Outcomes of sexual assault court cases involving people with intellectual disabilities within the Western Cape: The association between conviction of the perpetrator and the complainant's level of intellectual functioning

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Compulsory Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to and quotation in this dissertation from the work of other people has been attributed and has been cited and referenced.

Signature: **Date: 20 July 2022**

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Abstract

People with intellectual disabilities (PWID) are more likely to be survivors of sexual assault than people without intellectual disabilities (ID). Their cognitive, emotional, behavioral, and physical challenges increase their vulnerability and chances of being sexually assaulted. Despite this, individuals that disclose their sexual abuse face multiple barriers while seeking justice. This results in low prosecution and conviction rates of sexual offenders in cases involving complainants with ID. There is limited information available about specific factors that predict a court case outcome of sexual abuse cases involving PWID. This correlational study reviewed archival data of alleged survivors of sexual abuse with ID. The sample of 493 complainants had received assistance from Cape Mental Health (CMH) Sexual and Victim Empowered (SAVE) Program. This study showed that most of the complainants of sexual assault were female (86.8%), and 12.6% were male. Most complainants fell within the Mild ID range (54.6%), followed by Severe (20.3%) and Moderate ID (17%). More than half of the cases were withdrawn (58%), 22% of the perpetrators were found guilty, and 12% were acquitted of the charges. This study found that the ability to understand the consequences of sex and to refuse sexual advances increased the individual's ability to consent to sexual activity, while their ability to answer clarifying questions and take an oath significantly impacted their ability to testify in court. However, neither the ability to provide consent nor the ability to testify was significant in predicting the court case outcomes. This highlights the challenges complainants with ID face when seeking justice for sexual abuse. Sexuality education for PWID may mitigate their risk of sexual abuse and serve as a protective factor. Furthermore, the public’s awareness regarding the rights of, and responsibilities towards, PWID may also decrease their vulnerability and protect PWID from injustice.

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Abbreviations

AAID	American Association on Intellectual and Developmental Disabilities
APA	American Psychiatric Association
CHM	Cape Mental Health
CRPD	Convention on the Rights of Persons with Disabilities
DSM-IV	Diagnostic and Statistical Manuel of Mental Disorders, Fourth Edition
DSM-V	Diagnostic and Statistical Manuel of Mental Disorders, Fifth Edition
ICD	International Classification of Diseases
ID	Intellectual disability
IDD	Intellectual Developmental Disorder
ISGSA	Individual Scale for General Scholastic Aptitude
PTSD	Post-traumatic stress disorder
PWID	People with intellectual disability
SAVE	Sexual Abuse Victim Empowerment Programme
SOA	Sexual Offences and Related Matters Amendment Act 32 of 2007
Vinelands-II	Vinelands Adaptive behavior Scales 2nd edition
WHO	World Health Organization

Chapter 1

Introduction

1.1 Background

People with intellectual disability (PWID) are more vulnerable to sexual abuse than those without an intellectual disability (Beckene, Forestor-Jones, & Murphy, 2020; Brown & Turk, 1994; Brownridge, 2006). Intellectual disability (ID) is a neurodevelopmental disorder characterized by cognitive, social, and practical deficits (Diagnostic Statistical Manuel; APA, 2013). Those with the diagnosis have varying degrees of impairment in their receptive and expressive language abilities, memory, ability to think and reason, and understanding of social interactions (DSM; APA, 2013). In addition, PWID may also have physical disabilities that impact their mobility. These deficits increase the risk of exploitation by others and can lead to victimization, including sexual assault (DSM; APA, 2013).

Sexual assault is a global concern. Complainants of sexual assault are at risk for a wide range of mental and physical problems. These include post-traumatic stress disorder (PTSD), depression, substance use disorders, somatic complaints, and adverse reproductive health outcomes (Dworkin et al., 2021; Kroese & Thomas, 2006; Platt, 2017). Women and children are more vulnerable to sexual assault, and this risk is even greater for PWID (Phasa, 2009; Phasa & Myaka, 2014). According to Chave-Cox (2014), 49% of PWID experience ten or more sexually abusive episodes in their lifetime. Men with ID are twice as likely to be survivors of sexual assault than men without ID (Platt et al.,2017; Wilson et al.,2020; Wyman et al., 2019). When PWID are sexually assaulted, they may struggle to understand the violation, preventing them from disclosing it. Complainants who do disclose and report a sexual offence face multiple challenges and have a harder time engaging with the justice system.

Historically, the justice system has regarded PWID as incompetent witnesses who cannot provide reliable testimony in court (Beckene et al., 2020; Cossins, 2020, Henry et al., 2011). PWID have decreased cognitive abilities affecting multiple functioning areas, including memory and communication. This disadvantages them when filing a complaint or providing testimony in court. Complainants may also struggle to understand court proceedings, such as taking an oath, which may prevent them from testifying (Lee et al., 2010; Henry et al., 2011). The credibility of a complainant's testimony is doubted if their account of the assault is inconsistent, and the charge against the perpetrator may be dismissed (Cossins, 2020). As a result, cases of sexual assault involving PWID have low prosecution and conviction rates (Cossins, 2020).

1.2 Motivation for the Present Study

PWID are at increased risk for sexual assault and face multiple barriers when engaging with the justice system. Although there is a growing body of literature on the vulnerability of PWID to sexual assault, there is still a gap in the literature when it comes to exploring the factors that influence the conviction of the perpetrator (Gudjohsson et al., 2000; Dickman & Roux, 2005; Phasa 2009; Phasa & Myaka, 2014). This study's primary purpose is to describe the outcomes of court cases involving PWID. Moreover, this study aims to determine if the complainant's ability to testify and the ability to give consent to sexual relationships correlate with court case outcomes. To this end, several questions and hypotheses are proposed below:

1.3 Research Questions and Hypotheses

1. Does the level of ID predict the conviction of the perpetrator?

    H_1: Yes, individuals with mild ID will be more likely to have their cases concluded in a guilty verdict. Those with moderate and severe levels of ID may be more likely to receive a not guilty verdict than a guilty verdict.

2. Does the ability to consent to sexual activity predict the conviction of the perpetrator?

   H_2: Yes, survivors who can consent to sex may be more likely to have their cases result in a not-guilty verdict. Survivors who cannot consent to sex may be more likely to have their claims result in a guilty verdict than a not guilty verdict.

3. Does the ability to testify in court predict the conviction of the perpetrator?

   H_3: Yes, individuals who can testify are more likely to have their case appear in court rather than not appear in court. Should their cases appear in court, individuals who can testify are more likely to have their cases conclude in a guilty verdict instead of a not guilty verdict.

1.4 Structure of the Dissertation

This dissertation is presented in 5 chapters. This chapter, Chapter 1, is the introduction to this document. Chapter 2 provides an overview of the relevant literature. I begin by discussing the historical terminology and current definition of ID. Chapter 2 concludes by elaborating on the vulnerabilities of PWID to sexual assault and the interaction of complainants with the justice system when seeking legal reparation. Chapter 3 will describe the methodology, including the study design, participants, ethical considerations, data analysis, and setting. Chapter 4 presents the results, which are then discussed in Chapter 5.

Chapter 2

Literature Review

2.1 Historical and Current Terminology of Intellectual Disability

The psychological and medical terminology used to describe ID has changed in recent years. Initial classifications such as moron, retarded, feeble-minded, and idiotic were introduced by the American Association on Intellectual and Developmental Disabilities (AAID) in the early 18th and 19th centuries (Chiurazzi, 2011). Today these terms are considered derogatory and disrespectful. Terminology changes are associated with decreasing the stigma and prejudiced views held against PWID and ensuring that the rights of people with disability are upheld (Chiurazzi, 2011; Stuart, 2016; Werner & Moran; 2018).

Inclusionary and dignified language were advocated by associations such as the National Association of Parents and Friends of Mentally Retarded Children (1930), The National Mental Health Foundation (1964), and The National Alliance on Mental Health Illness (Werner & Moran, 2018). These organizations advocated for better rights, education, and inclusion of people with disabilities (Bowers, 2019). In the 20th century, the United States of America (USA) started using terms such as mental disability, mental deficiency, mental handicap, mental subnormality, and mental retardation (Gates & Mafuba, 2016; Werner & Moran, 2018). In the United Kingdom (UK), the term learning disability was preferred to terms such as mental retardation (Gates & Mafuba, 2016; Werner & Moran, 2018).

A learning disability is markedly different from learning difficulties. Learning difficulties refer to specific challenges with information processing, e.g., dyslexia or dyspraxia (Gates & Mafuba, 2016). In contrast, a learning disability is a global developmental delay synonymous with mental retardation (Gates & Mafuba, 2016).

Intellectual Disability (ID) is the classification used in public policies, service delivery systems, and research. Salvador-Carulla et al. (2011) note that using the same term across these platforms is essential. It informs and ensures consistency in PWID's diagnosis, treatment, and services (Salvador-Carulla et al., 2011). The need for homogeneity of the name has also been reflected in the two leading classification systems of mental disorders, namely the World Health Organization's (WHO's) International Classification of Diseases (ICD) and the American Psychiatric Association (APA) 's Diagnostic and Statistical Manual of Mental Disorders (DSM) (Salvador-Carulla et al., 2011; Wyman et al., 2019). Both the ICD-10 (published in 1983) and the DSM-IV (published in 1952) referred to ID as mental retardation (WHO, 1992; DSM; APA, 2000). In 2013 the DSM-V was released, replacing mental retardation with Intellectual Disability (ID), also known as Intellectual Developmental Disorder (IDD). The name changed after the president of the United States of America, Barack Obama, signed "Rosa's Law" in 2010, which changed 'mental retardation' to 'intellectual disability' (Tassé, Luckasson, & Nygren, 2013). In 2019 the ICD-11 also adopted this change in terminology.

Changing the terminology from mental retardation to intellectual disability was a contentious issue for the ICD-11 (Tassé, Luckasson, & Nygren, 2013). The ICD is a classification system that lists and provides critical information on human diseases' extent, causes, and consequences. A health condition refers to an impairment located in the body. In contrast, disability refers to the interaction between a health condition (e.g., Down syndrome, cerebral palsy, depression) and personal and environmental factors (e.g., negative attitudes, and limited social support) (WHO, 2021). Tasse et al. (2013) argued that retaining the name " mental retardation" in the ICD-11 would emphasize that this disorder is a health condition. According to the ICD 10- mental retardation is a health condition- a cluster of syndromes and disorders characterized by low intelligence and associated with limitations in adaptive

behaviour (Salvador-Carulla et al., 2011). The definition of mental retardation is the same as ID- impairment in intellectual functioning- which WHO's International Classification of Functioning, Disability, and Health (ICF) classifies as a disability (WHO, 2021). Chiurazzi (2011) argued that if ICD changed mental retardation to ID, then the term ID should be removed from ICD 11 and it should be seen only as a disability. Removing ID from the ICD would have detrimental consequences for PWID. The ICD is globally recognized and prescribes health care, education, and social services to eligible people (Read & Rushton, 2013; Tasse et al., 2013). PWID have varied health care needs, and some conditions require extensive care. The removal of ID from the ICD would decrease the awareness and responsibility toward people living with ID (Tasse et al., 2013). This would also negatively impact the national and global health statistics that influence the visibility of ID and increase the vulnerability of PWID (Bertelli, Munir, Harris, & Salvador-Carulla, 2016; Tasse et al., 2013).

The word disability has also received criticism. The term disability suggests that "disability" is a condition that can occur at any time in an individual's life, due to trauma or neurodegenerative disease (Elis, 2013). This contradicts the DSM-V definition of intellectual disability as a neurodevelopmental disorder that occurs before 18 years (DSM; APA, 2013). However, according to Elis (2013), it is to the advantage of PWID, legislatively, for ID to be understood as a developmental disorder rather than a medical condition. The law focuses on how disability affects the individual in everyday life rather than the aetiology or medical treatment of the condition.

When defendants or complainants engage with the court system, the emphasis would be placed on the individual's capacity to understand the act's wrongfulness, the individual's ability to consult with prosecutors, and their ability to testify in court. Services such as court preparation and support are then provided to individuals based on their functional skills and

limitations in society to ensure that they are not discriminated against in court (Adnams, 2016; Ellis, 2013).

With the publication of the ICD- 11 in 2019, the term mental retardation was changed to Disorders of Intellectual Development (DID). The International Statistical Classification of Diseases and Related Health Problems defines DID as a group of diverse conditions that develop during the neuro-developmental period characterized by significantly below-average intelligence and adaptive behaviour (ICD-11; World Health Organisation, 2019, p.2). Adding disorder in the name acknowledges that it is also a health condition while incorporating the less pejorative term ID (Salvador-Carulla et al., 2011). The crucial difference between the DSM V and the ICD 11 is that the latter emphasizes clinical assessment of intellectual functioning before a diagnosis can be made. The ICD-11 removed problem behaviours as indicators of ID and now describes these as associated disorder features. However, it does maintain subcategories indicating clinical severity – viz., borderline, mild, moderate, severe, and profound (APA, 2013; Salvador-Carulla et al., 2011).

In this study, ID or IDD as defined in the DSM-V (DSM; APA, 2013), which is also equivalent to the ICD 11's DID, will be used. This aligns with Rosa's Law instituted in the United States in 2010, which mandated that ID replace the term mental retardation in all policies and systems (Morera, 2014; Tasse, Lukasson, & Nygren, 2013).

The DSM-V defines ID as a disorder with onset during early development, which includes intellectual and adaptive deficits in conceptual, social, and practical domains (DSM; APA, 2013). The following three criteria must be met for a diagnosis to be made: (DSM; APA, 2013. p 33)

A. Deficits in intellectual functions, such as reasoning, problem-solving, planning, abstract thinking, judgement, academic learning, and learning from experience,

confirmed by both clinical assessment and individualized, standardized intelligence testing.

B. Deficits in adaptive functioning that results in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, adaptive deficits limit functioning in one or more daily life activities, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

C. Onset of intellectual and adaptive deficits during the early developmental period.

One of the significant changes in the DSM-V is that it no longer specifies a criterion for IQ scores but indicates that intellectual deficits need to be confirmed with a standardized IQ test and individual clinical assessment of adaptive functioning (Morera, 2014). Adaptive functioning is determined through clinical observation and collateral information provided by family members and educators (Morera, 2014). Like the ICD-11, the DSM-V has also retained the specifiers indicating varying degrees of impairment. These are Mild ID, Moderate ID, Severe ID, and Profound ID (Adnams, 2016; Gudjohsson et al., 2000). Borderline Intellectual Functioning is classified as an IQ level between 71-84. The IQ range falls slightly outside average intellectual functioning and ID (DSM; APA, 2013). Borderline Intellectual Functioning is included in the DSM-V under conditions that may require clinical attention but do not meet the full diagnostic criteria for any other disorder in the DSM-V (DSM; APA, 2013).

