

Sexuality and Incapacity

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Sexual incapacity doctrines are perhaps the most important form of sexual regulation, as they control access to sex by designating who is legally capable of sexual consent. Most states have adopted sexual incapacity tests for adults that focus narrowly on assessing an individual's cognitive abilities. These tests serve an important protective function for people with temporary cognitive impairments, such as those rendered incapable due to alcohol or drugs. However, this comes at the cost of barring many people with persistent cognitive impairments, such as Down Syndrome or Alzheimer's Disease, from any sexual activity. This is despite the fact that said individuals often still have sexual desires and are able to engage in sexual decision-making with support from caregiving networks. The central claim of this Article is that sexual incapacity doctrine should grant legal capacity to adults with persistent cognitive impairments if they are embedded in an adequate decision-making support network. In other words, the right to sexual expression should not be withheld due to cognitive impairment alone. To justify this claim, the Article provides a theory of sexual incapacity doctrine that is grounded in the practice of supported decision-making and the normative foundations of sexual capability and relational autonomy. The Article then sets forth a novel test for sexual consent capacity: cognition-plus. This test focuses on gauging the capacity for volition, assessing the mental capacity of the individual to understand the nature and consequences of the sexual decision, and evaluating the adequacy of the decision-making support system using principles of fiduciary law. The Article concludes by applying the cognition-plus test to the case of older adults with dementia, a group of increasing importance with the aging of the population.

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I. INTRODUCTION

Henry Rayhons and Donna Young did not expect to find love again after being widowed.¹ They met in their late 60s, and first flirted in church while singing for the choir. Two years later, they were getting married in front of over 350 guests. Now in their 70s, they enjoyed several activities together, such as beekeeping, farming, and long leisurely drives. They also had sex.² In 2010, Donna was diagnosed with Alzheimer’s Disease. As her condition worsened, two of her daughters from a previous marriage moved her to a residential care facility. Henry would regularly visit her, and on one visit in May 2014, Donna’s roommate thought she heard sexual noises coming from across the privacy curtain in their shared room. This led Donna’s daughters to seek guardianship over Donna and to limit Henry’s interactions with her. On August 8, 2014, Donna passed away. A week later, Henry was arrested and charged with felony sexual abuse on the basis that Donna Rayhons suffered a

¹This narrative is adapted from Bryan Gruley, *Rape Case Asks if Wife with Dementia Can Say Yes to Her Husband*, BLOOMBERG (Dec. 9, 2014), <http://www.bloomberg.com/news/articles/2014-12-09/rape-case-asks-if-wife-with-dementia-can-say-yes-to-her-husband> [<http://perma.cc/S7SZ-LPJ4>].

²*Id.* (“‘It was not a regular thing,’ Rayhons told the agent. At his age, he said, ‘you forget about that stuff and you just want togetherness.’ He said Donna on occasion asked for sex by saying, ‘Shall we play a little bit?’ He said he ‘never touched her when she didn’t want it and I only tried to fulfill her need when she asked for it.’”).

“mental defect” that made her unable to consent.³ Henry abandoned his run for another term as a state legislator, and the criminal case garnered national media attention.⁴ A week-long trial exposed details of Donna and Henry’s relationship, Donna’s medical condition, and their alleged sexual encounter in May. After two days of deliberations, the jury acquitted Henry of wrongdoing.⁵

Henry and Donna’s romance highlights how important sexuality can be to human flourishing, even in later life.⁶ It can bring pleasure and meaning, and can serve as a basis for identity and social relationships.⁷ The criminal charges against Henry show how the law can be used to regulate these relationships and sexuality. The sexual incapacity doctrines that were at play in that case are perhaps the most important form of sexual regulation, as they control access to sex by designating who is legally capable of sexual consent.⁸ When someone is deemed to lack legal capacity, the law imposes civil and criminal liability on sexual partners for battery and rape.⁹ In addition, it triggers vicarious liability

³ See Complaint & Affidavit at 1, *State v. Rayhons*, No. 02411 FECR010718 (Iowa Dist. Ct. Aug. 14, 2014), http://www.dps.state.ia.us/commis/pib/Releases/2014/Rayhons_Complaint_&_Affidavit.pdf [<http://perma.cc/93RR-XX2Q>].

⁴ See, e.g., Pam Belluck, *Sex, Dementia and a Husband on Trial at Age 78*, N.Y. TIMES (Apr. 13, 2015), <http://www.nytimes.com/2015/04/14/health/sex-dementia-and-a-husband-henry-rayhons-on-trial-at-age-78.html> [<http://perma.cc/WQ2T-7HZT>]; Sarah Kaplan, *In an Iowa Courtroom, an Astonishing Case of Sex and Alzheimer’s*, WASH. POST (Apr. 7, 2015), <http://www.washingtonpost.com/news/morning-mix/wp/2015/04/07/in-an-iowa-courtroom-an-astonishing-case-of-sex-and-alzheimers/> [<http://perma.cc/4NEU-JLEU>].

⁵ See Tony Leys & Grant Rodgers, *Rayhons: ‘Truth Finally Came Out’ with Not Guilty Verdict*, DES MOINES REG. (Apr. 22, 2015), <http://www.desmoinesregister.com/story/news/crime-and-courts/2015/04/22/henry-rayhons-acquitted-sexual-abuse/26105699/> [<http://perma.cc/56J4-LKX7>].

⁶ See Vicki Schultz, *Life’s Work*, 100 COLUM. L. REV. 1881, 1958 (2000) (“Sexuality and reproduction are a part of life, for example, as are disability and aging.”).

⁷ See GARETH MOORE, *THE BODY IN CONTEXT: SEX AND CATHOLICISM* 64–69 (2001) (arguing from a Catholic standpoint for the value of sexual pleasure); Gowri Ramachandran, *Delineating the Heinous: Rape, Sex, and Self-Possession*, 123 YALE L.J. ONLINE 371, 386 (2013) (“Who one has sex with often signifies something important about one’s social identity. It communicates what one finds desirable, who one is desirable to, even sometimes what one thinks about gender, domestic labor, and children.”); Carole S. Vance, *More Danger, More Pleasure: A Decade After the Barnard Sexuality Conference*, 38 N.Y.L. SCH. L. REV. 289, 316 (1993) (arguing that an understanding of sexuality must include an analysis of pleasure). Its absence, however, can cause loss, grief, and deterioration in health. See Evelyn M. Tenenbaum, *To Be or to Exist: Standards for Deciding Whether Dementia Patients in Nursing Homes Should Engage in Intimacy, Sex, and Adultery*, 42 IND. L. REV. 675, 681–82 (2009) (discussing the negative effects of the absence of close relationships).

⁸ See PETER WESTEN, *THE LOGIC OF CONSENT* 34–39 (2004) (describing capacity as a minimum requirement of consent).

⁹ See RESTATEMENT (SECOND) OF TORTS § 892A (AM. LAW INST. 1979) (noting that for consent to be valid as a defense to battery the person must have the capacity for

and regulatory consequences for institutions that are responsible for safeguarding those with cognitive impairments.¹⁰ The threat of this liability often leads institutions to establish highly restrictive sexual environments, especially in response to family member requests.¹¹

Sexual incapacity doctrines, however, shape more than just older adult sexuality. They have a wide reach, affecting sexually precocious minors, intoxicated teenagers on college campuses, and younger adults with Down Syndrome as well.¹² Most states have adopted incapacity tests for adults that focus narrowly on assessing an individual's cognitive abilities.¹³ These tests serve an important protective function for individuals with temporary and transient incapacity, such as those rendered incapable due to alcohol or drugs.¹⁴ However, this comes at the cost of barring many people with persistent forms of incapacity from any sexual activity.¹⁵ This is despite the

consent); 3 CHARLES E. TORCIA, *WHARTON'S CRIMINAL LAW* § 282 (15th ed. 1995) (describing incapacity as vitiating consent in the context of rape).

