on reliability and validity.

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