Complainants of sexual assault who are diagnosed with ID are acknowledged and protected by the "Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007" (SOA). When engaging with legislation, a PWID is defined as a " person affected

by any mental disability, including any disorder or disability of the mind that at the time of the offence the individual was :

A. Unable to understand the nature of the act or the foreseeable consequences of the sexual act.

B. Able to appreciate the nature and reasonably foreseeable consequences of such an act but unable to act in accordance with that appreciation.

C. Unable to resist the commission of any such act.

D. Unable to communicate his or her unwillingness to participate in any such act.

As noted above, PWID have varied developmental deficits, which prevent them from reaching specific milestones. They might have limitations in communication, taking care of themselves, and social skills. Depending on their level of ID, they require more support and supervision compared to their peers. This may include supervision and guidance in tasks such as managing time, money, personal hygiene, puberty, girls' menarche, sexuality and consent, and overall safety.

2.3 Models of Intellectual Disability

Historically society's understanding of disability has been shaped by various models. These models of disability are essential as they direct society's attention to particular aspects of disability and influence the psychological, political, economic, and social outcomes for people with disabilities (Dirth & Branscombe, 2017).

Disability models originated in Western society in the early 1970s. Some of the models developed over time are the Moral or Religious model, which understands disability as an act of God; the Medical model, which views disability as a disease and the Social model, which views disability as a socially constructed (Letšosa & Retief, 2017). Other

models, such as the Identity model, view disability as a marker of the individual's minority status in society and advocate that people with disability have a collective identity of anger and frustration towards barriers imposed on them (Letšosa & Retief, 2017). The Human Rights model believes disability is a human rights issue (Letšosa & Retief, 2017). The Biopsychosocial model views disability as an interaction between the body, environment, and society (Letšosa & Retief, 2017). The changes in models or frameworks of disability have coincided with increased awareness of the fundamental human rights of people with disabilities. The dominant model at the specific time guides legislation, policies, and regulations concerning people with disabilities (Bogart et al., 2020).

The medical and social models have been influential in disability studies. The medical model is the most prominent model of disability, and the social model has catalyzed the human rights movement for people with disabilities (Bogart et al., 2020). These two models will be discussed in this chapter.

The medical model originated in the UK in the early 1970s (Watermeyer, 2019). This model reduced aspects of the disability to bodily impairments (Grue, 2010; Grue, 2011; Shaboodien, 2016; Watermeyer, 2019). It understood disability as a medical or mental condition, and medication and prosthetics were the primary treatment forms. All interventions of the medical model –whether well-intentioned or malicious – were implemented based on the assumption that the individual was impaired and incapable of making decisions for themselves (Bogart et al., 2020). People with a disability were seen as defective and inferior to those without disabilities (Dirth & Branscombe, 2017)

According to Gru (2011), the medical model failed to empower PWID. It played a significant role in denying PWID's sexual and bodily rights, increasing their vulnerability to exploitation (Dirth & Branscombe, 2017; Gru, 2011). This model also perpetuated the belief

that people with disabilities threaten the genetic development of non-disabled people and should not reproduce (Bowers, 2019). As a result, women with ID were sterilized without permission to prevent them from having children. Although it might not have been the intention, the medical model contributed significantly to the prejudice against people with disabilities. It views disability as only a medical problem and neglects the social inequalities experienced by people with disabilities (Dirth & Branscombe, 2017). Challenges encountered in society by people with disabilities, such as access to education and employment, were viewed as a problem of the person with a disability and not as discriminatory treatment stemming from negative social attitudes toward individuals with disabilities (Dirth & Branscombe, 2017; Watermeyer, 2019).

The social model was developed in opposition to the medical model (Dirth & Branscombe, 2017). In the early 1970s, the Union of Physically Impaired Against Segregation pioneered the social model in the United Kingdom (UK) (Dirth & Branscombe, 2017; Gru, 2011; Oliver, 1996;). This social model focused on the economic and political oppression of people whose bodies were impaired and different from non-disabled individuals (Gru, 2011; Oliver, 1996; Schneider, 2006). It differentiated between the terms impairment and disability. Impairment refers to the dysfunction or difference in the body (Watermeyer, 2019). Disability refers to the loss or limitation of opportunities that prevent people with disabilities from participating in society due to physical or social barriers (Watermeyer, 2019). The social model argued that the institutionalization of PWID created barriers that made it difficult for PWID to live meaningful lives (Schneider, 2006). The placement of people with PWID in institutions, an intervention implemented by the medical model, denied individuals the right to build relationships and share group experiences with others. This model strongly advocated integrating people with disabilities into the community instead of creating spaces that effectively divided the population into abled and disabled

people (Bogart et al., 2020). The Social model advocated for inclusivity and believed that the experience of those who are disabled would change if they were involved in all areas of society (Oliver, 1996).

The Social model recognizes that all people with disabilities experience inequality and discrimination (Dirth & Branscombe, 2017; Higgins, 2010). Interventions based on the Social model are rooted more in activism, social justice, and advocacy for the rights of disabled individuals (Dirth & Branscombe, 2017; Grue, 2011; Higgins, 2010). This model advocated that all legislation should include people with disabilities and that all people with disabilities should enjoy socio-economic freedom and be represented fairly in decisions made for them (Dirth & Branscombe, 2017). One of the successes is the adoption of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2006 (Holness & Rule, 2017; Lawson & Beckett, 2021; UN, 2006). The CRPD is an international human rights treaty that sets out the human rights of disabled people (UN, 2006). This also includes combating stereotypes, prejudices, and harmful practices relating to persons with disabilities based on gender and sex (Holness & Rule, 2017).

Article 6 of the CRPD explicitly recognizes the vulnerability of women and children and highlights their increased risk of sexual violation. (UN, 2006). Article 12 emphasizes the equal recognition of disabled individuals before the law, and that appropriate support should be provided to people with disabilities (Holness & Rule, 2017; UN, 2006). Article 13 states that all people with disabilities should be provided with equal access to justice when engaging with the legal system, which includes appropriate support to witnesses and the training of all those who engage with PWID (Holness & Rule, 201; UN, 2006). The CRPD is an important document that requires all ratified countries to recognize the importance of autonomy, independence, freedom of choice, and involving people with disabilities in the decision-making of their own lives (Higgins, 2010; Lawson & Beckett, 2021; UN, 2007).

Our understanding of disability has changed over time. The changes have increased awareness, inclusion, and empowerment of people with disabilities (Wilson and Scior 2015). Despite these changes, most reforms have occurred in the employment, education, and service delivery sectors (Higgins, 2010). Reforms regarding the attitudes and responses toward the sexuality of people with disabilities have remained slow and are still shaped by the medical model (Higgins, 2011; UN, 2007). This is problematic for PWID, who are more likely to be sexually abused.

PWID who have been sexually abused face additional structural, economic, and attitudinal discrimination (Holness & Rule, 2017). Complainants may have to travel great distances when seeking medical or legal support. Traveling great distances can be costly, and PWID are often financially deprived (Higgins, 2010; Holness & Rule, 2017). Lastly, frontline workers' negative and insensitive attitudes about ID and sexual abuse perpetuate discrimination against PWID (Holness & Rule, 2017).

Since the early 1970s, models of disability have provided a framework that influences society's perceptions of people with disabilities. The medical model and the social model have been the most influential. Although the medical model advocated medical support and treatment of people with disabilities, it has also been criticized for being individualistic and perpetuating discriminatory behaviour towards people with disabilities. As such, the social model developed to oppose the medical model (Watermeyer, 2019). It advocated for the rights and inclusion of people with disabilities. Many changes have been implemented as a consequence of the social model, which has been beneficial for people with disabilities. However, pervasive stereotypical beliefs have been harder to shift (Higgins, 2010; Wilson & Scior, 2015). This has resulted in ongoing discrimination, marginalization, and exploitation of people with disabilities (Higgins, 2010; Wilson & Scior, 2015).

2.3 Sexual Assault

The following section will discuss the definition of sexual violence as proposed by WHO and the "Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007" (SOA) of South Africa.

The World Health Organisation (WHO) – defines sexual violence as:

> Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. (Krug, 2002, p. 147).

> Coercion relates to physical force and psychological intimidation, blackmail, or threats. Coercion often involves applying pressure to someone, either physical or psychological, to constrain their decisions or push them into making a particular decision. It can include instances when the victim cannot give consent, for example, when drunk, drugged, asleep, or mentally incapable of understanding the act of sexual violence (Krug et al., 2002).

WHO's conceptualization of sexual violence includes rape, defined as being physically forced or otherwise coerced penetration, even slight penetration of the vulva or anus, using a penis, other body parts, or an object (Krug et al., 2002). The definition of sexual violence differentiates between attempted rape, gang rape, and sexual assault. Attempted rape is when an attempt is made to commit the crime, rape refers to only one perpetrator, and gang rape refers to two or more perpetrators (Krug et al., 2002). Sexual assault refers to physical injury of the sexual organs (Krug et al., 2002).

The previous Sexual Offences Act, known as the Immorality Act of South Africa 1957, only recognized sexual intercourse as non-consensual and criminal if individuals could

demonstrate that they physically resisted or verbally said no (Artz, 2004). The Immorality Act criminalized sexual intercourse with people diagnosed with ID but provided limited insight into the sexual exploitation of PWID (Immorality Act, 1957). The Immorality Act was repealed by the " Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007" (SOA). The RSA, 2007, extended the number of sexual offences relating to PWID.

The current SOA identifies sexual violation as any direct or indirect act between the genital organs, anus, breast, mouth, or an object that resembles genital organs whereby one party does not consent or is coerced to agree to the act of sexual penetration (RSA, 2007).

The SOA also distinguishes between rape and sexual assault. Rape refers to any form of penetration, and sexual assault refers to engaging in masturbation, any form of arousal or stimulation, or a sexually suggestive act (RSA, 2007). A person who engages in these acts unlawfully and without consent can be charged with rape or sexual assault (RSA, 2007).

An essential change in the SOA, 2007 is acknowledging the vulnerability of PWID to sexual abuse. Chapter 4 (ss 23-26) of the SOA expands the definition of sexual violence by including sexual exploitation, grooming, the exposure or display of child pornography or pornography of persons with a mental disability, and using persons with a mental disability for pornographic purposes. Section 57 (2) of the SOA considers consent to sexual acts and stipulates that a person who is mentally disabled is incapable of consenting to sexual activity (RSA, 2007). Although the ability to provide informed consent is contentious, it is helpful to understand that this is a legal application similar to that of children under 12 in South Africa (Combrinck, 2017).

Similarly, to the World Health Organisation's definition of sexual violence, the SOA included a list of coercive circumstances, which extends the definition of consent. The

coercive circumstances can be summarised as the use of force, threat of harm, abuse of power and authority, unlawful detention, deceit, and incapacity to consent. A PWID may have difficulty identifying risk and understanding social interactions (APA, 2013; Mills, 2009). They can be easily manipulated and are vulnerable to coercion by perpetrators of sexual crimes (Mills, 2009).

The term sexual assault has been broadly defined and used interchangeably with sexual violence, exploitation, abuse, and rape. For this study, I will use the term sexual assault, which refers to both penetrative (rape) and violent assault. However, it is worth noting that these terms have different legal definitions and can be charged separately. Furthermore, the definition of sexual assault, as pointed out by WHO and SOA, has recognized the vulnerability of PWID to sexual assault. This has resulted in greater awareness, protection, and legal redress of complaints of sexual assault.

2.4 Vulnerability of People with ID to Sexual Abuse

PWID are vulnerable to sexual assault. ID is associated with significant cognitive impairments in learning, adaptive behaviour, and acquiring skills (APA, 2013). PWID may experience challenges in communication, caring for themselves, and navigating interpersonal relationships. These impairments significantly impact their ability to be independent and self-sufficient. As such, PWID requires varying degrees of assistance in their day-to-day lives. This increases their vulnerability to exploitation and abuse. PWID may face additional difficulties due to their race, gender, poverty, economic exclusion, and access to education (Werner & Moran, 2018). These concurrent adversities increase their risk of sexual assault. Holding these adversities in mind, this section will review why PWID experiences an increased vulnerability to sexual abuse.

2.4.1 Dependency

PWID are dependent on caregivers to support them with their daily functioning. Their reliance on others to assist them in self-care, decision-making, and safety leads to the development of an unequal power dynamic that can be easily manipulated (Brownridge, 2006). They are vulnerable to sexual abuse by caregivers whom they trust. According to Tomsa et al. (2021), perpetrators of sexual abuse against PWID are often caregivers who have access to the individual in the home, group home, or institution where the complainant may live, attend school, or work (Dickman & Roux, 2005; Phasa, 2009). It is common for PWID for others to make decisions about their lives. A PWID's decision to engage in sexual relationships can be easily exploited (Euser et al., 2016; Kramers-Olen, 2016; McGuire & Bayley, 2011). Their cognitive challenges impact their ability to learn and retain knowledge. They may struggle to understand issues of sexuality and not be able to differentiate between appropriate and inappropriate sexual contact (Euser et al., 2016; Swango- Wilson, 2011). Some may recognize the sexual abuse but struggle to remember and disclose the offence (Euser et al., 2016). Perpetrators can exploit complainants' limited ability to disclose the sexual assault, leading to repeated abuse and preventing survivors from gaining appropriate support and treatment (Herskowitz, Lamb, & Horowitz, 2007; Swango-Wilson, 2011; Tomsa et al., 2021; Wyman et al., 2019). Lastly, PWID are more agreeable and vulnerable to undue pressure, threats, and persuasion. This contributes to the heightened incidence of sexual abuse against them (McCormack & Kavanagh, 2005; McGuire & Bayley, 2011; Schneider, 2006).

Their vulnerability is further compromised as they might not have adequate emotional and social skills to respond to vulnerable situations (Fisher et al., 2016; Tomsa et al., 2021). PWID have an increased need to be valued and accepted in the community (Nyokangi & Phasa, 2012; Phasa & Myaka, 2014; Spaan & Kaal, 2019; Vadysinghe et al., 2017). PWID are also socialised to be more submissive and accede to the wishes of others who are

generally perceived as higher functioning. They are therefore more willing to do anything for their perceived friends without questioning their intentions (Morano, 2001; Tharinger, Horton, & Millea, 1990). This can result in exploitation by others, possible victimization, unintentional criminal involvement, and an increased risk for physical and sexual abuse (APA, 2013).