¹⁰ See Alan O. Sykes, *The Boundaries of Vicarious Liability: An Economic Analysis of the Scope of Employment Rule and Related Legal Doctrines*, 101 HARV. L. REV. 563, 563 (1988) (“‘Vicarious liability’ may be defined as the imposition of liability upon one party for a wrong committed by another party.”); Elizabeth Hill, Note, *We’ll Always Have Shady Pines: Surrogate Decision-Making Tools for Preserving Sexual Autonomy in Elderly Nursing Home Residents*, 20 WM. & MARY J. WOMEN & L. 469, 479 (2014) (discussing the regulatory consequences in the context of nursing homes).

¹¹ See Daniel Engber, *Naughty Nursing Homes: Is It Time to Let the Elderly Have More Sex?*, SLATE (Sept. 27, 2007), http://www.slate.com/articles/life/the_sex_issue/2007/09/naughty_nursing_homes.html [<http://perma.cc/JJ2M-P8WG>] (“Why are nursing-home administrators so queasy about sexual expression? They’re afraid of getting sued.”). There is a notable exception to this trend. See Bryan Gruley, *Boomer Sex with Dementia Foreshadowed in Nursing Home*, BLOOMBERG (July 22, 2013), <http://www.bloomberg.com/news/articles/2013-07-22/boomer-sex-with-dementia-foreshadowed-in-nursing-home> [<http://perma.cc/4RKJ-HVYA>] (discussing the sex-positive policies of Hebrew Home in New York).

¹² See *State v. McCurdy*, No. 13-0460, 2014 WL 467916, at *3 (Iowa Ct. App. Feb. 5, 2014) (minors); *Nicholson v. Commonwealth*, 694 S.E.2d 788, 789 (Va. Ct. App. 2010) (Down Syndrome); Amanda Hess, *How Drunk Is Too Drunk to Have Sex?*, SLATE (Feb. 11, 2015), http://www.slate.com/articles/double_x/doublex/2015/02/drunken_sex_on_college_campus_universities_are_struggling_to_determine_when_intoxicated.html [<http://perma.cc/2WWG-DYCM>] (students on college campuses).

¹³ See, e.g., *Melton v. State*, 639 S.E.2d 411, 415 (Ga. Ct. App. 2006) (noting that the victim could not “understand the consequences of her actions, including sexual acts”); *Durr v. State*, 493 S.E.2d 210, 212–13 (Ga. Ct. App. 1997) (emphasizing the victim’s weak memory capacity and the inability to relate cause and effect).

¹⁴ See Patricia J. Falk, *Rape by Drugs: A Statutory Overview and Proposals for Reform*, 44 ARIZ. L. REV. 131, 186 (2002) (discussing how the incapacity test helps “protect and vindicate the right of all citizens to be free of nonconsensual sexual exploitation”).

¹⁵ See Deborah W. Denno, *Sexuality, Rape, and Mental Retardation*, 1997 U. ILL. L. REV. 315, 324 (“In nearly all institutions, such a high consent standard can totally prohibit sexual relations among residents.”).

fact that said individuals often still have sexual desires and are able to engage in sexual decision-making with support from caregiving networks.¹⁶ By applying a test that focuses narrowly on cognitive abilities to individuals with persistent impairments, courts are unnecessarily and permanently restricting the sexual expression of millions of individuals, with intensely negative social, psychological, and health consequences.

The central claim of this Article is that sexual incapacity doctrine should grant legal capacity to adults with cognitive impairments if they are embedded in an adequate decision-making support network. In other words, the right to sexual expression should not be withheld due to cognitive impairment alone. To justify this claim, it provides a theory of sexual incapacity doctrine that is normatively grounded in sexual capability—a concept derived from the capabilities approach in economics and moral philosophy.¹⁷ Sexual capability is the opportunity to achieve certain states of being or perform certain activities associated with sexuality, such as experiencing sexual pleasure or forming a sexual identity.¹⁸ An individual's sexual capability is a product not only of that person's cognitive abilities, but also of her social resources and the legal treatment of those abilities and resources. For people with persistent cognitive impairments, those resources often include a decision-making support network composed of a single caregiver, a set of family members, or an institution's staff. These supportive networks highlight the relational nature of autonomy in the lived experience of people with persistent cognitive impairments.¹⁹

With this normative understanding, the Article sets forth a novel sexual consent capacity test for this population: cognition-plus.²⁰ It derives its name from a joint focus on the mental capacities of the subject (cognition) and the recognition that some individuals achieve sexual decision-making capacity through the assistance of a decision-making support network (plus). The test proceeds in three general steps. The first step is to gauge whether the individual has the threshold capacity to express volition with respect to a sexual decision. Without this manifestation of desire, one cannot proceed to be a sexual agent. If the first step is satisfied, the second step is to assess whether the individual has the necessary mental capacities to understand and reason about the nature and consequences of a given sexual decision. If one meets this requirement, then one has sexual consent capacity without the need for assistance.

If one does not meet that requirement, however, the third step is to evaluate whether there is an adequate decision-making support network in place. These networks can provide support to an individual in formulating her

¹⁶ *Id.* at 324–30.

¹⁷ *See generally* MARTHA C. NUSSBAUM, *CREATING CAPABILITIES: THE HUMAN DEVELOPMENT APPROACH* (2011); AMARTYA SEN, *INEQUALITY REEXAMINED* (1992).

¹⁸ *See infra* Part III.A.

¹⁹ *See infra* Part III.B.

²⁰ *See infra* Part IV.A.

purposes, connecting her desires with options, communicating with others, and creating a safe space to engage in sexual expression. Assessment of the system would be contextual in nature, guided by the principles of loyalty and care from fiduciary law. Thus, courts would evaluate whether the system is free from conflicts of interest, has adequate knowledge of the individual and the sexual decision, and has taken reasonable steps to protect the individual with cognitive impairments from the threat of sexually transmitted diseases and pregnancy. If the system is adequate, then the individual possesses sexual consent capacity.

The Article concludes by applying the cognition-plus test to the specific case of older adults with dementia.²¹ This population has received scant attention in the legal literature, even though it is a group of increasing importance with the aging of the population.²² The cognition-plus test would facilitate sexual expression among older adults with dementia by removing an unnecessary threat of liability from nursing homes and assisted living facilities, provided they supply an adequate supported decision-making environment. At the same time, it maintains the protective nature of sexual incapacity doctrines for those with persistent cognitive impairments.

This Article proceeds in three parts. Part II provides the background for understanding adult sexual incapacity doctrines. It defines key concepts, presents a taxonomy of incapacity, reviews how doctrines exert regulatory control over sexual life, and examines the weaknesses with existing doctrinal approaches. Part III argues for sexual capability as the normative basis of sexual incapacity doctrine and introduces the emerging concept and practice of supported decision-making, a manifestation of relational autonomy. Part IV outlines the key features of the cognition-plus test for sexual consent capacity and applies it to the case of older adults with dementia.

II. SEXUALITY AND INCAPACITY

This Part provides the background for understanding the sexual incapacity doctrine, its effects, and the contexts in which it is applied. Part A defines the key terms of sexuality and incapacity. It also introduces a taxonomy of the four contexts of incapacity, which are differentiated primarily by their temporal scopes. Part B examines how the law in this area exerts regulatory power through its imposition of liability on sexual partners and through its part in creating and reinforcing social norms. Part C reviews existing doctrinal and scholarly tests of sexual incapacity and their weaknesses.

²¹ See *infra* Part IV.B.

²² See Liesi E. Hebert et al., *Alzheimer Disease in the US Population: Prevalence Estimates Using the 2000 Census*, 60 ARCHIVES NEUROLOGY 1119, 1120 (2003) (projecting that the number of people with Alzheimer's Disease will increase to 13.2 million by 2050).