According to Spaan & Kaal (2019) and Tomsa et al. (2021), most PWID who are complainants of sexual assault have mild (IQ 50-69) or moderate (IQ 35-49) ID. Perpetrators often seek out individuals who are easily coerced and capable of responding to their requests (Tomsa et al., 2021). This might increase the vulnerability of people with mild and moderate ID who have more control over their body, instead of passive and physically deformed individuals, like those with severe and profound ID (Tomsa et al., 2021). Nevertheless, the literature cautions against neglecting people with severe and profound ID (Herskowitz et al., 2007, Pillay, 2012). The lower number of complaints with severe and profound ID might be due to significant speech production and cognition challenges (Herskowitz et al., 2007). Reports of sexual assault may be less noticeable and under-reported in people with severe and profound ID (Herskowitz et al., 2007; Pillay, 2012).

2.4.2 Historical Beliefs and Myths

Unhelpful beliefs about the sexuality of PWID exist in homes, communities, police stations, and the judicial system (Antaki et al., 2015; Keilty & Connelly, 2010; McCormack, Kavanagh, Caffrey & Power, 2005). These historical beliefs about the sexuality of PWID contribute to the ongoing victimization (Vadysinghe et al., 2017; Werner & Moran, 2018). The sexuality of PWID has sometimes been miscategorized as either asexual or hypersexual. Those who view PWID as asexual beings believe that PWID are uninterested in sex or unable to participate in sexual activities (Claassens et al., 2019; Hanass-Hancock, Nene, Johns, & Chappell, 2018; Meer & Combrinck, 2015; Phasa & Myaka, 2014; Vadysinghe et

al., 2017; Watermeyer et al., 2019). Others are believed to be hypersexual and cannot control their sexual drive (Claasens et al., 2019; Meer & Combrinck, 2015; Vadysinghe et al., 2017). These perceptions are harmful as they denigrate affected individuals and portray them as less than human which creates doubt or leads to dismissing sexual assault reports within this population (Meer & Combrinck, 2015; Vadysinghe et al., 2017).

2.4.3 Finance

PWID requires daily support, including specialized services such as health care, education, housing, and physical support. Their disability limits opportunities to access gainful employment and the ability to support themselves financially. As a result, most PWID becomes the financial responsibility of their families, caregivers, or the State. The financial cost of their care may burden the family system and increase the vulnerability of PWID. This section examines the economic impact of supporting PWID in the Western Cape, South Africa.

Approximately 180 500 people live with ID in the Western Cape (WC), and South Africa (SA) (Western Cape Government, 2014). Of this total, only 3828 (2.1%) PWID have access to community-based care or residential placements (Western Cape Government, 2014). Most PWID are cared for by their families (Western Cape Government, 2014). Family structures in SA are complex and influenced by multiple factors (Khan et al., 2020). A third of SA's children live with their biological parents; others live with single parents, on their own, with relatives, or in foster care (Khan et al., 2020).

In some cases, HIV and AIDS have contributed to child-headed households or resulted in grandparents raising young children whose parents have died (Khan et al., 2020). These different family structures typically have higher levels of unemployment and poverty and tend to be home to a large proportion of people with disabilities, including ID (Khan et

al., 2020). Families who care for PWID are more disadvantaged than those who don't care for PWID (Khan et al., 2020). These families frequently depend on state-funded facilities when accessing health and education services. They are likely to travel greater distances when accessing services, which may directly impact their finances, as parents or caregivers often have to spend time away from work (Khan et al., 2020).

To assist with the financial cost of living with ID, the South African government provides a social security grant to vulnerable individuals. PWID receive a monthly social grant of R1890.00 while their carer receives an additional R400.00 (Western Cape Government, 2014). The social grant received is insufficient to meet the financial needs of persons with ID (Khan et al., 2020). This includes medical care, education, living costs, social and leisure, and day-to-day living expenses (Bowers, 2019). According to Bowers (2019), ID is a life-long disability, and the demand for care increases with age. Individuals with ID might also be diagnosed with co-existing and co-occurring mental, neurodevelopmental, medical, and physical conditions, which place an additional financial burden on families caring for PWID (Bowers, 2019).

2.4.4 Race and Class

The overlaps between race and ID cannot be ignored, especially in South Africa, with its history of Apartheid and legislated racist exclusion. This section will briefly discuss the intersection of race and ID.

Apartheid was a system of governance that divided and distributed resources according to race. As part of the Apartheid ideology, White people were regarded as superior to persons of colour, particularly with regard to attributes such as intelligence. White South Africans were given access to superior education, healthcare, employment, and living conditions (Watermeyer, 2018). Those classified as Black- a collective term ascribed to racial

groups previously identified as Coloured, Indian, and Black African- were forcefully removed and relocated to segregated areas, which were overcrowded and poorly serviced (Mkabile & Swartz, 2020; Watermeyer, 2018). The quality of education was graded, so that white people received the best education, while coloured people received an intermediate education. Black South Africans were offered the lowest quality of education; this limits them only to seek out low-income employment opportunities. The Apartheid system was discriminatory and perpetuated conditions of poverty and inequality, which still exist more than two decades after South Africa became a democratic country (Mckenzie & McConkey, 2016; Meth, 2016, Mkabile & Swartz, 2020).

Although ID can occur across all races, those who live in poverty are more vulnerable to being born with ID (APA, 2013). Poverty-stricken communities are known to have high crime, violence, and substance abuse, and these factors contribute to poor neonatal, prenatal, and perinatal health care which are also implicated in the development of ID (APA, 2013; Meth, 2016). Although the Apartheid system has been abolished, the impact of racial discrimination has not been addressed (Mkabile & Swartz, 2020). Individuals classified as Black and diagnosed with ID may still experience extreme levels of exclusion and exploitation in most areas of their social life, including education, employment, recreation, and sexual relationships (Meth, 2016; Watermeyer, 2018).

2.4.5 Gender and ID

The chances of being sexually assaulted are higher for women and girls than men regardless of the presence of ID (Calitz et al., 2014; Dickman & Roux, 2005; Gil-Llario et al., 2019; Platt et al., 2017; Vadysinghe et al., 2017). This vulnerability increases for women with ID (Medina-Rico et al., 2017). Historically girls have been raised to be more dependent, submissive, and agreeable (Wilson et al., 2020). The socialization of gender roles increases women's chances of being more vulnerable to sexual abuse (Wilson et al., 2020). Those with

ID are even more at risk, as they might not question the appropriateness of the perpetrator's actions and are less able to avoid exploitation.

Men with ID are twice as likely to be sexually abused than men without ID (Medina-Rico et al., 2017; Wilson et al., 2020). Despite this, the sexual activity of men with ID is mostly discussed as problematic sexual behaviour (Wilson et al., 2020). This often includes public masturbation, prescription anti-libidinal medication, and unwanted touching of female caregivers and does not adequately address the sexual abuse of men with ID (Wilson et al., 2020).

2.4.6 Education and ID

Education is a protective factor against sexual assault (Fisher et al.,2016; Swango-Wilson, 2011). Sexuality education empowers PWID to make decisions about their sexuality and increases their ability to recognize when others' sexual behaviour towards them is inappropriate (Murphy & O'Callaghan, 2004; Swango- Wilson, 2011). Individuals who receive limited or no education are more vulnerable to exploitation. Education of PWID has often been under-resourced and resulted in PWID being excluded or overlooked (Brownridge, 2006; Horton & Shakespeare, 2018). The following section discusses the education of PWID within the South African context.

After the abolishment of Apartheid, the South African government attempted to address the inequalities of apartheid, this included service delivery of education. The right to basic education is included in the South African constitution; however, implementing these rights for PWID has remained slow. In 2001 the South African government adopted White Paper 6: Special Needs Education: Building an inclusive education and training system to address the educational needs of people with disabilities (DOE, 2001). White Paper 6 outlined a 20-year plan which included the upskilling of teachers to accommodate children

with disabilities, including learners with mild and moderate ID in the mainstream school. It also emphasized the importance of early identification of learning barriers and high-quality service for learners with severe and multiple disabilities (Horton & Shakespeare, 2018). Since the adoption of White Paper 6, the educational services for PWID have accommodated mostly people with mild and moderate ID (Fosket, 2014). The educational needs of people with severe and profound ID have been neglected (Fosket, 2014; Ngwena & Pretorius, 2012; McKenzie et al., 2019). Learners with Severe and Profound ID have high-intensity support needs and require continuous care and support (McKenzie et al., 2019). They cannot enroll in mainstream or special needs schools that are unequipped to meet their needs (McKenzie, 2021). This lack of service provision for those with Severe and Profound ID has been challenged by support groups such as the Western Cape Forum for Intellectual Disability (WCFID), which maintains that the education of PWID are still neglected (Horton & Shakespeare, 2018).

Inability to access education has increased the vulnerability of PWID, as it restricts their autonomy and ability to live self-directed lives (Swango- Wilson, 2011). A study on the life experiences of PWID who had access to education found that education increases the individual's self-esteem, they feel more confident and independent, have a wider social network, and better employment opportunities (Corby, Taggart, & Cousins, 2020; Werner & Moran, 2018).

2.4.7 Sexuality Education

The right to sexuality education and understanding of sexual and reproductive health is important for empowering all individuals as it increases self- esteem, confidence, and overall wellbeing. Historically these rights have been neglected in PWID and increased their vulnerability to sexual abuse. Similar to people without ID, PWID are challenged with issues of sexual development, sexual identity, sexual expression, and navigating social relationships.

Navigating these areas of sexuality are particularly difficult for PWID who have additional challenges such as forming social and intimate relationships. The lives of PWID are often characterised by discrimination, coercion, and violence. To mitigate this vulnerability parents and caregivers are often risk-averse and restrict access to opportunities that would develop their individual social and sexual identity (Frawley & Wilson, 2016). The rights of PWID are frequently violated and this includes sexuality rights and access to sexuality education (de Wit, van Oorsouw, & Embregts, 2022).

Sexuality education has been identified as a protective factor against sexual abuse (Murphy & O'Callaghan, 2004; Swango- Wilson, 2011). A qualitative study about the capacity of PWID to consent to sexual relationships found that individuals with ID have less sexual knowledge than people without ID (Borawska-Charko, Rohleder, & Finlay, 2016; Hanass-Hancock et al., 2018; Murphy and O'Callaghan, 2004). This could be attributed to inadequate sexuality education received in the home schools or workshops. PWID are cognitively and emotionally less developed than peers without ID. They are less likely to be exposed to informal learning opportunities, such as information shared between peers or magazines, or to have conversations with their parents about sex (Hanass-Hancock et al., 2018; Murphy and O'Callaghan,2004).

A study conducted with nursing staff who worked with PWID found that staff only engaged in sexuality education when individuals reached puberty, have specific questions about sex or displayed problematic sexualized behaviours (Schaafsma et al., 2014). The initiation of sexuality education due to individuals' cognitive, emotional and physiological appropriate capacity was rated as the lowest reason to initiate sexuality education (Schaafsma, et al., 2014). Caregivers and people who work with individuals with ID might avoid sexuality education due to their discomfort with teaching subject matter that includes

sexuality (Hanass- Hancock et al., 2018; Kramers-Olen, 2016; Schaafsma et al., 2014). Staff may also infantilize PWID and fear that discussing sex with PWID will lead to sexually inappropriate behaviours (Schaafsma et al., 2014).

The absence of comprehensive sexuality education increases vulnerability to sexual abuse. Sexuality education for PWID often focuses on puberty, physiology, body boundaries, and the identification of improper sexual relationships (Swango- Wilson, 2011). Although these themes are helpful, they are not comprehensive and do not adequately prepare individuals to engage in sexual relationships. Sexuality education should also include information about pregnancy, sexually transmitted infections (STIs), self-assertion skills, means of escaping the perpetrator, and what they should say or do when they are confronted with a threatening situation (Schaafsma et al., 2014; Swango- Wilson, 2011). In addition to this, knowledge about their sexual rights and the legal aspects of sex should also form part of sexuality education for PWID (Borawska-Charko et al., 2016; Murphy & O'Callaghan, 2004). The lack of knowledge about sexual rights and how to respond in situations that involve sexual decision-making skills increases the risk of sexual exploitation (Borawska-Charko et al., 2016; Murphy & O'Callaghan, 2004; Schaafsma et al., 2014).

As noted in this chapter, PWID are disadvantaged and marginalized on multiple levels. Their neurodevelopmental deficits impair their communication, cognitive and social abilities. These deficits increase their vulnerability to sexual abuse as they are less likely to recognize a dangerous situation. PWID have to navigate membership to multiple social groups. They may be disadvantaged or discriminated against based on race, gender, access to education, and economic resources. The interconnectedness of these different factors can challenge individuals' capacity to protect themselves against sexual assault and their ability to access legal reparation.

2.5 Engagement with the Justice System

PWID are more disadvantaged when interacting with the criminal justice system than the general population (Beckene et al., 2020; Cooke & Davies, 2001; Cossins, 2020; Green, 2001). The cognitive deficits of an individual with ID, including their ability to reason, solve problems, plan, think and perform daily tasks, may disadvantage a complainant when providing a statement and filing a charge. These deficits affect complainants of sexual assault who engage with the justice system.

Sexual assault is one of the most under-reported crimes globally (Dworkin et al., 2021). Complainants who report sexual assault may struggle to gain justice, as sexual assault is associated with low prosecution and conviction rates (Cossins, 2020; Phasa, 2009). It is difficult to prove allegations of sexual assault as the complainant is often the only witness against the perpetrator (Cossins, 2020). The difficulty of proving allegations of sexual assault leads to high attrition rates for charges of sexual assault (Cossins, 2020). Attrition refers to dropping out of cases within the criminal justice system before being prosecuted (Lea et al., 2003). Charges can be dismissed at various stages of investigation by the police, prosecutor, or court services. While interviewing the complainant, legal professionals and prosecutors decide how credible they think the complainant is (Antaki et al., 2015; Lea et al., 2003;). When a complaint is filed, police officials determine whether the act is an offence or a "no-crime'' (Cossins, 2020). The case is referred to the prosecutor if the charge is an offence. Based on the evidence provided, the prosecutor decides if the evidence is sufficient to prosecute in court. The courts must determine if the perpetrator is guilty or not guilty. If the witness is deemed unreliable, the charge against the perpetrator may be dropped without it reaching court. Historically the criminal justice system has regarded PWID as unreliable witnesses (Beckene et al., 2020; Calitz, 2011, Cossins, 2020; Green, 2001). This disadvantages a complainant with ID who seeks to gain justice for sexual assault. The

following section will discuss the challenges faced by PWID when interacting with the criminal justice system.