A. Definitions

In this Article, I adopt a broad definition of *sexuality*, encompassing the variety of desires, practices, identities, and relationships deemed sexual by an individual.²³ Thus, it includes the desire for sexual pleasure and the objects towards whom it is directed or not directed.²⁴ It also encompasses practices deemed sexual, including everything from holding hands and flirting to stimulation of the genitals, “kinky sex,” and a host of other practices.²⁵ These sexual practices, in turn, may help to form one’s identity, which could be based on one’s objects of desire (e.g., heterosexual), one’s sexual proclivities (e.g., dominatrix), or one’s method of sociosexual interaction (e.g., “ladies man”).²⁶ Finally, these desires, practices, and identities are social in nature, as other people are often the targets of desire, the participants in sexual activities, or members of shared sexual communities.²⁷ This definition is capacious, with the goal of being inclusive of the many forms sexuality takes.²⁸

Sexuality is also important.²⁹ It represents a unique source of pleasure, meaning, and social connection.³⁰ The Supreme Court has recognized a sexual

²³ See Ruth Colker, *Feminism, Sexuality, and Self: A Preliminary Inquiry into the Politics of Authenticity*, 68 B.U. L. REV. 217, 219 (1988) (defining sexuality as “in its broadest sense to refer to the full range of intimate connectedness that we might experience, including, but not limited to, sexual love or ‘eros.’”). My definition embraces the notion that sexuality is defined in part by a given social context in which an individual is situated. See JEFFREY WEEKS, *SEXUALITY* 7 (Routledge 2d ed. 2003) (1986) (claiming that “what we define as ‘sexuality’ is a historical construction, which brings together a host of different biological and mental possibilities, and cultural forms—gender identity, bodily differences, reproductive capacities, needs, desires, fantasies, erotic practices, institutions and values—which need not be linked together, and in other cultures have not been”).

²⁴ See IGOR PRIMORATZ, *ETHICS AND SEX* 46 (1999) (defining sexual desire as the “desire for certain bodily pleasures”); Alan H. Goldman, *Plain Sex*, 6 PHIL. & PUB. AFF. 267, 268 (1977) (defining sexual desire as “desire for contact with another person’s body and for the pleasure which such contact produces”).

²⁵ See Deborah Tuerkheimer, *Judging Sex*, 97 CORNELL L. REV. 1461, 1504 (2012) (discussing the importance of considering all sexual practices, “mainstream or outlandish, common or unusual, quotidian or kinky, normal or deviant”).

²⁶ See Ramachandran, *supra* note 7, at 386.

²⁷ See, e.g., JOHN D’EMILIO, *SEXUAL POLITICS, SEXUAL COMMUNITIES* 23–39 (1983) (tracing the creation of an urban gay subculture after World War II).

²⁸ It also reflects the reality that defining sex, a core facet of sexuality, is exceedingly difficult. Philosophers of sexuality have debated this conceptual-definitional question at length, with some claiming that no satisfying definition of sex is readily available. See RAJA HALWANI, *PHILOSOPHY OF LOVE, SEX, AND MARRIAGE* 123–30 (2010) (discussing how specifications of sex fail through counterexample).

²⁹ The degree of importance will vary across the population, with asexuals perhaps finding it less important than most due to the lack of sexual attraction they experience. See generally Elizabeth F. Emens, *Compulsory Sexuality*, 66 STAN. L. REV. 303, 316 (2014) (“[C]ontemporary asexuality is generally defined by two related ideas: lack of sexual attraction and lack of choice.”). The relatively capacious definition of sexuality used in this

liberty interest in *Lawrence v. Texas*, though its dimensions are actively debated by scholars.³¹ Other areas related to sexuality have also received constitutional protection. Marriage, which is the social institutionalization of a form of sexuality, has been deemed fundamental by the Court.³² The Court has also closely guarded the related principle of bodily integrity, though the constitutional justifications for this principle vary.³³ Whatever the contours of a right to sexual expression might be, the degree to which it extends to people who have cognitive impairments remains unexplored.³⁴

Capacity and *incapacity* are functional concepts. This means that incapacity is assessed with respect to the ability to make a particular decision,

Article would still be inclusive of the asexual experience, even if the legal implications of sexual contact that are explored here might not be as relevant for that population.

³⁰ See PAUL R. ABRAMSON & STEVEN D. PINKERTON, WITH PLEASURE: THOUGHTS ON THE NATURE OF HUMAN SEXUALITY 8–10 (rev. ed. 2002) (discussing the neurobiology of sexual pleasure); Rosalind Dixon, *Feminist Disagreement (Comparatively) Recast*, 31 HARV. J.L. & GENDER 277, 282–83 (2008) (describing the value of sex to women in particular).

³¹ *Lawrence v. Texas*, 539 U.S. 558 (2003). The literature on the meaning of *Lawrence* is voluminous. See, e.g., Randy E. Barnett, *Justice Kennedy's Libertarian Revolution: Lawrence v. Texas*, 2003 CATO SUP. CT. REV. 21, 21 (arguing that *Lawrence* stands for a broad liberty-based sexual entitlement); Katherine M. Franke, *The Domesticated Liberty of Lawrence v. Texas*, 104 COLUM. L. REV. 1399, 1400 (2004) (arguing the sexual right does not extend beyond the bedroom); Cass R. Sunstein, *Liberty After Lawrence*, 65 OHIO ST. L.J. 1059, 1060 (2004) (arguing that the scope of *Lawrence's* liberty interest is primarily constrained by consideration of third-party interests).

³² See *Obergefell v. Hodges*, 135 S. Ct. 2584, 2598 (2015) (“Over time and in other contexts, the Court has reiterated that the right to marry is fundamental under the Due Process Clause.”); *Loving v. Virginia*, 388 U.S. 1, 12 (1967) (characterizing marriage as “fundamental to our very existence and survival”). Some scholars, however, remain skeptical that the right to marry is more than a minimal right of equal access or that it is fundamental as a matter of due process. See Cass R. Sunstein, *The Right to Marry*, 26 CARDOZO L. REV. 2081, 2118 (2005).

³³ Sometimes it is rooted in an understanding of the body as being integral to a concept of personal autonomy or negative freedom against governmental intrusion. See *Rochin v. California*, 342 U.S. 165, 172 (1952) (holding that the state forcibly pumping a suspect's stomach for evidence “shocks the conscience”); *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891) (“No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person . . .”). At other points, it reflects a positive right to privacy, which indirectly protects some forms of reproductive sexuality. See *Roe v. Wade*, 410 U.S. 113, 152–53 (1973) (recognizing a sphere of personal privacy that protected a variety of autonomous decisions); *Eisenstadt v. Baird*, 405 U.S. 438, 453–54 (1972) (protecting a right to the use of contraception, regardless of marital status).

³⁴ The Court has explored the scope of other important rights in situations of incapacity. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) (recognizing a constitutionally protected liberty interest in the refusal of medical treatment, which can be exercised through surrogates during periods of incapacity).

rather than as a general status.³⁵ For instance, one might lack the capacity to engage in complex financial transactions, but still have the capacity to decide whether to eat broccoli or asparagus for lunch. Thus, we have numerous decisional capacity “switches,” which may be flipped on or off in various constellations. These switches may be understood either mentally or legally.³⁶

Mental incapacity is the condition of lacking the requisite psychological abilities to engage in autonomous decision-making.³⁷ The primary form is *cognitive incapacity*, or the inability to process decisions. In this situation, one either cannot appreciate information necessary to understand a decision or has defects in reasoning and judgment. In shorthand: “She didn’t know what she was doing.”³⁸ Mental incapacity is the product not only of internal psychological faculties but also of external circumstances. For example, people with Alzheimer’s Disease sometimes experience the phenomenon of “sundowning.”³⁹ These individuals may be relatively lucid when waking up in

³⁵ See THOMAS GRISSO & PAUL S. APPELBAUM, *ASSESSING COMPETENCE TO CONSENT TO TREATMENT: A GUIDE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS* 23 (1998) (discussing how capacity must be considered in terms of “the match or mismatch between the patient’s abilities and the decision-making demands of the situation that the patient faces”); Susanna L. Blumenthal, *The Default Legal Person*, 54 *UCLA L. REV.* 1135, 1176 (2007) (arguing that judges created a “default legal person” whose capacities varied by the doctrinal area in question); Lawrence A. Frolik & Mary F. Radford, “Sufficient” Capacity: *The Contrasting Capacity Requirements for Different Documents*, 2 *NAELA J.* 303, 305 (2006) (discussing the different levels of capacity required for different legal tasks).