2.5.1 Reporting Sexual Abuse

PWID are more vulnerable to sexual assault and less likely to report it than the general population. According to Chave-Cox, (2014), only 3% of sexual abuse cases involving PWID are reported to the police. This first step of reporting the crime is critical if the complainant seeks legal justice. When reporting sexual assault, PWID faces additional barriers (Chave-Cox, 2014). These include needing the assistance of caregivers or family members to report the offence (Phasa, 2009). They may also struggle when engaging with police officials. Reporting sexual assault can be retraumatizing, especially for complainants with ID (Gudjonsson et al., 2000). What follows is a brief discussion of these challenges.

The cognitive impairments of PWID make it more difficult for them to communicate, express their emotions and report the sexual assault to authorities (Beckene, Forrester-Jones, & Murphy, 2017). As a result, PWID who have been sexually assaulted often depend on others to report the sexual abuse (Beckene et al., 2017; McCarthy, 2000; Phasa, 2009; Pillay,2012). This becomes problematic when caregivers choose not to report the incident to authorities. Caregivers may choose not to report the incident based on a number of factors, such as their beliefs, guilt, or shame (McCarthy, 2000; Phasa,2009). Caregivers might also dismiss incidents of sexual assault if the perpetrator is a family member or colleague (Dworkin, Krahé, & Zinzow, 2021; Phasa, 2009). Institutions may neglect to report sexual assault for fear of losing funding or damaging their reputation (Phase,2009). They may record the offences as inappropriate behaviour or misconduct, not sexual assault (Phasa, 2009). Failure to report increases the vulnerability of PWID and may lead to ongoing sexual assault.

Reporting the offence is crucial in accessing justice. While providing a statement to police officials, the complainant has to recall details of the assault. This interview is a forensic interview that differs from other interviews (Antaki et al., 2015). To assess if a crime was committed, the officer solicits information about the crime and the perpetrator. Their primary goal is to gather evidence to help the investigation, locate the perpetrator and lead to prosecution. During this interview, the police official evaluates the complainant's credibility as a witness. This process can be compromised if the police officer conducting the interview has a limited or no understanding of ID (Beckene et al., 2020). A complainant might struggle or take longer to answer questions. If the police officer is not knowledgeable about the PWID's communication and comprehension deficits, they may perceive the complainant as an unreliable witness.

The process of reporting can be retraumatizing. A complainant of sexual abuse often experiences severe emotional, physiological, and behavioral symptoms resulting from the assault (Antaki et al., 2015; Gudjonsson et al., 2000). These symptoms would increase in frequency for a complainant with ID, whose adaptive functioning is limited. While conducting the forensic interview, the police officer may be less attentive to the complainant's emotional status. A study that reviewed how officers deal with expressed distress from complainants with ID found minimal or no acknowledgment of the complainant's emotional pain (Antaki et al., 2015).

PWID are more reliant on others for support in their daily lives due to their impaired cognitive and adaptive abilities (Joke, 2018). This support is essential for complainants of sexual assault during the initial interview. Without the help of family members or caregivers, most complaints of sexual assault go underreported (Gudjonsson et al., 2000). When the assault is reported, the police officials' ability to identify and understand a complainant with ID may provide support and decrease the trauma experienced by complainants. PWID are

more likely to report and seek prosecution when feeling supported, which may contribute to the perpetrator's conviction (Chave-Cox, 2014).

2.5.3 Evidence Gathering

The credibility of the witness and the evidence gathered during initial police interviews determine whether the offence will be placed on the court roll and prosecuted. Although providing a statement can be challenging for all complainants of sexual abuse, PWID may have greater difficulty engaging with the justice system. While giving a statement, a PWID may have significant challenges with recall, understanding time frames, communicating, and managing emotional and behavioural responses. This may impact the process of gathering the evidence needed for the successful prosecution of the perpetrator. A South African study reporting the prevalence rate of sexual assault found cases may not be referred for prosecution for several reasons (Steele et al., 2019). Administrative inconsistencies, the quality of evidence gathered against the perpetrator, and the extent of the complainant's physical injuries determine if an alleged assault will be prosecuted (Steele et al., 2019; Vetten, et al., 2016). This section elaborates on these factors.

The lack of identifying information obtained during the first interview can influence further investigation and prosecution (Vetten et al., 2016). Police officials may struggle to investigate if the complainant's contact details, such as an address, telephone number, and alternative numbers, are incorrect (Steele et al., 2019; Vetten et al., 2016). The lack of witness statements or identifying information about the perpetrator also negatively impacts the chances of prosecution (Steele et al., 2019; Vetten et al., 2016).

Prosecution of sexual assault cannot occur unless the complainant identifies a perpetrator and sufficient evidence proves the alleged assault. Forensic evidence collected from the complainant and the alleged perpetrator is essential. In most countries, the collection

and analysis of DNA have become a routine part of sexual assault investigations (Malema, 2020). If collected, preserved, and analyzed correctly, it can provide a DNA profile of the perpetrator (Kaur et al., 2021, Malema, 2020). This medico-legal evidence contributes to making an arrest and filing a criminal charge and can lead to the perpetrator's conviction. In South Africa, evidence is typically gathered via the Sexual Assault Evidence Collection Kits (SAECKs), also known as rape kits. The SAECKs are used to gather biological forensic evidence after a sexual offence occurs (Malema, 2020). The forensic examination should happen within 72 hours of the assault (National Health Act, No 61 of 2003). This might be difficult when the complainant has ID. Like children, PWID rarely discloses the assault immediately (Kaur et al., 2021). They might hesitate to report because they don't understand the nature of the offence or are threatened by the perpetrator (Kaur et al., 2021). Accidental disclosures may occur when the complainant experience pain in the abdomen or genital parts or if blood is noted on their underwear (Blackie, 2014; Kaur et al., 2021).

Medical officials should consider two factors when examining PWID: the ability of the PWID to consent to the medico-legal exam and if conducting the exam is in the individual's best interest (Kramers-Olen, 2016). PWID's cognitive age differs from their mental age; they are developmentally younger than their peers and may lack the capacity to consent. Consent needs to be obtained from the PWID before the examination. The individual must understand what a medico-legal exam is and use this information to decide if they want to proceed with the examination (Chave-Cox, 2014). Given the deficits of ID and the trauma of being sexually assaulted, this decision may be more difficult for a PWID (Chave-Cox, 2014). Practitioners must consider the best interest of the PWID. A medico-legal examination is intrusive and can be distressing for any complainant of sexual assault (Chave-Cox, 2014). The likelihood of recovering DNA evidence should be considered using the timeframes for DNA collection and how much the complainant has washed since the assault. Other options,

such as obtaining DNA from clothing and underwear, may be less traumatizing (Chave-Cox, 2014; Kaur et al., 2021).

It has been shown that sexual assault cases are more likely to go to court when there are physical injuries (Cossins, 2020; Steele et al., 2019). Should a complainant have no injuries, the perpetrator has an increased chance of not being prosecuted (Steele et al., 2019). Caregivers and family members are often perpetrators of the sexual assault of PWID (Euser et al., 2016; Wyman et al., 2019). As PWID depend on their caregivers, they would likely be more agreeable and vulnerable to exploitation. This decreases the chances of being physically injured by a perpetrator who may not have to use force.

The sexual assault cases of PWID have a high chance of not being prosecuted. The inability to recall identifying details when filing a complaint prevents further investigation. Medico-legal and physical evidence are determining factors for referring the offence for prosecution, and these examinations can be intrusive and may be more challenging to obtain. In addition, some PWID are assaulted by caregivers who they trust. This can result in delayed reporting, which impacts the gathering of DNA evidence or may not have any physical injuries.

2.5.4 PWID and Oath Taking

Historically PWID is regarded as unreliable witnesses (Henry et al., 2011). As a result, their competency to testify is evaluated at various points in the justice system. In South Africa, public prosecutors who may have identified a complainant with ID as identified by official police statements or the medical practitioners' reports will refer the complainant for forensic psychological assessment before providing testimony in court (Pillay, 2012). This expert assessment informs the court about the complainant's level of ID and their ability to testify which activates certain parts of the legislation that serve to protect the rights of PWID

(Pillay, 2012). This includes the Criminal law Amendment Act No 51 and the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (Republic of South Africa, 2007; Republic of South Africa, 2007). For example, Section 51 of the Criminal Law Amendment Act No 51 provides for a life sentence for the sexual assault of a PWID (RSA, 2007). Expert opinion on the complainant's ability to testify is essential as the absence of it could decrease the chances of the complainant's receiving justice (Pillay, 2012). The report can also serve as motivation for the use of an intermediatory as noted in Section 68 of the SOA.

The ability to testify is divided into the individual's basic competency to observe, remember and communicate information and their understanding of abstract concepts such as "oath," a "promise," and "truth" before they provide testimony (Beail, 2002). If the witness cannot display this competency, the court may choose not to hear her/his evidence (Cossins, 2020). Although these capacities are needed requirements by legislation it should not be assumed that all PWID cannot participate in court proceedings (Gudjonsson et al., 2000). According to Lee, Lindsay, Talwar, & Bala; 2010 children's capacity to understand and answer questions is a more meaningful and realistic evaluation of their capacity to testify than an inquiry into their ability to understand abstract concepts. The justice system's emphasis on understanding concepts such as oath-taking and truth-telling may prevent vulnerable complainants such as children and PWID who have cognitive deficits from giving testimony (Lee et al., 2010; Henry et al., 2011). This also negatively impacts their chances of having the perpetrator convicted.

Studies also suggest an individual's ability to correctly identify abstract concepts such as truth, lies, and promise, does not mitigate lying in court (Beail, 2002; Lee et al., 2010; Talwar et al., 2004). The dependency on care that PWID require in their daily lives might prevent them from telling the truth, as survivors of sexual abuse may lie to protect the

perpetrator if the perpetrators are caregivers or family members (Phasa, 2009; Talwar et al., 2004).

2.5.5 PWID and Capacity to Consent

According to section 1 of SOA consensual sexual activity is voluntary and free from coerced circumstances for all parties involved (RSA, 2007). This is particularly important for PWID. Compared to their typically developed peers, PWID are socially and emotionally immature. They may struggle to understand the intentions of a perpetrator, and their cognitive deficits may decrease their knowledge of the consequences of sex (Green, 2001). As such, PWID may have difficulty resisting sexually exploitive situations and have an increased chance of being sexually assaulted. Although PWID have an increased vulnerability to sexual abuse, people with mild or moderate intellectual disability can form consensual relations. This is important as denying that all people with ID are unable to consent to sexual relationships due to deficits discriminates against PWID. According to the SOA PWID cannot consent to sexual activity if any one of the four criteria stipulated in the ACT are met (RSA, 2007). This includes if the complainant was unable to appreciate the nature and consequences of the act; where complainants are able to understand the appreciate sexual activity but unable to appreciate the alleged offence; are unable to resist the alleged offence and unable to communicate his or her unwillingness to participate in the act. When evaluating the capacity to consent for legal purposes, the psychologist is only responsible for commenting on the complainant's capacity of consent during the alleged assault (Dickman, 2019). By only focusing on the alleged assault PWID are not portrayed as someone with no capacity for consent but just unable to give consent at the time of the sexual assault (Dickman, 2019).

2.5.6 Testifying in Court

PWID are often viewed as unreliable witnesses who have greater difficulty conveying their testimony consistently and coherently (Phasa, 2009). Their cognitive challenges increase the likelihood of being more compliant and suggestible than witnesses without ID (Gudjusson et al., 2000). These challenges are amplified for complainants of sexual assault who have to convey sensitive details in a courtroom. The cognitive and adaptive impairments of PWID significantly disadvantage them when engaging with the justice system. The following section will discuss the challenges that witnesses with ID face in the courtroom.

According to Cossins (2020), the prosecution and conviction of the perpetrator are performed using the adversarial justice system in many countries. The adversarial justice system relies on the cross-examination of the witness. The witness must repeat precise details of the sexual assault while the defence counsel questions them. The complainant's ability to remember facts is crucial in determining successful prosecution and conviction. Any complainant who has been sexually assaulted may struggle to remember specific details, irrespective of an ID diagnosis. A victim of sexual assault may activate coping mechanisms such as dissociation (detachment from their environment) or thought suppression (avoiding any thoughts related to the trauma) to manage the trauma of sexual assault (Berliner et al.,2003). These coping mechanisms may cause the complainant to forget and leave out details of the assault (Berliner et al.,2003). The defence can use the discrepancies in the witness's testimony to discredit the witness and lead to the acquittal of the perpetrator (Bettenay et al., 2014; Kebbell, Hatton, Johnson, & O'kelly, 2001). For PWID, these risks are even greater. Memory deficits are a significant feature of ID, and the ability to recall is poorer among PWID than those without. Their deficits with recall become even greater when they have been sexually assaulted (Beail, 2002; Kebbel et al., 2001).

Memory impairment also increases the chances that the witness will be suggestible. PWID may struggle to answer misleading questions and are likely to be influenced by the opinions of others (Beail, 2002). The defence might argue that the complainant is not a competent witness. The questioning style of defence lawyers have been criticized as unsuitable for PWID (Antaki et al., 2015; Beail, 2002; Kebbel et al., 2001). The current interview techniques have been developed and tested on people without ID and do not consider the developmental and social needs of PWID. The deficits of PWID also present differently in each individual, and the varied adaptive functions can be overwhelming for criminal justice professionals who are not adequately prepared. Criminal proceedings interview techniques are often limited to suggestive and unreliable questions such as closed-ended and forced-choice methods, which could elicit a yes or no response from the complainant and do not encourage more detailed answers (Antaki et al., 2015; Wyman et al., 2019).

Free recall is an interview technique that is advantages for complainants with ID (Henry et al., 2011; Wyman et al., 2019). It allows witnesses to give their account of the sexual assault in their own words and at their own pace without interruptions (Henry et al., 2011). This technique enables the complainant to provide a more detailed and accurate account (Brown et al., 2012; Wyman et al., 2019; Kebbel et al., 2001). Another technique that might elicit more information is cognitive load interviews. Cognitive load interviews are an interview technique that asks the responder to reconstruct the event in their mind, recalling sights, smells, emotions, and things that they heard or touched, describing the events from another perspective, or recollecting events in reverse order (Wyman et al., 2019). When used with vulnerable groups like children and PWID, it elicits more expansive and accurate testimonies (Wyman et al., 2019). Lastly, scaffolding and explaining each part of the

interview or facilitating the interview using non-verbal techniques may also be more suitable for PWID (Cooke & Davies, 2001; Wyman et al., 2019).

Although these interview techniques are more suitable for PWID, legal professionals tend to use closed-ended questions when interviewing complainants with ID (Wyman et al., 2019). Closed-ended questions are criticized for encouraging suggestive responses by complainants, and responders can be intentionally or accidentally manipulated into choosing a specific answer (Brown et al., 2012; Brown et al., 2017; Cooke & Davies, 2001; Wyman et al., 2019). Furthermore, closed-ended questions can lead the complainant to omit essential facts, which can be used to discredit the witness as unreliable and avoid prosecution of the perpetrator (Beail, 2002).

In South Africa, sexual assault charges are tried in specialized sexual offence courts. These courts were established across the country after a successful pilot project in the Western Cape in 1993 (Dickman, 2019). The courts are intended to support complainants in achieving legal redress in a quick, responsive, and caring manner that does not lead to secondary traumatization (Dickman, 2019). Education about legal processes and the terms used in court is provided to witnesses. Witnesses are also provided with skills and information to cope with the stress of giving evidence. An intermediary is an individual appointed by the court to convey questions from either legal team to the witness. They may also simplify questions without changing the meaning, subject to court monitoring processes. In addition, witnesses are allowed to testify through camera services, which limits contact between the perpetrator and the complainant. (Cooke & Davies, 2001; Department of Justice and Correctional Development, 2021).

Although these courts have done remarkable work in the field of sexual violence, they are not without limitations. The costs required to sustain the courts have reduced resources

and services distributed amongst courts. The lack of resources led to the closing down of some courts (Dickman, 2019). Prosecutors and complainants have different opinions about the courts. Prosecutors reported their experience of the court as positive (Walker & Louw, 2005; Department of Justice & Correctional Division, 2021). At the same time, complainants and their families found the service provided by the specialized courts less favorable (Walker & Louw, 2005). Complainants report that they receive insufficient support after testifying and are not always informed of the trial's outcome or the perpetrator's sentence (Walker & Louw, 2005). In 2013, a governmental task team recommended reopening the courts that had closed while attempting to avoid the original shortcomings (Department of Justice & Correctional Division, 2014). Currently, 108 courts are active, as noted in the 2020/2021 Department of Justice and Correctional Services report (Department of Justice & Correctional Division, 2021).

2.6 Conclusion and Rationale for the Present Study

Compared to people without ID, PWID have a greater risk of being targeted for sexual assault (Calitz et al., 2014; Dickman & Roux, 2005; Gil-Llario et al., 2019; Platt et al., 2017; Vadysinghe et al., 2017). Their risk of sexual abuse is more significant as they depend on others to assist them in their daily lives. These may include eating, bathing, dressing, and more complicated tasks like navigating their safety in society. Furthermore, their developmental deficits limit their emotional and social skills, which may be inadequate for assessing and responding to vulnerable situations (Fisher et al., 2016; Tomsa et al., 2021).

Individuals with mild and moderate ID are particularly vulnerable to sexual abuse as they are likely to live in communities with family and friends and may be exposed to a broader circle of perpetrators (Phasa & Myaka, 2014; Todd, 2005). They are also more able to follow the instructions of perpetrators compared to individuals with severe and profound ID whose functioning is severely impaired. Therefore, individuals with mild and moderate ID

have a greater risk of being sexually abused than those who are more severely impaired. Despite the increased risk of sexual abuse, complainants with ID struggle to gain justice for sexual abuse crimes committed against them. They are regarded as unreliable witnesses who cannot understand legal proceedings, which prevents them from providing testimony in court. Given this, PWID who have been sexually assaulted have a low chance of gaining prosecution and conviction of their perpetrator.

The present study used data from Cape Mental Health (CMH). CMH is a non-profit organization that provides psycho-legal services to sexual assault complainants with ID in the Western Cape. This study aims to contribute to the existing literature by investigating if the court case outcomes are associated with specific factors of the complainant with ID. This would include if the complainant's level of ID predicts the court case's outcome. The study also investigated if the complainant's ability to consent to a sexual relationship and their ability to testify in court would predict the outcome of the court case.

Chapter 3

Method

3.1 Study Design

This research followed a cross-sectional, correlational study design. Cross-sectional studies allow us to describe the overall phenomenon and its prevalence within a given sample from data collected around the same time (Leavy, 2017). In turn, correlational research enables us to test for potential associations between variables of interest (Leavy, 2017). According to Levin (2017), one of the advantages of a cross-sectional correlational study design is estimating the prevalence of multiple outcomes and assessing various risk factors. This is particularly useful in this study because the perpetrator's conviction may be linked to multiple factors. One disadvantage of cross-sectional data is that although cross-sectional studies help determine the prevalence of an outcome, they do not explain why the outcome was achieved (Mann, 2003).

The data were primarily archival information previously collected by others (Jones, 2010). There are several advantages of archival data. An extensive dataset's availability may be advantageous when limited resources are available Jones (2010). It is also time-effective, as information is already recorded. Archival data provides a large data set which is valuable when conducting statistical analysis (Jones, 2010). However, as archival data relies on data collected in the past, there may be a strong probability of missing information that is vital to the study (Jones, 2010).

3.2 Setting

The research was conducted at Cape Mental Health (CMH). CMH, formerly known as the Cape Province for Mental Hygiene, is a non–profit organization situated in Cape Town, Western Cape, that provides services to adults and children with mental health problems

(CMH, 2018). All clients served by Cape Mental Health live in the Western Cape, with the majority of clients from areas in greater Cape Town, as well as the Cape Flats (including areas such as Elsies River, Khayelitsha, Manenberg, and Mitchell's Plain) (CMH,2018). . CMH also serves clients in rural areas, including the Overberg region and other West Coast areas. The clients served by CMH do not have access to private medical care and are state-funded. The centre plays a vital role in advocacy, disability training, education, and awareness among clients and stakeholders (CMH, 2018).

Cape Mental Health has been doing ground-breaking work in supporting individuals with ID. One of its contributions is implementing the Sexual Abuse Victim Empowerment (SAVE) programme. SAVE was established in 1991 in response to a request by the Department of Justice for assistance in cases involving complainants with intellectual disabilities who reported crimes of sexual violence, sexual assault, and rape (Dickman & Roux, 2005). This psycho-legal programme provides complainants and their families with the necessary support before, during, and after the court case. This includes court preparation of the complainant, a psychological evaluation to assess the complainant's level of intellectual functioning, ability to consent to sexual activity, and competence to act as a witness (Dickman, 2019; Mckenzie,2010; Todd, 2005). Finally, the clinical psychologist compiles and submits a report to the court as evidence and is available to act as an expert witness should the need arise. The inception of SAVE has contributed to a steady increase in attention to such cases within the justice system (Todd, 2005). Currently, the Department of Justice refers more than 120 cases per annum to CMH for psychological assessment, court preparation, case planning, and support throughout the court process (CMH, 2015). This clinical assessment model and the expert witness have enormous potential to influence prosecution and conviction processes. A previous study – which assessed 100 Save cases between 1990 and 2000 – found that SAVE achieved a 28% conviction rate, higher than the

21% rate for those cases from the general population that go to trial in South African Sexual Offences courts (Dickman & Roux, 2005)

3.3 Participants

All complainants included in this study were referred to CMH for court assessment between 2011 and 2016 by the assigned investigating officer or prosecutor. The client had allegedly either been sexually assaulted and /or raped in each instance. Moreover, all complainants of sexual abuse had to have a confirmed ID diagnosis. Finally, each case had to have been proposed for presentation in court, been presented in court and subsequently withdrawn, or resulted in either a guilty or not guilty verdict.

Although an initial review of CMH's dataset produced a sample of 623 participants, only 493 of these cases were included in the final sample as not all participants met the full criteria outlined above. A further reduction in the sample occurred when exploring factors associated with court outcomes. Only cases that received either a guilty or not guilty verdict were included in the statistical analysis, reducing the sample to 167.

The complainants varied in terms of sex, age, and race. The complainants lived either in a rural or urban area within the Western Cape at the time of assessment at CMH. The demographics of the sample will be presented in the Results chapter (Chapter 4). The sample size exceeded that used in many other similar studies, for example, that of Dickman and Roux (2005). Therefore, it was deemed large enough to conduct descriptive and inferential statistics while ensuring that the study could be completed within the given period.

3.4 Measures

Level of ID.

The level of ID of complainants was determined by the DSM-IV-TR diagnostic criteria, using both an Intelligence Quotient (IQ) and a measure of adaptive functioning

(DSM; APA, 2013; Mckenzie,2010). Adaptive functioning was determined by the Vinelands Adaptive Behaviour Scales 2nd edition (Vinelands-II). The Vinelands- II is a semi-structured interview with the complainant's caregiver that determines their performance of daily activities according to four domains: communication, daily living, socialization, and motor skills (Sparrow, Cicchetti, & Balla, 2005; Mackenzie, 2010). The performance in these domains informs the range of the individual's functioning, i.e., mild, moderate, severe, or profoundly impaired. The IQ scores were measured with the Individual Scale for General Scholastic Aptitude (ISGSA), developed in 1994. This is an adjusted, standardized version of the Old South African Individual Scale (Van Eeden, 1991). The ISGSA are used to diagnose and classify children with ID to be referred for special education (Louw, 1998; Mackenzie, 2010). The ISGSA is suitable for children with English and Afrikaans as their primary language ages between six and 12 years old (Louw, 1998). The DSM-IV diagnostic criteria were applied for this study, emphasizing the individual's adaptive behaviour as assessed by the Vinelands-II and not the individual's IQ scores.

All complainants had to have a diagnosis of ID to be included in this study. Complainants with Borderline Intellectual Functioning were included in this study as complainants diagnosed with Borderline Intellectual Functioning were also referred to SAVE and underwent psychological assessment similar to PWID.

CMH 'psychologists' interview guide.

Each complainant was interviewed and assessed by an individual psychologist using a standard interview guide (Appendix A). Data for this study were extracted from this interview guide. The information obtained included biographical information, such as sex, age, race, language, education, and socio-economic status (SES). The SES was determined by assessing the parents' level of education, occupation, and if complainants receive any income

through employment or social grants. Court-specific data such as the type of charge filed and the outcome against the perpetrator were also noted. The level of ID as specified by the psychometric assessments was also extracted.

Case outcomes.

The outcome of court cases was unknown to the assessing psychologist and, therefore, not recorded in the interview guide. With permission from CMH, the case outcome was gathered through telephonic interviews and emails with the respective investigating officers or clerks at the police station.

3.5 Procedure

The archival data used in this study were collected from case files recorded by consulting clinical psychologists who assessed the complainants. Files from 2011-2016 were selected and captured by the researcher on the Cape Mental Health (SAVE) Microsoft Excel spreadsheet database. The researcher was situated at Cape Mental Health and accessed all SAVE case files.

3.6 Ethical Considerations

This study formed part of a more extensive study that seeks to ascertain the factors which predict outcomes in sexual cases where complainants are PWID. Permission to conduct this study was received from the Research Ethics Committee of the Department of Psychology at the University of Cape Town (Appendix B). CMH also permitted us to access their files, database, and premises (Appendix C).

Ensuring that the research caused no further trauma to complainants, or their families was essential. For this reason, no contact was made between the researcher and the individual clients whose case files were used. Case files were only accessed at the CMH, and anonymity

ensured that no identifying details were visible in the thesis, thus respecting the confidentiality of all individuals. A copy of the dissertation will be made available to CMH.

3.7 Data Analysis

All statistical analyses were conducted using the Statistical Package for the Social Sciences (SPSS) version 26. The data analysis process was twofold: first, descriptive statistics were generated to ascertain the number of cases in the final sample and determine how many cases had been withdrawn or resulted in a guilty or not guilty verdict. After that, multinomial logistic regressions were performed to test whether the complainants' level of ID, ability to consent to sexual activity, and ability to testify would predict their court case outcomes.

Chapter 4

Results

This chapter presents the results of the analysis of archival data as discussed in chapter 3. The results are presented in two sections. The first part is descriptive and provides the demographic details of the sample. This is followed by listing the education the complainant received, including where the complainant received sexuality education. The participants' level of ID, as determined through the Vinelands Adaptive Behaviour Scales, second edition (Vineland-II), is also described. In addition, court-related factors such as the charges filed by the complainants and the outcome of these court cases will be provided. A description of the court case outcomes across the different levels of ID concludes the first part of the results.

The second half of this chapter reports the results of the logistic regression analyses. The analysis only included the complainants' data who received a court outcome; this sample decreased from 493 to 167. Regression models tested three hypotheses, each relating to the conviction rates of the perpetrators. They were:

- H1: The Level of ID predicts whether the perpetrator would be convicted
- H2: The complainant's ability to consent to sexual activity predicts whether the perpetrator would be convicted.
- H3: The complainants' ability to testify in court would predict whether the perpetrator would be convicted.

A summary of the results of these regression tests concludes this chapter.

4.1 Descriptive Statistics

The following section briefly describes the sample's gender, language, race, and socio-economic status. It also describes the participants' type of community such as urban or rural areas, living arrangements, and the level of care experienced.

As seen in Table 1[1], most of the complainants seen by the SAVE program were females. Afrikaans was the sample's predominant language spoken by the participants (66%), and IsiXhosa (26%) was the second most spoken language. A small percentage (4%) of the sample indicated English as their primary language. Thirty-seven percent of the SAVE complainants in this study identified as Coloured (37%), followed by Black African (26%) and Whites (3%). Most complainants had a low socioeconomic status, with 65% of the sample falling into this category and a further 13% living below the poverty threshold. Only one complainant reported a high socioeconomic status. The majority (60%) of the sample reported living in urban areas. As noted in Table 1, almost all the complainants lived in the community (85%), and only 8% lived in residential care. Most of the sample reported adequate care (70%), 9% of the sample lacked supervision, and 11% reported neglect. Furthermore, 2% of the sample reported physical abuse, and 4% reported a previous history of sexual abuse.