³⁶ Some authors call what I refer to as mental capacity simply as “capacity” while referring to the legal evaluation of mental capacity as “competence.” See, e.g., Michael L. Perlin & Alison J. Lynch, “All His Sexless Patients”: *Persons with Mental Disabilities and the Competence to Have Sex*, 89 *WASH. L. REV.* 257, 263 (2014).

³⁷ See generally Kathryn Kaye & Jim Grigsby, *Medical Factors Affecting Mental Capacity*, in *CHANGES IN DECISION-MAKING CAPACITY IN OLDER ADULTS* 91 (Sara Honn Qualls & Michael A. Smyer eds., 2007) (describing the various conditions that can cause decreases in mental capacity).

³⁸ See 3 JOEL FEINBERG, *THE MORAL LIMITS OF THE CRIMINAL LAW* 316–17 (1986). The second type of mental incapacity is *volitional incapacity*, in which one can take in information and reason about it, but cannot act in accordance with it. As an example, an individual with certain serious forms of obsessive-compulsive disorder might find herself under some kind of compulsion to act, even if it might not be what she wants. In shorthand, this translates as “She couldn’t help herself.” See *id.* The third type of mental incapacity is *communicative incapacity*, or the inability to express a decision to others. For example, an individual who has suffered a stroke may be fully capable of forming preferences, processing information, and coming to a decision, but cannot express this choice to others. See *id.*; see also George J. Demakis, *State Statutory Definitions of Civil Incompetency/Incapacity: Issues for Psychologists*, 19 *PSYCHOL. PUB. POL’Y & L.* 331, 332 (2013) (noting that several states explicitly require communication skills in their incapacity statutes).

³⁹ See Ladislav Volicer et al., *Sundowning and Circadian Rhythms in Alzheimer’s Disease*, 158 *AM. J. PSYCHIATRY* 704, 704–05 (2001).

the morning, but at sundown their dementia will increase, leading to confusion and the inability to process decisions.⁴⁰

Legal incapacity, in contrast, is the condition of lacking the requisite legal authority to engage in autonomous decision-making. Put another way, the legal capacity inquiry determines whether a person is a legally recognized subject or not.⁴¹ Legal capacity is a prerequisite to making various decisions, such as voting, getting married, or hiring a lawyer.⁴² Being deemed a legally recognized subject may also expose an individual to negative consequences to which a person who lacks legal capacity would not be subject, such as criminal liability for illegal acts.⁴³

This Article uses the term *legal incapacity doctrine* to refer to any civil or criminal legal doctrine that deems an individual to lack decisional capacity in a particular domain. *Sexual incapacity doctrines* refer to those doctrines that do this with respect to sexual decision-making. In other words, even if one gives unambiguous, verbal, affirmative consent to sex—what I call *apparent consent*—this “Yes” may be transformed into a legal “No” by the sexual incapacity doctrine.⁴⁴ Sexual incapacity doctrines are part and parcel of a legal regime of sexual consent.⁴⁵ They serve to vitiate apparent consent due to some internal problem with perception, cognition, or emotion.⁴⁶ This contrasts with

⁴⁰ *Id.*

⁴¹ See Nancy J. Knauer, *Defining Capacity: Balancing the Competing Interests of Autonomy and Need*, 12 TEMP. POL. & C.R. L. REV. 321, 323 (2003) (“The determination of incapacity represents a crucial dividing line between legal subjects and those who are the object of legal protections.”).

⁴² See Naomi R. Cahn, *The Moral Complexities of Family Law*, 50 STAN. L. REV. 225, 256 (1997) (noting that capacity to marry is one of the few elements of common law marriage); Cynthia Godsoe, *All in the Family: Towards a New Representational Model for Parents and Children*, 24 GEO. J. LEGAL ETHICS 303, 334 (2011) (discussing the requirements of Model Rule of Professional Responsibility 1.14, governing attorney interactions with clients of diminished capacity); Sally Balch Hurme & Paul S. Appelbaum, *Defining and Assessing Capacity to Vote: The Effect of Mental Impairment on the Rights of Voters*, 38 MCGEORGE L. REV. 931, 935–45 (2007) (reviewing the constitutional and statutory provisions requiring capacity to vote).

⁴³ See generally Arlie Loughnan, *Mental Incapacity Doctrines in Criminal Law*, 15 NEW CRIM. L. REV. 1 (2012) (reviewing how mental incapacity doctrines play out in criminal law).

⁴⁴ See Emily J. Stine, *When Yes Means No, Legally: An Eighth Amendment Challenge to Classifying Consenting Teenagers as Sex Offenders*, 60 DEPAUL L. REV. 1169, 1183 (2011) (discussing this transformation in the context of statutory rape). Just because one cannot give legal consent to sex does not mean that one cannot dissent from sex. See *People v. Thompson*, 48 Cal. Rptr. 3d 803, 810 (Ct. App. 2006) (“Even a severely disabled person may object to a sexual touching because he or she finds it unpleasant—a ‘bad touch’; this does not necessarily mean he or she could give legal consent.”).

⁴⁵ See ALAN WERTHEIMER, *CONSENT TO SEXUAL RELATIONS* 215 (2003).

⁴⁶ See JOAN MCGREGOR, *IS IT RAPE?: ON ACQUAINTANCE RAPE AND TAKING WOMEN’S CONSENT SERIOUSLY* 141 (2005).

coercion or deception doctrines, which focus on external factors that vitiate consent because it is not voluntary or informed.⁴⁷

Mental and legal incapacity converge in many cases. Consider a recent case of intoxication and rape from Vanderbilt University.⁴⁸ On June 23, 2013, a young woman was drinking with several football players at an establishment called the Tin Roof Bar.⁴⁹ On the way back to their dorm, she passed out.⁵⁰ Several of the football players carried her body to the room of one of the players and proceeded to penetrate her mouth and vagina with their fingers and penises, as well as to insert a water bottle into her anus.⁵¹ All the while, they documented the event with their cell phones and sent text messages to other players.⁵² The sexual incapacity doctrine uncontroversially applies in cases such as this, when the subject is unconscious.⁵³ The lack of consciousness means that there is no capacity or opportunity to express volition—either in acceptance or refusal of sexual contact.⁵⁴ Two of the Vanderbilt players have been convicted of rape, with other involved players facing a variety of charges.⁵⁵

Mental and legal evaluations of incapacity may also diverge. One may be deemed legally capable when one arguably does not have the mental capacity for certain decisions. The application of the mature minor doctrine to minors who are convicted of serious crimes may be such an example.⁵⁶ Conversely, one may in fact be able to make certain decisions—in other words, one may

⁴⁷ This is not to say that these doctrines do not overlap or interact in many cases. *See id.* at 141–42 (“Notice that sometimes these categories are blurred, for example, . . . someone who is mentally retarded, an internal condition, is more likely to believe something that a ‘normal’ adult would not, and thereby would be more vulnerable to fraud.”).