[1] See Table 1 for missing data

Table 1

Demographic Information

Variable	*N*	%
Gender		
Female	428	86.8
Male	62	12.6
Missing	3	0.6
Language		
Afrikaans	323	65.5
English	21	4.3
Xhosa	130	26.4
Other	8	1.6
Missing	11	2.2
Racial distribution		
Coloured	181	36.7
Black African	128	26.0
White	14	2.8
Missing	170	34.5
Socio-economic status		
Below poverty level	66	13.4
Low SES	319	64.7
Middle SES	20	4.1
High SES	1	0.2
Missing	87	17.6
Community		
Urban	296	60.0
Rural	184	37.3
Missing	13	2.6
Living arrangements		
Living in community	419	85.0
Residential care	41	8.3
Missing	33	6.7
Level of care		
Adequate	343	69.6
Lack of supervision	45	9.1
Neglect	52	10.5
Physical abuse	12	2.4
History sexual abuse	18	3.7
Missing	23	4.7

4.2 Education.

Table 2 presents the type of formal education and where the complainant received sexuality education. The education setting included mainstream school, i.e., a school that follows the general education system and accommodates learners with and without special learning needs. Adaptation education allows certain adaptations and modifications to ensure that learners receive an equal opportunity to education. LSEN schools refer to schools that accommodate learners with special educational needs. The majority of the complainants attended mainstream schools (55%) This is followed by LSEN (53.5%) and Adaptation class (7.7)[2]. As reported in case notes, 10% of the sample had no record of any form of formal education.

The psychologist also assessed whether complainants had received any sexuality education and where this education was received. Some received sexuality education either in school (26%) or at home (7%). Half of the sample did not have anything recorded for sexuality education. It is difficult to assess if this is due to the complainant's challenges with memory, if the complainant had received no sexuality education or if the psychologist failed to ask if the complainant had received sexuality education.

[2] Complainants attended multiple educational settings and may have been counted more than once.

Table 2

Education

	N	%
Formal Education		
Mainstream	273	55.4
Adaptation Class	38	7.7
Lsen School	264	53.5
Special Needs	6	1.2
None	47	9.5
Missing	43	8.7
Sexuality Education		
Home	36	7.3
School	126	25.6
Media	11	2.2
Other	37	7.5
None[3]	34	6.9
Missing	249	50.5

[3] These participants reported that they received no sexuality education

4.3 Level of ID as Determined by Psychometric Assessments.

The level of ID was measured by both the Vinelands Adaptive Behaviour Scales, second edition (Vinelands-II), and the Individual Scale for General Scholastic Aptitude (ISGSA). A psychologist assessed each complainant, and this was recorded in case notes and clinical reports submitted to the court. Table 3 describes the level of ID as indicated by these two assessments. According to the Vinelands-II, the majority of the sample had mild ID (55%), followed by severe (20%) and moderate (17%) ID. Only one of the complainants fell within the profound range (0.2%), and 3.9% of the complainants had Borderline Intellectual Functioning According to the ISGSA, roughly one-third of the sample had mild ID (38%) and moderate ID (33%), respectively, followed by severe (15%) ID.

Table 3

Level of ID

Level of ID	*n*	%
Vinelands-II		
[4]Borderline	19	3.9
Mild	269	54.6
Moderate	84	17.0
Severe	100	20.3
Profound	1	0.2
Missing	20	4.1
ISGSA		
[5]Borderline	23	4.7
Mild	189	38.3
Moderate	163	33.1
Severe	72	14.6
Profound	6	1.2
Missing	40	8.1

[4] Borderline Intellectual Functioning
[5] Borderline Intellectual Functioning

4.4 Offence-Related factors.

This section provides descriptive information on offence-related factors. These include offences filed by the complainant and the outcome of the court cases. As indicated in Table 4, most offences were rape (87%). Other charges included sexual assault (10%) and rape with assault (1%). Of these offences filed, 58% were withdrawn, 22% received a guilty verdict, 12% received a not guilty verdict, and 9% of cases were ongoing at the time of this study.

Table 4

Offences filed by Complainant

	n	%
Offences		
Rape	428	86.8
Sexual Assault	49	9.9
Rape with assault	5	1.0
Missing	11	2.2
Verdict		
Guilty	110	22.3
Not guilty	57	11.6
Case withdrawn	284	57.6
Ongoing	42	8.5

4.5 Distribution of Court Case Outcomes across Levels of ID

This section describes the distribution of court case outcomes of the sample. Within the CMH dataset that was examined for this research project, complainants with Mild ID had the lowest chance of receiving a not guilty outcome (10%), closely followed by Borderline Intellectual Functioning (11%), Moderate ID (13%), and Severe ID (17%). Complainants with moderate ID had the highest chance of receiving a guilty verdict (24%) compared to those with Mild, Severe, and Borderline Intellectual Functioning. As noted in Table 5, however, there was little variation between the different levels of ID, and the chances of receiving a guilty verdict were similar across the different ID levels. Charges that included

complainants with Borderline Intellectual Functioning had the highest probability of being withdrawn compared to charges involving complainants with mild, moderate, and severe ID. At the time of research, there were still ongoing cases across all ID levels except Borderline Intellectual Functioning, and no outcome for these cases was available.

Table 5

Distribution of Court Case Outcomes across Level of ID (Vinelands-II)

	Nature of verdict				
Level of ID	Not Guilty	Guilty	Case withdrawn	Case ongoing	Total
Mild	26 (9.7%)	59 (21.9%)	151 (56.1%)	33 (12.7%)	269
Moderate	11 (13.1%)	20 (23.8%)	50 (59.5%)	3 (3.6%)	84
Severe	17 (17%)	23 (23%)	55 (55%)	5 (5%)	100
[6]Borderline	2 (10.5%)	4 (21.1%)	13 (68.4%)	0 (0%)	19
Missing	1 (4.8%)	4 (19.0%)	16 (76.2%)	0 (0%)	21

4.6 Statistical Analyses

This section describes the results of the statistical analyses conducted to assess the hypotheses outlined in chapter 1. As previously stated, only cases that received a verdict of guilty or not guilty were included, reducing the sample size for these analyses from 493 to 167. In addition to this, only the Vinelands-II assessment results, which emphasize the individual's adaptive abilities, were used as the complainant's level of ID. The diagnostic criteria of ID identified in the DSM-V emphasize the individual's adaptive behaviour as measured by the Vinelands-II and not the IQ scores measured by ISGSA. The traditional .05 criterion of statistical significance was employed for all tests.

[6] Borderline Intellectual Functioning

Hypothesis 1. The level of ID of the complainant will predict the conviction of the perpetrator.

A logistic regression test was performed to model the relationship between the perpetrator's conviction, the dependant variable (DV), and the complainant's level of ID, the independent variable (IV). The reference category for the dependent variable was not guilty, and the IV reference category was mild ID. The primary interest was to test whether the level of ID of the complainant would impact the conviction of the alleged perpetrator, and this model was not significant (see Table 6). This means that the complainant's level of ID did not impact the outcome of the court case and did not predict a guilty or not guilty verdict.

Table 6

Associations between Level of ID (Vinelands- II) and Conviction of the Perpetrator

	B	SE	OR	95% CI	Wald	*p*
Intercept	0.819	0.235	2.27	-	12.12	< .001***
Moderate	-0.222	0.443	0.80	0.34 – 1.91	0.25	.617
Severe	-0.517	0.397	0.60	0.27 – 1.30	1.70	.193
Borderline	-0.126	0.897	0.88	0.15 – 5.12	0.02	.888
R^2 = .010 (Cox & Snell), .014 (Nagelkerke)						
Model χ^2 (165) = 0.44, p = .506						

Note. The reference category is not guilty.

Hypothesis 2: The ability to consent will predict the perpetrator's conviction.

A logistic regression test was performed to model the relationship between the nature of the verdict (DV) and the ability to give consent (IV). The model was not significant, indicating that the ability to consent to sexual activity did not impact the nature of the verdict (guilty versus not guilty; see Table 7 for parameter estimates of this model).

Table 7

The Relationship between the Complainant's Ability to Consent and the Nature of the Verdict

	B	SE	OR	95% CI	Wald	*p*
Intercept	0.70	0.18	15.57	-	15.57	<.001***
Ability to Consent	-0.30	0.45	0.74	0.31 – 1.78	0.45	.503
R^2 = .003 (Cox & Snell), .004 (Nagelkerke)						
Model χ^2 (165) = 0.44, p = .506						

As a first step towards improving the model depicted in Table 7, a logistic regression was performed to establish which factors best predict the complainant's ability to provide consent. As identified by the psychologist during the assessment, the factors were: knowledge about sex, understanding the consequences of sex, the complainant's vulnerability to coercion, and the complainant's ability to refuse sexual advances. The overall model was significant, χ^2 (4, N = 162) = 57.46, Nagelkerke R^2 = .511, p < .001. As shown in Table 8, significant independent contributions were made by understanding the consequences of sex and the ability to refuse sexual advances. The odds of being able to provide consent increased when the individual understood the consequences of sex (OR = 12.62) and had the ability to refuse (OR = 7.88).

Table 8

Predictors of the complainant's ability to consent

	B	SE	OR	95% CI	Wald	*p*
Intercept	-3.29	0.51	0.04	-	41.34	<.001***
Knowledge	0.86	0.72	2.37	0.58 – 9.77	1.43	.232
Consequences	2.54	0.67	12.62	3.37 – 47.33	14.14	<.001***
Coercion	-0.81	0.72	0.45	0.11 – 1.82	1.26	.261
Ability to refuse	2.06	0.73	7.88	1.90 – 32.68	8.08	.004**
R^2 = .291 (Cox & Snell), .511 (Nagelkerke)						
Model χ^2 (162) = 57.46, p < .001						

Considering the two significant predictors of the ability to provide consent, logistic regression was performed to model the relationship between the verdict and the two

predictors of consent which were significant in the previous model. The dependent variable was the nature of the verdict, with the reference group set to not guilty. The overall model was not significant, χ^2 (2, N = 164) =0.36, Nagelkerke R^2 = 0.003, p = .835 (see Table 9). Although variables such as understanding the consequences of sex and having the ability to refuse improved the individual's capacity to provide consent, they did not have any impact on the outcome of the verdict.

Table 9

Understanding the Consequences and the Complainant's Ability to Refuse as predictors of the Verdict

	B	SE	OR	95% CI	Wald	*p*
Intercept	0.70	0.19	2.02	-	14.44	<.001***
Consequences	-0.26	0.44	0.77	0.33 – 1.82	0.35	.552
Ability to refuse	0.06	0.57	1.06	0.35 – 3.27	0.01	.951
R^2 = .002 (Cox & Snell), .003 (Nagelkerke)						
Model χ^2 (164) = 0.36, p = .835						

Hypothesis 3: The Ability to be a Competent Witness will Predict Conviction.

For this hypothesis, a logistical regression was performed to model the relationship between the independent variable (ability to testify) and the dependent variable (nature of the verdict), either a guilty or not guilty verdict. The model approached significance, χ^2 (1, N= 165) = 2.97, p = .085) with Nagelkerke R^2 = 0.025. Table 10 indicates a trend for the individual's ability to testify to predict the verdict. However, this fell short of statistical significance (p = .093). The complainant's ability to testify did not predict the verdict.

Table 10

The relationship between the complainant's Ability to Testify and the Nature of the Verdict

	B	SE	OR	95% CI	Wald	*p*
Intercept	1.32	0.33	3.75	-	16.55	<.001***
Ability to testify	-0.64	0.38	0.53	0.25 – 1.11	2.82	.093
R^2 = .018 (Cox & Snell), .025 (Nagelkerke)						
Model χ^2 (165) = 2.97, p = .085						

To improve the previous model, the complainants' ability to testify, as identified from the case notes of the psychologist, was deconstructed. The psychologist considered four factors in determining the complainants' ability to testify. They were the ability to give a narrative account, the ability to give a narrative account using anatomical dolls, the ability to answer clarifying questions, and the ability to take an oath. The model was significant, χ^2 (4, N = 162) = 74.97, p < .001 (see Table 11). Two predictors, namely the ability to answer clarifying questions and the ability to take an oath, significantly impacted the ability to testify. Table 11 indicated for each one standard deviation increase in the variable answer clarifying questions, the odds of the complainant being able to testify increased by 17.44 (p < .001) and was statistically significant. For each one standard deviation increase in the ability to take an oath, the odds of being able to testify increased by 3.47 (p = .023).

Table 11

Predictors of the Complainant's Ability to Testify

	B	SE	OR	95% CI	Wald	*p*
Intercept	-1.69	0.45	0.19	-	14.1	<.001***
Narrative Account	0.11	0.85	1.11	0.21- 5.84	0.02	.899
Answer Clarifying questions	2.86	0.86	17.44	3.25 – 93.47	11.13	<.001***
Narrative with dolls	0.88	0.88	2.40	0.43 – 13.47	0.99	.320
Ability to take an oath	1.24	0.55	3.47	1.18 – 10.15	5.14	.023*
R^2 = .362 (Cox & Snell), .515 (Nagelkerke)						
Model χ^2 (162) = 74.97, p < .001						

Considering the two significant predictors of the ability to testify, a third logistic regression was performed to model the relationship between the verdict and the two predictors of the ability to testify, which were significant in the previous model. The outcome variable was the nature of the verdict, with the reference group set to not guilty. The overall model was not significant, χ^2 (2, N = 167) = 1.75, Nagelkerke R^2 = 0.01, p = .417 (see Table 12). This means that the complainant's ability to answer clarifying questions and take an oath did not significantly impact the verdict of the perpetrator.

Table 12

Relationship between the Complainant's Predictors of Ability to testify and the Nature of the Verdict

	B	SE	OR	95% CI	Wald	*p*
Intercept	0.74	0.34	2.09	-	4.76	.029*
Answer Clarifying questions	0.04	0.44	1.04	0.44 – 2.48	0.01	.928
Ability to promise	-0.24	0.38	0.79	0.38 – 1.65	0.40	.528
R^2 = .003 (Cox & Snell), .004 (Nagelkerke)						
Model χ^2 (167) = 1.75, p = .417						

Chapter 5

Discussion

This study focused on the outcome of sexual assault court cases involving people with intellectual disabilities (PWID) in the Western Cape and explored the association between the conviction rate of court cases and the complainant's level of intellectual functioning. Descriptive statistics were considered to understand the sample's demographic characteristics, and statistical analyses were conducted to test four hypotheses. Hypothesis one predicted that the complainant's level of ID would predict the conviction rate; however, no relationship was found between the conviction rate and the complainant's level of ID. Therefore, this hypothesis -that individuals with mild ID would be more likely to have their cases conclude in a guilty verdict than those with moderate or severe levels of ID was rejected.

The second hypothesis predicted that the complainant's ability to consent to sexual activity would predict the perpetrator's conviction. This was not significant, and the hypothesis was that those who could consent to sex would be more likely to have their cases result if a not guilty verdict was rejected. The statistical model was improved by deconstructing the predictor variable, consent, and tested again. Consent consisted of the complainant's knowledge about sex, understanding of the consequences of sex, the complainant’s vulnerability to coercion, and the ability to refuse sexual advances. The complainant's ability to understand the consequences of sex and the ability to refuse sex increased the individual's chances of being able to consent. However, the model continued to fall short of significance when a regression was performed, with only these two variables related to court case outcomes.