⁴⁸ *See* Tony Gonzalez, *What Happened in the Vanderbilt Dorm? Rape Trial Starts Monday*, TENNESSEAN (Nov. 3, 2014), <http://www.tennessean.com/story/news/crime/2014/11/01/happened-dorm-room-vanderbilt-rape-trial-starts-monday/18277999/> [<http://perma.cc/XL4J-UPF4>].

⁴⁹ *See id.*

⁵⁰ *See id.*

⁵¹ *See* Tony Gonzalez, *Vanderbilt Rape Trial: Complete List of Charges*, TENNESSEAN (Jan. 27, 2015), <http://www.tennessean.com/story/news/crime/2015/01/27/vanderbilt-rape-trial-verdict-breakdown/22385025/> [<http://perma.cc/97C5-PF7F>].

⁵² *See Vanderbilt Rape Trial: Defendants Found Guilty on all Charges*, TENNESSEAN (Jan. 30, 2015), <http://www.tennessean.com/story/news/2015/01/27/vanderbilt-rape-case-verdicts/22419381/> [<http://perma.cc/QBK2-TN33>].

⁵³ *See* Commonwealth v. Erney, 698 A.2d 56, 59–60 (Pa. 1997) (accepting that unconscious sex is rape but exploring what unconsciousness means in the context of the Pennsylvania statute).

⁵⁴ *See id.*

⁵⁵ *See Vanderbilt Rape Trial: Defendants Found Guilty on all Charges*, *supra* note 52 (noting that the deliberations took three hours for a trial that lasted 12 days).

⁵⁶ *See* Elizabeth S. Scott, *The Legal Construction of Adolescence*, 29 HOFSTRA L. REV. 547, 548 (2000) (noting that even “[y]ouths who are in elementary school may be deemed adults for purposes of assigning criminal responsibility and punishment”).

not be psychologically impaired at all—but be deemed legally incapable of doing so. An example of this is the doctrine of coverture, which deemed a married woman legally incapable of making decisions about property because her legal personality had merged with that of her husband.⁵⁷

There are four primary types of mental incapacity, which are primarily differentiated by their temporal scopes.⁵⁸ *Temporary extended incapacity*, such as minority (i.e. being a minor), has a long duration but a definite end point. The mental incapacity is due to the fact that the individual's psychological faculties are not yet mature, but almost everyone will eventually age out of this condition.⁵⁹ In contrast to minority, *temporary transient incapacity* is relatively short-lived—it comes and goes. Examples include intoxication, episodic mental illness, or bouts of delirium.⁶⁰ *Persistent lifelong incapacity* does not go away and exists from a very early age. There is no “aging out,” and there is no “wearing off.” The paradigmatic example is intellectual disability, an umbrella term for a variety of cognitive impairments, including genetic conditions such as Down Syndrome.⁶¹ Finally, *persistent acquired incapacity* exists when a person suffers an impairment that does not go away, but which arises after a period of relatively unimpaired functioning.⁶² The paradigmatic example is dementia. The persistent incapacities are the primary

⁵⁷ See Jill Elaine Hasday, *The Canon of Family Law*, 57 STAN. L. REV. 825, 841–48 (2004) (reviewing the place of coverture in the canon of family law but noting its continued existence in other forms).

⁵⁸ See DERYCK BEYLEVELD & ROGER BROWNSWORD, CONSENT IN THE LAW 96 (2007) (discussing the “non-ideal-types” that deviate from the standard capable subject: “Some involve ostensible agents who are temporarily incapacitated or who have incapacitated themselves; some involve potential ostensible agents; some involve parties who are no longer ostensible agents; and some parties who never have been and never will be ostensible agents.”).

⁵⁹ See DAVID ARCHARD, SEXUAL CONSENT 116 (1998) (“They are not permanently disabled since they will (normally) acquire this capacity with age.”); Jennifer Ann Drobac & Leslie A. Hulvershorn, *The Neurobiology of Decision Making in High-Risk Youth and the Law of Consent to Sex*, 17 NEW CRIM. L. REV. 502, 504 (2014) (arguing that neurobiological evidence demonstrates that juveniles have different and less developed cognitive processes for sexual decision-making). Unfortunately, some individuals pass away before they reach the age of majority.

⁶⁰ See FEINBERG, *supra* note 38, at 320–21 (noting that sometimes these conditions can be recurring).

⁶¹ See Natalie Cheung, *Defining Intellectual Disability and Establishing a Standard of Proof: Suggestions for a National Model Standard*, 23 HEALTH MATRIX 317, 321–25 (2013) (describing the different definitions of intellectual disability adopted by various professional organizations).

⁶² This raises interesting and difficult issues of personal identity, as the preexisting self may have sexual interests that extend to the present impaired self. See A. Harry Lesser, *Dementia and Personal Identity*, in DEMENTIA: MIND, MEANING, AND THE PERSON 55, 56–61 (Julian C. Hughes et al. eds., 2006) (discussing the relationship of one's self to one's past); Evelyn M. Tenenbaum, *Sexual Expression and Intimacy Between Nursing Home Residents with Dementia: Balancing the Current Interests and Prior Values of Heterosexual and LGBT Residents*, 21 TEMP. POL. & C.R. L. REV. 459, 460 (2012).

focus of this Article, as the law is currently poorly calibrated to their unique nature.⁶³

B. *Liability and Social Norms*

Sexual incapacity doctrines exert regulatory control by imposing legal liability and influencing social norms about sexuality. The primary target for liability is the sexual partner of the person lacking legal capacity. Secondary targets are individuals or institutions that in some way have responsibility for individuals deemed to lack capacity.⁶⁴ Criminal liability arises from prohibitions on rape or sexual assault, which are applied to the sexual partner of the person lacking legal capacity.⁶⁵ Civil liability arises from tortious battery, which involves a tortfeasor engaging in harmful or offensive contact.⁶⁶ Consent serves as an affirmative defense to such a claim, but that defense is unavailable when the party in question is incapable of consenting.⁶⁷ In

⁶³It is important to keep in mind that these types of incapacity are not mutually exclusive. *See, e.g.*, KATE GORDON ET AL., *IDD AND DEMENTIA* 28 (July 2015), http://www.aoa.acl.gov/AoA_Programs/HPW/Alz_Grants/docs/IDD-and-Dementia.pdf [<http://perma.cc/BAR8-DND8>] (discussing the challenges of identifying and providing services to those who have both intellectual disabilities, a persistent lifelong incapacity, and dementia, a persistent acquired incapacity). In addition, people with persistent lifelong incapacity experience the temporary extended incapacity of minority, and anyone can experience the temporary transient incapacity of intoxication along with one of the other forms of incapacity.

⁶⁴*See, e.g.*, *Lindeman v. The Corp. of the President of the Church of Jesus Christ of Latter-Day Saints*, 43 F. Supp. 3d 1197, 1208 (D. Colo. 2014) (church); *Bjerke v. Johnson*, 727 N.W.2d 183, 189 (Minn. Ct. App. 2007) (farm employer); *Doe v. Mama Taori's Premium Pizza, LLC*, No. M1998-00992-COA-R9-CV, 2001 WL 327906, at *1 (Tenn. Ct. App. Apr. 5, 2001) (restaurant employer).

⁶⁵*See* TORCIA, *supra* note 9, § 282; Donald A. Dripps, *Beyond Rape: An Essay on the Difference Between the Presence of Force and the Absence of Consent*, 92 COLUM. L. REV. 1780, 1797–98 (1992) (discussing the liability regime of criminal rape). Sexual incapacity doctrines can be helpful to prosecutors when consent is ambiguous. *See* *Commonwealth v. Fuller*, 845 N.E.2d 434, 439 (Mass. App. Ct. 2006) (noting how prosecutors used evidence of incapacity to prove lack of consent when complainant and defendant dispute whether sex was consensual).

⁶⁶*See* RESTATEMENT (SECOND) OF TORTS § 13 (AM. LAW INST. 1965) (“An actor is subject to liability to another for battery if (a) he acts intending to cause a harmful or offensive contact with the person of the other or a third person, or an imminent apprehension of such a contact, and (b) a harmful contact with the person of the other directly or indirectly results.”); *id.* § 18 (substantially the same provision but offensive contact results); Ellen M. Bublick, *Tort Suits Filed by Rape and Sexual Assault Victims in Civil Courts: Lessons for Courts, Classrooms and Constituencies*, 59 SMU L. REV. 55, 67–84 (2006) (describing how tort suits may be a useful alternative to criminal trials for victims of sexual assault).

⁶⁷*See* RESTATEMENT (SECOND) OF TORTS § 892A(2) (AM. LAW INST. 1979) (“To be effective, consent must be (a) by one who has the capacity to consent or by a person empowered to consent for him, and (b) to the particular conduct, or to substantially the

addition to that direct civil liability, there may be vicarious civil liability for institutions. For example, the family of a nursing home resident might press a claim for negligent supervision if that resident was sexually battered while in the institution's care.⁶⁸

Finally, institutions face a body of regulatory law that punishes them for inappropriately caring for people who lack capacity and who are in their care.⁶⁹ This may include the loss of state or federal funding, which would have disastrous consequences for institutions that are reliant on such money.⁷⁰ It could further include loss of accreditation by relevant quasi-governmental regulatory bodies.⁷¹ Finally, individuals that work at such institutions might face sanctions in the form of revocation of professional licensure.⁷²

These impacts were on display in a recent case in which a 78-year old man and an 87-year old woman, both with dementia, were discovered having sex in

same conduct.”). See generally Nancy J. Moore, *Intent and Consent in the Tort of Battery: Confusion and Controversy*, 61 AM. U. L. REV. 1585 (2012) (exploring how intent and consent play out in the tort of battery).

⁶⁸ See, e.g., *Ayuluk v. Red Oaks Assisted Living, Inc.*, 201 P.3d 1183, 1190 (Alaska 2009) (adjudicating a vicarious liability claim for sexual assault of cognitively impaired patient by certified nurse's assistant); *Regions Bank & Trust v. Stone Cty. Skilled Nursing Facility, Inc.*, 49 S.W.3d 107, 115 (Ark. 2001) (adjudicating a negligent supervision claim for sexual assault of a semi-comatose patient); Jennifer Gimler Brady, *Long-Term Care Under Fire: A Case for Rational Enforcement*, 18 J. CONTEMP. HEALTH L. & POL'Y 1, 40 (2001) (“Tort lawsuits against nursing homes, as well as the size of verdicts in such cases, are increasing at an alarming pace.”); Marshall B. Kapp, *Malpractice Liability in Long-Term Care: A Changing Environment*, 24 CREIGHTON L. REV. 1235, 1239 (1991) (discussing the increasing liability concerns of nursing homes); Michael L. Rustad, *Neglecting the Neglected: The Impact of Noneconomic Damage Caps on Meritorious Nursing Home Lawsuits*, 14 ELDER L.J. 331, 385–87 (2006) (noting that forty-two percent of cases against nursing homes used a negligent supervision theory).

⁶⁹ See Philip C. Aka et al., *Political Factors and Enforcement of the Nursing Home Regulatory Regime*, 24 J.L. & HEALTH 1, 8 (2011) (discussing the history of nursing home regulations).

⁷⁰ See William Pipal, *You Don't Have to Go Home but You Can't Stay Here: The Current State of Federal Nursing Home Involuntary Discharge Laws*, 20 ELDER L.J. 235, 247–48 (2012) (“Because nursing homes receive more than sixty percent of their income from Medicaid and Medicare, the loss of federal funding can have significant financial consequences.”).

⁷¹ See Frederick Robinson & Melissa Thompson, *Accreditation, Licensure, Certification, and Surveying Bodies*, in 3 RISK MANAGEMENT HANDBOOK FOR HEALTHCARE ORGANIZATIONS 53, 60–62 (Glenn T. Troyer ed., 6th ed. 2011) [hereinafter RISK MANAGEMENT HANDBOOK] (describing the work of the Joint Commission on Accreditation of Healthcare Organizations, the voluntary body that accredits many health care organizations).

⁷² See Carl F. Ameringer, *State-Based Licensure of Telemedicine: The Need for Uniformity but Not a National Scheme*, 14 J. HEALTH CARE L. & POL'Y 55, 70–84 (2011) (examining the licensing and disciplinary functions of state boards); Jennifer P. Lundblad, *Rethinking Patient Safety Regulation: A Framework for Evaluating Regulatory Tools*, 32 HAMLINE J. PUB. L. & POL'Y 437, 438–41 (2011) (describing the professional licensing regime).

a nursing home.⁷³ When nurses tried to remove the woman from the situation, she screamed and bit and kicked them, showing her displeasure with the termination of the sexual contact. The head administrative staff had to determine whether to report the incident to the Iowa Department of Inspections and Appeals as a sexual assault. They concluded that no report was necessary, because there was no injury or evidence of force, and the woman appeared to consent to the encounter. They did, however, tell the families of the residents about the encounter, and the family of the woman sued the nursing home and nursing home staff, alleging rape. The Iowa Department of Inspections and Appeals caught wind of the situation, fined the nursing home, and threatened a loss of Medicaid and Medicare funding. The nursing home responded by expelling the man in the encounter to a nursing home more than two hours away from his family and firing the director of nursing and the nursing home administrator. The Iowa Board of Nursing revoked the license of the director of nursing as well.⁷⁴

In addition to these explicit legal and regulatory effects, the law has expressive effects when it invalidates the apparent consent choices of those who are deemed to lack legal capacity.⁷⁵ This is clearest in the case of criminal prohibitions, which carry the weight of societal condemnation for the acts that are deemed criminal.⁷⁶ But both civil and criminal doctrines act to construct the sexualities of citizens by demarcating the boundaries of acceptable and unacceptable sex and reinforcing existing understandings of the sexuality of certain groups.⁷⁷ Thus, the sanction and expressive functions of the law work in mutually reinforcing ways to regulate sexuality both in the behavior and attitudes of the people they govern.

⁷³ This narrative is adapted from Gruley, *supra* note 11, and Steve Drobot, Case No. 11-003, (Iowa Bd. of Nursing Home Adm'rs Sept. 11, 2012) (notice of hearing and statement of charges), <http://www.idph.state.ia.us/IDPHChannelsService/file.ashx?file=AEA204EE-AC91-428C-90E3-173949AE5407> [<http://perma.cc/2QGL-SVPE>].

⁷⁴ After a hearing, the Iowa Board of Nursing Home Administrators concluded that the nursing home administrator should keep his license. See Drobot, *supra* note 73, at 25.

⁷⁵ See Elizabeth S. Anderson & Richard H. Pildes, *Expressive Theories of Law: A General Restatement*, 148 U. PA. L. REV. 1503, 1514–27 (2000) (examining the difficulties of conceptualizing the state as an agent of expression); Cass R. Sunstein, *On the Expressive Function of Law*, 144 U. PA. L. REV. 2021, 2051 (1996) (“Many debates over the appropriate content of law are really debates over the statement that law makes, independent of its (direct) consequences. . . . [T]he expressive function of law has a great deal to do with the effects of law on prevailing social norms.”).

⁷⁶ See JOEL FEINBERG, *The Expressive Function of Punishment*, in *DOING & DESERVING: ESSAYS IN THE THEORY OF RESPONSIBILITY* 95, 98 (1970); CHARLES FRIED, *AN ANATOMY OF VALUES: PROBLEMS OF PERSONAL AND SOCIAL CHOICE* 125–32 (1970).