The third hypothesis that the conviction rate will be predicted by the complainant's ability to be a competent witness fell short of significance, i.e., the hypothesis that the complainant’s ability to testify did not predict the perpetrator's conviction. This model was

improved by deconstructing the variable ability to testify. Four variables determined the individual's ability to testify. They were the ability to give a narrative account, the ability to provide a narrative account using anatomical dolls, the ability to answer clarifying questions, and the ability to take an oath. When using this enhanced model, two predictor variables, namely the complainant's ability to give a narrative account with dolls and take an oath, significantly impacted the ability to testify. When used independently, these two variables were not significant predictors of the nature of the verdict. A more detailed discussion of the results is provided below.

5.2 Descriptive statistics

Neurocognitive deficits leave PWID vulnerable to sexual assault. A PWID has greater difficulty assessing dangerous situations as their judgment is impaired (Gil-Llario et al., 2019). They might struggle to recognize and remove themselves from a dangerous or risky environment (Messman-Moore & Brown, 2006). Societal beliefs (such as PWID are either asexual or oversexualized) increase their risk of victimization. These negative beliefs can cause family members and society to dismiss or doubt complaints of sexual abuse (Meer & Combrinck, 2015; Vadysinghe et al., 2017).

The concurrent adversities experienced by PWID may increase their vulnerability to sexual abuse.

Globally, crime statistics and the research literature indicate that the prevalence rate of sexual abuse is significantly higher for women than for men, regardless of the presence of ID (Calitz et al., 2014; Dickman & Roux, 2005; Gil-Llario et al., 2019; McCarthy & Thompson, 1997; Platt et al., 2017; Vadysinghe et al., 2017). Due to the pervasive deficits of ID, a woman with ID is more likely to be a complainant of sexual assault than men with ID. The dataset in this study aligns with this trend. Of the 493 complainants in this study,

86.8% were women, and 12.6% were men. Wilson et al. (2020) report that girls are socialized to be more dependent, submissive, and agreeable. Perpetrators can exploit these internalized behaviours for their benefit (Wilson et al., 2020).

The majority of this study's sample (60%) lived in urban areas in greater Cape Town. This includes the Cape Flats and regions such as Elsies River, Khayelitsha, Manenberg, Mitchell's Plain, and surrounding informal settlements. Despite the significant changes in South Africa, those living in previously disadvantaged areas are still structurally disproportionately disadvantaged by unemployment and economic exclusion (Mkabile & Swartz, 2020). Sixty-five percent of the sample were of low socioeconomic status, and 13,4% lived below the poverty level. These findings correspond with the literature, which indicates that the prevalence of PWID are higher in low- and middle-income countries than in high-income countries (Emerson & Wigham, 2015; Mkabile & Swartz, 2020; UN, 2007).

Structural barriers faced by individuals living in low-income areas include difficulty accessing services, such as education, work, nutrition, and safe living conditions. These factors all increase the possibility of being a victim of crime. The most vulnerable groups in the community, such as children, women, and even more so, PWID, are often complainants of sexual abuse. In low socioeconomic areas, caregivers are more likely to rely on the support of neighbours and other family members to assist them in supervising PWID (Khan et al., 2020). PWID may be in the care of others as parents have to work and travel great distances between their homes and places of work (Khan et al., 2020; Vadysinghe et al., 2017). A large portion of the sample reported adequate care during the interview with the psychologist, as extracted from the interview form. While this may be a true reflection of their level of care, it may also be a social desirability response, i.e., overstating their care level for fear of being judged or viewed as negligent caregivers.

In South Africa, race and socioeconomic status are highly correlated. South African communities are still largely racially segregated, and services are distributed accordingly. Community organizations and NPOs such as Cape Mental Health (CMH) primarily assist families and individuals who cannot afford private care or services. Most complainants in this study who received psycho-legal support from CMH were from previously disadvantaged racial groups. The complainants were mainly Coloured (37%) or Black (26.0%), and only a small percentage were White (3%); 35% of the sample did not indicate their racial category.

The complainant's level of education was also reviewed. This study found that the complainant's level of education varied within our sample. The majority of the complainants in this study attended mainstream and LSEN schools, and at times individuals had exposure to both educational settings. More than half of the sample attended mainstream (55.4%), and the complainants attended Learners with Special Educational Needs (LSEN) (53.5 %) schools. Others indicated adaptation classes, a form of teaching in a mainstream school that allows learners to be assessed according to their current skills and level of performance. This might also include individual lessons and activities to support the learner. A small percentage (6%) attended other special needs schools. Although this was not specified in the study, special needs schools differ from LSEN schools as they provide more intense care and educational support for specific groups such as individuals with ID. This study also found that some complainants attended multiple educational settings and indicated both mainstream and LSEN schools during the interview with the psychologist. More concerning is that 10% of the sample reported no form of education.

Education, specific education about sexuality, is a protective factor against sexual abuse (Murphy and O'Callaghan,2004). Those with higher levels of knowledge about sexuality, sexual rights, and sexual exploitation have a decreased vulnerability to sexual abuse than those without information (Johns, 2016; McCabe & Cummins, 1994). As part of

this study, I reviewed whether complainants received sexuality education. Half of the sample (50.5 %) had no recollection of receiving any sexuality education. Others indicated that they received sexuality education at school (26%) or at home (7%), a small group (2%) indicated learning about sex through media, and 7% reported not receiving any sexuality education.

Fifty percent of the complainants indicated that they had not received sexuality education. It is unclear whether this is a true reflection of sexuality education or whether most participants struggled to recall if they had received education about sexuality. Gil-Llario et al. (2019) and (Borawska-Charko et al. (2016) noted that PWID presents with lower levels of sexual knowledge when compared to people without ID. The lack of sexuality education could be attributed to the attitude that carers and professionals hold about the sexuality of PWID. Many caregivers and professionals also experience anxiety and ambivalence when discussing sexuality and relationships with PWID, often due to concerns about causing harm or the belief that providing sexuality education will lead to inappropriate sexual Behaviour (Borawska-Charko et al., 2016; Gil-Llario et al., 2019 Medina-Rico et al., 2017). For these reasons, caregivers and professionals might avoid teaching sexuality education (Gil-Llario et al., 2019 Medina-Rico et al., 2017).

A lack of sexual knowledge might increase the risk of sexual abuse. Complainants of sexual abuse might be less able to distinguish between proper and improper sexual practices and not report sexual abuse if it occurs. (Gil-Llario et al., 2019 Medina-Rico et al., 2017). PWID must be provided with skills-based sexuality education, which considers their ability to learn and retain the required knowledge, as well as their ability to form relationships, understand sexual and romantic relationships, and practice safe sex if or when they choose to engage in sexual relationships (Bowers, 2019; Healy, McGuire, Evans, & Carley, 2009). Sexuality education should be the responsibility of multiple stakeholders and environments, such as the school, home, and healthcare settings. This will ensure that people with ID are

afforded numerous opportunities to learn and talk about their sexual needs. Providing people with ID with education about sexuality can empower them and leave them less vulnerable to sexual abuse (Gil-Llario et al., 2019).

5.3 Levels of ID of the Complainants

Within this study, 54.6% of the complainants of sexual abuse were diagnosed with Mild ID, 17% with Moderate ID, and 20.3% with Severe ID. Profound ID and Borderline Intellectual Functioning represented the smallest group in this sample. According to Medina-Rico et al. (2017), Spaan & Kaal (2019), and Vadysinghe et al.(2017), sexual abuse occurs more commonly in people with Mild or Moderate ID. Their ability to learn essential life skills allows them greater engagement with the community than those with more severe forms of ID. When people with ID become familiar with their surroundings and more independent, their caregivers may be less worried about victimization. The communicative abilities of complainants with Mild and Moderate ID may also enable them to disclose abuse more easily than those with Severe or Profound ID. Similar to other studies, most complainants in this cohort had Mild ID. However, according to Hershkowitz et al. (2007) and Spaan and Kaal (2019), the prevalence of sexual abuse amongst people with severe and profound ID might be underestimated, as these complainants' functioning levels are significantly lower. Complainants with Severe ID may be at increased risk as their ability to understand and assess risky situations is significantly impaired. They are also more dependent on the care of others to support them in their daily functions. Individuals with severe and profound ID have significant delays in speech production and receptive speech and would have difficulty understanding what a perpetrator may propose (Hershkowitz et al., 2007; Spaan & Kaal, 2019). Their communication and speech difficulties may also prevent them from verbally communicating their thoughts and feelings and reporting what has happened to them (Hershkowitz et al., 2007; Spaan & Kaal, 2019).

5.4 Offence-Related Factors

Of the cases reviewed in this study: more than half were withdrawn(58%), 11.6% resulted in acquitted, and 22.3% of the accused were found guilty. The conviction rate of the current cohort is similar to another study, which reviewed 100 case outcomes over ten years between 1990 and 2000. In that study, the conviction rate was 28%, 25% of the accused were found not guilty, and 47% of the cases were withdrawn (Dickman & Roux, 2005). A study conducted in the UK similarly found that 61% of cases of adult rape survivors with learning disabilities drop out of the legal system (Antaki et al., 2015; Lea et al., 2003). Although that study did not investigate reasons for withdrawal in these cases, Lea et al. (2003) suggest complainants' lack of competency as a witness, family refusal to pursue the court case, and evidence contradicting the complainant's account may be some of the reasons why charges are withdrawn.

PWID are disadvantaged by the justice system when reporting complaints of sexual abuse (Spaan and Kaal, 2019). A complainant with ID may face barriers such as difficulty accessing the police station or courts, difficulty understanding legal terminology, and insufficient knowledge about the process of filing a charge. They may also experience negative perceptions about ID and rape survivors as their case progresses through the justice system. These factors influence the prosecution of the perpetrator. If the witness is believed to be unreliable and unable to provide a coherent testimony, the charges may also be dismissed. During the investigative stage, police officials assess the victim's allegations' credibility and decide whether an identified suspect should be arrested and if the case should be forwarded to the prosecutor (Spohn, 2020). When the case is referred to the prosecutor, they decide if a charge will be filed as sexual assault and if it should be tried in court. At this level, charges can be categorized as false, inconclusive, or not a crime, impacting the conviction rates (Spohn, 2020).

5.5 Hypothesis 1: The complainant's Level of ID will Predict the Conviction of the Perpetrator

The first research question was that the complainant's level of ID would predict the court case outcome. Findings from this study showed no significant relationship between the level of ID and the court case outcome. This finding is similar to that of Dickman & Roux (2005). As this is a selected sample who have all been referred to the SAVE program, the evidence presented was likely perceived as sufficiently strong for the investigation to proceed. Therefore, as shown in the results it was not the complainant's level of ID that predicted the court case outcomes but other characteristics of the assault, complainant, and perpetrator.

According to Cossins, 2020; Wyman et al., 2019, no single predictor strongly influences the outcome of a sexual abuse court case. A collection of legal and non-legal factors contributes to the perpetrator's conviction. Positive physical evidence such as genital or non-genital injuries (bruising and lacerations) and the presence of DNA collected through medical and forensic investigations are strong predictors of conviction (Steele et al., 2019). Obtaining this evidence can be difficult, especially when the complainant has ID. PWID's cognitive deficits impair the individual's ability to understand others' behaviour, remember important details of the assault, and report it. This may delay reporting sexual assault and gathering medicolegal evidence. Collection of DNA evidence should occur within 72 hours of the assault. Complainants with ID might report sexual assault outside this period, as they rely on others to report the assault. Assaults may only be disclosed by the complainant when they experience abdominal pain or notice blood on their underwear. Physical injuries may also be less common for PWID. PWID struggles to understand social interactions and can be easily manipulated by others to engage in risky behaviour without using force.

Eyewitness reports and information reported by professionals and organizations can contribute to a conviction (Wyman, Lavoie, & Talwar, 2019). Behavioural changes which are common to individuals who experienced trauma, such as difficulty sleeping/nightmares, inappropriate displays of affection with parents, reluctance to undress, reluctance to bathe, withdrawal, or problems at school after the alleged sexual assault, can also play a role in the conviction (Lewis, Klettke, & Day, 2014)

Medico-legal evidence, collected by examining the complainant for physical injuries and collecting DNA samples can assist in identifying the perpetrator, which is essential for making an arrest, prosecuting, and achieving a conviction of the perpetrator (Kaur et al., 2021, Malema, 2020).

As noted, the level of ID in this study the level of ID did not predict the conviction of the perpetrator. However, some literature has found that the characteristics of the perpetrator may also impact the outcome of court cases (Cossins, 2020). These might include any prior convictions, multiple survivors, if the perpetrator used a weapon and if any penetration occurred. According to Cossins(2020), non-legal factors include the prosecutor, judges' and jurors' expectations and beliefs. Biases and misconceptions of the defendant's and complainants' characteristics also significantly impact the trial outcomes. A study on mock jurors in Australia found that many jurors have pre-existing beliefs about how a victim of sexual abuse would behave before, during, and after an alleged sexual assault (Cossins, 2020). Therefore, pre-existing beliefs held by legal professionals such as prosecutors and judges can influence their assessment of the complainant's credibility during the trial (Cossins, 2020). So, while hypothesis 1 focussed narrowly on the complainant's level of ID, it is clear that factors such as how the complainant is perceived by the prosecutors and judges may affect the course of outcomes.

5.6 Hypothesis 2: The Capacity to Consent will Predict the Perpetrator's Conviction.

One of the defining characteristics of sexual assault is the absence of the complainant's consent (Cossins, 2020). The vulnerability of people with ID increases as their capacity to consent decreases. Historical beliefs, such as PWID are promiscuous and oversexualized, which may make them vulnerable to sexual assault.

The Criminal law (Sexual Offences and Related Matters Amendment Act) Act 32 of 2007, includes "coercive circumstance" and defines consent as an agreement that is not coerced. Coercion refers to the use of force, psychological intimidation, abuse of power, threats, pretense, and blackmail that results in the complainant's inability to indicate unwillingness or resistance (Sexual Offences and Related Matters Amendment Act, No. 32, 2007). Section 57 (2) of the SOA 2007 further stipulates that a person who is mentally disabled as defined by section 1 of the SOA is incapable of consenting to sexual activity if they meet one of the four criteria of consent as stipulated by the legislation.

Although the law protects people with ID by including coercive circumstances and consent, it should not be assumed that people with ID cannot consent (Dickman, 2019). The literature suggests that the capacity to consent should be judged individually. The ability to consent increases when the individual is given adequate support to understand the information relevant to the decision, retain information, use it as part of the decision-making process, and communicate their choices verbally, using sign language or other communicative means (Dickman, 2019; Renasaincelegal, 2018).