⁷⁷ See MARY JOE FRUG, *POSTMODERN LEGAL FEMINISM* 128–31 (1992) (discussing how the law’s regulation of sex creates a certain normative vision of sexuality); Kate Sutherland, *From Jailbird to Jailbait: Age of Consent Laws and the Construction of Teenage Sexualities*, 9 WM. & MARY J. WOMEN & L. 313, 313 (2003) (describing how the law helps to construct adolescent sexuality).

C. Problems with Existing Approaches

In criminal law, state statutes prescribe sexual incapacity. The standard statutory construction is to list a variety of incapacitating conditions that vitiate consent, including everything from age to intoxication, mental disorder, being asleep, or being in the custody of the state.⁷⁸ Other statutes use more general language, just referencing “mental incapacity” or “unsoundness of mind.”⁷⁹ Courts have interpreted this more general language flexibly, including various conditions under it.⁸⁰ In tort law, judges often draw from the criminal law’s methods of constructing incapacity on a case-by-case basis.⁸¹

After the conditions potentially constituting incapacity have been identified and labeled, courts must flesh out what these identifying labels mean

⁷⁸ See, e.g., ARIZ. REV. STAT. ANN. § 13-1401(1)(b) (2010) (“The victim is incapable of consent by reason of mental disorder, mental defect, drugs, alcohol, sleep or any other similar impairment of cognition . . .”); OKLA. STAT. tit. 21, § 1111 (2015) (separating out minority, mental illness or unsoundness of mind, involuntary intoxication, unconsciousness, in legal custody, or under educational supervision); TEX. PENAL CODE ANN. § 22.011(b) (West 2011) (listing eleven different conditions). People with persistent cognitive impairments are often referred to by antiquated terms such as “mentally defective.” See, e.g., ALA. CODE § 13A-6-70(c)(2) (LexisNexis 2005); MONT. CODE ANN. § 45-5-501(1)(a)(ii)(A) (2013). Even when statutes spell out these different situations of incapacity, courts sometimes interpret factual situations that would clearly fall under one prong of the statute under another prong. See, e.g., *State v. Farnum*, 554 N.W.2d 716, 721 (Iowa Ct. App. 1996) (“It appears the ‘incapacity’ alternative of section 709.4(2)(a) is generally applied in cases of retarded or low-functioning victims. However, nothing in the statute or case law indicates the term ‘incapacity’ could not extend to a person rendered unconscious from intoxication.” (citations omitted)).

⁷⁹ See, e.g., VA. CODE ANN. § 18.2-61(A) (2014) (“If any person has sexual intercourse with a complaining witness, whether or not his or her spouse . . . through the use of the complaining witness’s mental incapacity or physical helplessness . . . he or she shall be guilty of rape.”). Mental incapacity is often provided for in a definitions section. See *id.* § 18.2-67.10(3) (defining “mental incapacity” as “condition of the complaining witness existing at the time of an offense under this article which prevents the complaining witness from understanding the nature or consequences of the sexual act involved in such offense and about which the accused knew or should have known”); see also IDAHO CODE § 18-6101(3) (Supp. 2015) (“unsoundness of mind”); LA. STAT. ANN. § 14:43(A)(2) (Supp. 2015) (same).

⁸⁰ See, e.g., *Molina v. Commonwealth*, 636 S.E.2d 470, 474 (Va. 2006) (rejecting a construction of the Virginia statute that would not include intoxication under the definition of the mental incapacity); see also *Ragsdale v. State*, 23 P.3d 653, 656–57 (Alaska Ct. App. 2001) (construing “mentally incapable” to include intoxication, a temporary impairment); *Jackson v. State*, 890 P.2d 587, 589 (Alaska Ct. App. 1995) (construing “mentally incapable” to include a woman with mental retardation, a persistent impairment).

⁸¹ See, e.g., *Reavis v. Solminski*, 551 N.W.2d 528, 539 (Neb. 1996) (noting that the criminal law analysis of consent is “equally applicable in tort law”); *Wilson v. Tobiassen*, 777 P.2d 1379, 1384 (Or. Ct. App. 1989) (holding that incapacity under criminal statutes extends to civil cases); *C.C.H. v. Philadelphia Phillies, Inc.*, 940 A.2d 336, 339 (Pa. 2008) (“[E]vidence of the victim’s consent to sexual contact, like in criminal proceedings, is not an available defense in determining a defendant’s civil liability.”).

through legal tests. For the temporary extended incapacity of minors, this is an easy task, as all states have adopted a bright-line age of consent rule for sexual activity, typically set between sixteen or eighteen years of age.⁸² The bright-line age of consent rule embodies multiple policy aims, such as preventing those who lack mental capacity from making unwise decisions and protecting individuals from coercion, whereas these doctrines are unbundled for adults.⁸³ This treatment of sexual incapacity for minors is justified by the fact that the age of consent rule represents only a temporary disability, and everyone will eventually outgrow the incapacity.⁸⁴ It is also highly administrable, as it only requires evidence of age.⁸⁵

For adults, sexual incapacity is considered as a separate doctrine, which is typically more standard-like in form.⁸⁶ A key feature of many states' legal tests is that they focus narrowly on the mental capacities of the subject. At the most basic level, these tests require that an individual have the capacity to understand that there is a decision to be made and that she has the ability to say yes or no, to consent or not.⁸⁷ Beyond this, tests vary. Some are relatively underdeveloped, focusing simply on evidence of disability⁸⁸ or on whether a

⁸² See, e.g., ARIZ. REV. STAT. ANN. § 13-1405(A) (2010) (eighteen); 720 ILL. COMP. STAT. ANN. 5/11-1.50(b) (West Supp. 2015) (seventeen); NEV. REV. STAT. ANN. § 200.364(6) (LexisNexis Supp. 2013) (sixteen). The picture is complicated slightly by "Romeo and Juliet" exceptions in many states, which permit sex between minors or between minors and adults who are close in age. See, e.g., N.H. REV. STAT. ANN. § 632-A:3(II) (Supp. 2014) (permitting sexual relations with someone aged 13–16 if within four years of age); VT. STAT. ANN. tit 13, § 3252(c)(2) (2009) (permitting sexual relations between individuals aged fifteen to nineteen). Some states have also adopted marital exceptions. See, e.g., CAL. PENAL CODE § 261.5(a) (West 2014) ("Unlawful sexual intercourse is an act of sexual intercourse accomplished with a person who is not the spouse of the perpetrator, if the person is a minor."). In these cases, the court merely has to ascertain the ages or marital status of the sexual partners in question.

⁸³ See Kathleen M. Sullivan, *The Justices of Rules and Standards*, 106 HARV. L. REV. 22, 58–59 (1992) (noting how rules captures background policies imperfectly while standards apply them directly).

⁸⁴ See ARCHARD, *supra* note 59, at 116.

⁸⁵ See Sullivan, *supra* note 83, at 58 ("A legal directive is 'rule'-like when it binds a decisionmaker to respond in a determinate way to the presence of delimited triggering facts."). Whether or not this form of the rule is correct or desirable is beyond the scope of this Article, but if states were to depart from such a bright-line rule, this Article's analysis of the appropriate legal test might prove useful. See generally Joseph J. Fischel, *Per Se or Power? Age and Sexual Consent*, 22 YALE J.L. & FEMINISM 279, 311 (2010) (providing helpful analysis of some of these age-of-consent issues).

⁸⁶ See Sullivan, *supra* note 83, at 58 ("A legal directive is 'standard'-like when it tends to collapse decisionmaking back into the direct application of the background principle or policy to a fact situation.").

⁸⁷ See, e.g., *In re David K.*, No. 1 CA-JV 08-0182, 2009 WL 1606018, at *1 (Ariz. Ct. App. June 9, 2009) (showing the court's discomfort with the victim's inability to express discontent).