No significant relationship was found between the complainant's capacity to consent and the perpetrator's conviction. When the ability to consent was deconstructed into four variables, namely the complainant's knowledge about sex, understanding of the consequences of sex, the complainant's vulnerability to coercion, and the complainant's ability to refuse sexual advances, it was found that the complainant's ability to give consent increased when

they understood the consequences of sex and could refuse sexual advances. This would suggest that education about sex and understanding the consequences of sex significantly increases the individual's capacity to consent and decreases vulnerability to sexual abuse (Murphy & O'Callaghan, 2004; Johns and Adnams, 2016). Literature indicated that sexuality education is essential for supporting the sexual health of PWID by equipping PWID with the knowledge that will help them make informed decisions and provide protection when encountering the sexual advances of others (Murphy & O'Callaghan, 2004). Despite this, the sexual health of PWID is still largely controlled by caregivers. PWID remains excluded from sexuality education. Myths that PWID are asexual and incapable of having intimate relationships as well as the infantilisation of PWID limits access to sexuality education. Caregivers also fear that sexuality education may lead to sexualised behaviour (Frawley & Wilson, 2016). Withholding information about appropriate and inappropriate sexual behaviour increase PWID's to be easily coerced and compliant to the perpetrator (Johns and Adnams; 2016). Although sexuality education increases the individual's ability to consent it is not related to the conviction of the perpetrator. This would suggest that when a sexual assault case is tried in court other factors which may be related to the investigation and legislation are also determining factors in the conviction of the perpetrator.

5.7 Hypothesis 3: The Ability to Testify in Court will Predict Conviction.

The results from this study found that the complainant's ability to testify did not predict the perpetrator's conviction. Testifying is important in sexual assault offences as the complainant is often the only witness against the perpetrator, especially when gaining medicolegal evidence is also not possible (Cossins, 2020). To improve this model, the ability to testify was deconstructed to determine which factors would increase the odds of the complainant testifying. The individual's ability to take an oath and answer clarifying questions increased the chance of them testifying.

Oath-taking forms part of an adversarial justice system, which depends on the cross-examination of the witness to prove that the allegations against the perpetrator are accurate (Cossins, 2020). If a complainant can understand court proceedings, such as taking an oath, they are allowed to testify. Compared to their peers, PWID may have cognitive deficits and require assistance in all areas of their lives. Witnesses with ID are often compared to child witnesses, who are believed to be more suggestible and more likely to confabulate events (Lee et al., 2010). This discredits PWID and increases the belief that they are unreliable witnesses who cannot understand court proceedings such as taking an oath. If the court system finds the witness unreliable, they may be denied the opportunity to provide testimony, which may reduce the chances of prosecution and conviction of the perpetrator.

Sexual assault cases are more complex than other offences, as the complainant is often the only witness to the crime (Cossins, 2020). The charge can be dismissed if the witness struggles to testify in court. The defence can argue that the complainant's account of details is incorrect and that the charge of sexual assault against the perpetrator is false. When the witness testifies, it is crucial that they can answer questions while being cross-examined. This study found that if the witness can answer clarifying questions, their chances of being a reliable witness increase.

The justice system often considers PWID unreliable witnesses (Cossins, 2020). Any discrepancies in their account can result in the dismissal of their testimony. If the witness's testimony is the only evidence, the perpetrator may be acquitted. This is disadvantageous for PWID who have impairments in their ability to remember and communicate. In general, complainants of sexual assault may struggle to recount details of the sexual assault, which are retraumatizing. Difficulties in recalling maybe even more significant for PWID who are compromised because of the level of ID and the trauma of the sexual assault.

The questioning style used in the adversarial court system is unfavorable for PWID. According to Antaki et al. (2015) and Wyman et al. (2019), questions by the defense are often closed-ended and forced-choice methods that would elicit a yes or no response from the complainant. Interview techniques that encourage the complainant to elaborate and share more details would allow the complainant to provide more reliable testimony. Additional support such as court preparation and using an intermediatory are also beneficial for PWID. The South African sexual offence courts provide such services whereby a trained intermediatory conveys questions between the legal professionals and the complainant (Cooke & Davies, 2001; Department of Justice and Correctional Development, 2021). Considering PWID's limitations, the specialized courts aim to support complainants in understanding the legal proceedings, engaging with the justice service, and limiting secondary trauma.

The ability to take an oath and answer clarifying questions improved the chances of testifying. However, these two factors did not have any significant impact on the conviction of the perpetrator. This would suggest that other variables, such as characteristics of the perpetrator and medicolegal evidence as discussed under section 5.5, may have contributed to the conviction of the perpetrator.

5.8 Limitations and Directions for Future Research

This study cannot be used to generalize the outcomes of court cases of complainants with ID. This study is archival, and information was previously collected and captured on CMH records. Jones (2010) points out that one of the disadvantages of archival studies is the high likelihood of missing data. This significantly impacted the sample size, which was initially 623, reduced to 493, and then to a final sample of 167. This mirrors the dropout rate of sexual abuse court cases. As noted previously, the attrition rate of sexual abuse court cases is high. One of the factors that influence the fall-out of cases is the inconsistent recording of

the data. As there was no contact between the researcher and the complainants, verifying the information and specific factors related to court case outcomes was challenging. Data on whether the witness testified, their experience of the adversarial judicial system, the support provided to complainants with ID, and the outcome of their court case could have enhanced the findings in this study.

Many cases were not yet tried in court and had not been finalized at the time of data collection. This sample set is also limited to a specific group of complainants who accessed CMH services. Recognizing the multiple factors that influenced the reduction of the original sample set from 623 to 167, it would not be accurate to make a broad generalization about the outcome of court cases based on this study.

5.8 Strengths

This study adds to the growing body of literature focusing on the interaction of sexual abuse complainants with ID and the justice system. Other than the Dickman & Roux (2005) study, no other studies have explored the outcome of conviction rates of complainants with ID using this particular cohort. This study also analyzes specific variables such as consent and ability to testify. The results highlight the significant difficulty that complainants with ID have when engaging with the justice system. Despite reforms and improvements in the justice system to accommodate people with ID, discrimination and inequality still exist due to historical beliefs and practices.

5.9 Summary and Conclusion

Accessing justice for complainants of sexual abuse is complex, and historically the attrition rate of such cases is high, resulting in a low conviction rate. An expanding body of literature indicates that people with ID are more likely to be survivors of sexual abuse than persons without ID (Beckene et al., 2020; Brown & Turk, 1994; Brownridge, 2006;

Mackenzie, 2010). At the same time, they are less likely to report the incident (Beckene et al., 2020, Chave-Cox, 2014; Cossins, 2020). The cases that are reported are associated with a low conviction rate. This study sought to examine the factors that affected the outcome of sexual assault cases against people with ID in the Western Cape. The participants were complainants of sexual abuse who had received psycho-legal support from CMH SAVE Program. Initially, 634 cases were included in the data set. After applying the inclusion and exclusion criteria, only 493 cases were included for the descriptive statistics, and the sample was reduced further to 167 for the statistical analysis.

The growing body of literature about people's experiences with ID has improved awareness and led to multiple interventions and reforms (Beckene et al., 2020; Brown & Turk, 1994; Brownridge, 2006). These can be noted in the health, educational and legal systems. Despite these changes, the conviction rate of sexual assault has remained low, as indicated in this study. The court case outcome was as follows: 22.3% of the accused persons were found guilty, 11.6% were not guilty, and 47% of the cases were withdrawn. The ability to testify in court and consent to sex was deconstructed to determine if their constituent variables impact conviction rates. This study found that no single factor significantly contributed to the conviction rate.

The ability to testify is fundamental in sexual assault cases, as the complainant is often the only witness. Historically people with ID have been viewed as unreliable witnesses, and if the witness with ID shows that they may be reliable, the chances of testifying and conviction increase. The statistical analysis results indicated the ability to take an oath in court and answer clarifying questions while testifying increased the chances of being a more credible witness. Complainants of sexual assault have to engage with an adversarial justice system, which requires the complainant to prove that the allegation of sexual assault is true. Cross-examination techniques such as close-ended questions are not well suited to the

communicative capabilities of an individual with ID. Therefore, the adversarial system may disadvantage PWID when participating in court proceedings. Interview techniques such as scaffolding questions, non-verbal methods, allowing the participant to recount events at their own pace and in their own words, and cognitive load techniques whereby the responder reconstructs the event are more suitable for PWID (Cooke & Davies, 2001; Wyman et al., 2019).

A psychologist assessed all complainants in this study's capacity to consent. This data was extracted to determine if the complainant's ability to consent to sexual relationships predicts conviction rates. No significant association was found between the capacity to consent and the conviction rate. The individual's capacity to consent to sexual relationships improves when PWID understands the consequences of sex and can refuse. The ability to communicate their refusal would be difficult for individuals with ID, as their cognitive development and adaptive functioning are compromised, making them more agreeable to others' suggestions than individuals without ID. The variable understanding of the consequences of sex highlights the importance of sexuality education. The literature has indicated that advanced knowledge of sexuality, including learning about puberty, physiology, body boundaries, and identifying improper sexual relationships, can be a protective factor (Loui, 2013; Messman-Moore & Brown, 2006, Matson & Hong, 2019).

In conclusion, PWID experiences significant barriers when accessing the justice system. Unhelpful beliefs and the adversarial system disadvantage complaints with ID. Therefore although complaints with ID have an increased vulnerability to sexual abuse, they have a greater chance of not reporting the assault and not gaining justice. This study aligns with the literature that indicates that the prosecution and conviction rates of sexual assault cases involving complainants with ID are low.

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Appendix A

INTERVIEW GUIDE FOR PSYCHOLOGICAL ASSESSMENT

Identifying Info:

Client name: Psychologist name:

Address:

Tel:
Urban/Rural town/ Rural farm
Male/ Female D.O. B
Age at assessment: Dates of assessment:

Date of referral to SAVE:

Accompanied by:
Relationship: Mother/ Father/ Caregiver/ Family member/ Other…….

Referred by: Social worker (CMH):

Police Investigating Officer involved: Tel:

Case No: Police Station Reported:

Home Language:

Has the case been to court? Name of Perpetrator:

Next appearance date?

Prosecutor's name: Tel

Personal history:

Cause of ID if known: Birth trauma/ Childhood illness/ FAS/ Epilepsy/ Trauma

Other……..

Level of care: adequate/ lack of supervision/ neglected/ phys abuse/ history of sexual abuse/

other……

Living arrangements: residential care/ Living in community.

Access to special needs education: mainstream/ adaptation class/ Elsen school/

Special care/ None/ Other……..

Other medical/psychiatric history: (incl Substance history) …….

……

Family SES:

Maternal occupation…….

Maternal level of education……..

Paternal Occupation…….

Paternal level of education……...

Client employment: workshop / protected employment / open labour with support /

open labour/ unemployment/ NA

Family SES: below poverty level/ low SES/ middle SES/ High SES

Grant: disability/ care dependence / other……..

Assault History:

Date of assault:

Charge: Rape/ Sexual/ Indecent assault / Other……..

Date reported to the police:

Name/s of perpetrator:

No of perpetrators:

Relationship to perpetrator: stranger / acquaintance / friend / family member distant / family member immediate / staff member / other……

Reported account:

Level of functioning of perpetrator: Intellectually disabled/ psychiatric illness /
Not known / not applicable/other……..

Did the perpetrator know of the client's disability? Yes / No

Degree of violence: verbal threat of harm or shame / threat of weapon / weapon used / death threat / need med. Intervention / other…….

Emotional changes since incident…….

…….

…….

Behavioral changes since incident…….

…….

…….

No of incidents: Once/ Several/ Repeated

…….

…….

Previous history of rape/sexual assault: Yes / No

Supporting Evidence: DNA/ other witnesses / med exam / other……

Referral source: FCS / NPA / NGO / Other…….

Family Support: No support / ambivalent/full support

Post-assault counselling received: None / State / NGO / CMH / Private /
Other……

Appearance and Behaviour at assessments:

Understanding of sexual matter

Sexual vocab:

Conception:

Contraception:

STI's & HIV:

Sex education: School /media/home/other…….

Previous consensual sexual relationship	Yes / No
Sexual interest	Yes / No
Ability to consent	
Knowledge	Yes / No (mechanics and vocabulary)
Consequences	Yes / No (STIs, pregnancy, HIV/ AIDS)
Vitiated Consent (coerced)	Yes / No
Ability to refuse	Yes / No
Overall assessment	Yes / No

Competence as a witness:

Understanding of court proceedings

Differentiate truth and falsehood:	Yes- concrete / Yes- abstract / No
Perjury punishable	Yes / further prep / No
Narrative account	Yes / No / N.A.
Narrative account with dolls	Yes / No / N.A.
Answer clarifying questions	Yes / No
Ability to promise	Yes / No
Motivation to testify	Yes: motivated / Wanting Justice but ambivalent No: No understanding of injustice / not a crime / consequences of testifying
Use of Intermediary	Yes / No
Overall assessment:	Yes / No

NOTES:

Appendix B

Ethical Clearance

UNIVERSITY OF CAPE TOWN

Department of Psychology

University of Cape Town Rondebosch 7701 South Africa
Telephone (021) 650 3417
Fax No. (021) 650 4104

17 April 2018

Roslyn Adams
Department of Psychology
University of Cape Town
Rondebosch 7701

Dear Roslyn

I am pleased to inform you that ethical clearance has been given by an Ethics Review Committee of the Faculty of Humanities for your study, *Outcomes of sexual assault court cases against people with ID in the Western Cape.* The reference number is PSY2018-014.

I wish you all the best for your study.

Yours sincerely

Lauren Wild (PhD)
Associate Professor
Chair: Ethics Review Committee

Appendix C

Permission from Cape Mental Health

Cape Mental Health
all about ability

05 September 2017

Nokuthula Shabalala
C/o 18 & 22 Ivy Street
Observatory
7935

Dear Nokuthula

Research Request – SAVE

Your research proposal dated 20 July 2017 refers.

Permission is hereby granted for you to commence your research as per your proposal at CMH.

We require the following:

1. A report at the conclusion of the research project
2. Joint publication with CMH and
3. Acknowledgement of the organisation in all documents and publications related to the research.

Thank you for sourcing the necessary funding for this study.

We look for to the results and outcome of the research.

Wishing you all of the best.

Kind regards

Yours sincerely

Ingrid Daniels
Director
Cc Carol Bosch