⁸⁸ See, e.g., *Anderson v. State*, 381 So. 2d 1019, 1021–22 (Miss. 1980) ("Here, the proof shows without contradiction that the victim was mentally incapable of consenting to

person can exercise “judgment.”⁸⁹ In states with more developed tests, courts tend to analyze whether an individual has the ability to understand the nature and consequences of sexual activity.⁹⁰ Courts typically group consequences into physical and nonphysical categories.⁹¹ The physical consequences include the possibility of pleasurable sexual release, pregnancy, or sexually transmitted diseases. Nonphysical consequences consist of the potential feelings of mental pleasure or displeasure from the sexual encounter, mental consequences for one’s sense of self, or social consequences in the form of changes in the nature of relationships with others.

New York has adopted a broad test for determining capacity, requiring the ability “to appraise the sexual act, its significance and its consequences,” including consideration of the “‘moral quality’ of the act as it would be measured by society.”⁹² This incorporates moral consequences into the test, an approach that few courts have followed, often citing problems with the vagueness of this standard.⁹³ North Dakota’s case law is characteristic of a more moderate and common approach, requiring that an individual “understand the nature of the sexual act as well as its consequences such as pregnancy and sexually transmitted diseases but not the moral nature of their participation in the act of intercourse.”⁹⁴

sexual intercourse.”); *State v. Burks*, 267 S.E.2d 752, 753 (W. Va. 1980) (merely repeating the statutory language stating that someone who is “mentally defective or mentally incapacitated” cannot consent).

⁸⁹ See *Ely v. State*, 384 S.E.2d 268, 271–72 (Ga. Ct. App. 1989) (declaring “a female victim, who due to the degree of mental retardation suffered, is incapable of giving an intelligent assent or dissent and to exercise judgment”); *State v. Willenbring*, 454 N.W.2d 268, 270 (Minn. Ct. App. 1990) (repeating the statutory language requiring “judgment to give a reasoned consent to sexual contact or to sexual penetration”).

⁹⁰ Note that capacity does not require actual knowledge of the consequences of sex; it just requires the capacity to process whatever these consequences might be. Of course, whether one has actual knowledge may be relevant to the inquiry into whether one has the capacity to acquire such knowledge. See, e.g., *State v. Ferguson*, No. 99AP-819, 2000 WL 675042, at *6–7 (Ohio Ct. App. May 25, 2000) (finding probative the victim’s lack of understanding of social mores).

⁹¹ For another typology, see, for example, RICHARD A. POSNER, *SEX AND REASON* 111 (1992), categorizing the consequences as “*procreative, hedonistic, and sociable*.”

⁹² *People v. Easley*, 364 N.E.2d 1328, 1333 (N.Y. 1977); see also *People v. Cox*, 709 N.W.2d 152, 156 (Mich. Ct. App. 2005) (noting as relevant that the victim could not understand the repercussions of engaging in homosexual acts with the perpetrator); *People v. Breck*, 584 N.W.2d 602, 605 (Mich. Ct. App. 1998) (“We find persuasive, and therefore adopt, the reasoning contained in the *Easley* decision and hold that the statutory language in question is meant to encompass not only an understanding of the physical act but also an appreciation of the nonphysical factors, including the moral quality of the act, that accompany such an act.”).

⁹³ See *State v. Sullivan*, 298 N.W.2d 267, 272 (Iowa 1980) (striking down as unconstitutionally vague a statute requiring “the mental capacity to know the right and wrong of conduct in sexual matters”).

⁹⁴ *State v. Mosbrucker*, 758 N.W.2d 663, 667 (N.D. 2008).

The nature and consequences test has its conceptual merits, especially in its application to situations of temporary transient incapacity.⁹⁵ In those situations, it serves to protect a baseline non-impaired self (who will reemerge) against sexual exploitation by others while one is in a temporarily altered mental state.⁹⁶ Because of the relatively short duration of the incapacity in that context, the restriction on sexual opportunities is relatively minor. In contrast, people with persistent incapacity may face lifetime restrictions on sexual activity if their cognitive abilities are deemed inadequate. There is also no non-impaired self who will reemerge to benefit from any restriction that is placed on sexual activity.⁹⁷ This result also has concrete effects on social and

⁹⁵This is not to say that the test is without its problems. First, the level of incapacity at the time of the encounter is often difficult to assess because the incapacitating condition wears off, often before incapacity can be evaluated. See Sharon Cowan, *The Trouble with Drink: Intoxication, (In)capacity, and the Evaporation of Consent to Sex*, 41 AKRON L. REV. 899, 902 (2008) (reviewing methods of determining whether there is capacity to consent in situations of intoxication). Second, many intoxication cases involve situations of voluntary and mutual intoxication, and courts sometimes pick up on this contextual fact to protect male defendants and disadvantage female complainants. See Karen M. Kramer, *Rule by Myth: The Social and Legal Dynamics Governing Alcohol-Related Acquaintance Rapes*, 47 STAN. L. REV. 115, 115 (1994) (“If the rapist was drunk, it reduces his culpability, but if the victim was drunk, it increases her culpability.”). Scholars have struggled with how to deal with these issues. See Falk, *supra* note 14, at 187–88 (arguing for the intoxication to be specifically referenced in statutes and involuntary intoxication and subsequent “rape by drugs” to be punished more severely); Christine Chambers Goodman, *Protecting the Party Girl: A New Approach for Evaluating Intoxicated Consent*, 2009 BYU L. REV. 57, 86 (2009) (arguing for a sliding-scale notion of consent in intoxicated encounters); Clare Carlson, Comment, “*This Bitch Got Drunk and Did This to Herself: Proposed Evidentiary Reforms to Limit “Victim Blaming” and “Perpetrator Pardoning” in Rape by Intoxication Trials in California*,” 29 WIS. J.L. GENDER & SOC’Y 285, 308–10 (2014) (arguing for the inadmissibility of evidence of voluntary intoxication under California rules).

⁹⁶In fact, this reasoning derives from the traditional distinction at common law between the lunatic, whose condition was temporary, and the idiot, whose condition was lifelong and persistent. See Louise Harmon, *Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment*, 100 YALE L.J. 1, 16–18 (1990) (describing how the Crown was limited in its control over the lunatic’s property because if the lunatic regained capacity, her property would have to be returned to her).

⁹⁷One could argue that a mitigating factor for those with persistent acquired incapacity is that they already had sexual opportunities early in life. In other words, they had their “fair innings.” See, e.g., Alan Williams, *Intergenerational Equity: An Exploration of the ‘Fair Innings’ Argument*, 6 HEALTH ECON. 117, 129 (1997) (making this argument in the allocation of health care). This argument is not valid in this context, for two reasons. First, persistent acquired incapacity can strike at any age, even if it might affect older adults more. This raises the question of where to draw the line of when one has achieved sufficient sexual opportunities. Second, this argument is typically applied in situations of scarce resources, when one has to trade off between two individuals who need the same resource. Sexual opportunities are not limited resources in the same way, and allowing more people sexual opportunities will actually have the effect of increasing potential sexual partners for others.

sexual norms. To the degree that a class of individuals is deemed to lack sexual consent capacity, this can devalue them and construct them either as asexual and undesirable or as hypersexual and in need of control.⁹⁸

Thus, the nature and consequences test leads to undesirable outcomes in two important contexts in which it is applied—persistent lifelong incapacity and persistent acquired incapacity—creating the need for an alternative test for persistent cognitive impairments. This problem has not gone unrecognized by courts or in the legal scholarship, but the proposed solutions have their own significant drawbacks. For example, in an attempt to get away from tests that focus on the mental capacity to judge consequences, New Jersey follows a “nature of the conduct” test, as expressed in *State v. Olivio*:

The cognitive capacity . . . involves the knowledge that the conduct is distinctively sexual. In the context of this criminal statute, that knowledge extends only to the physical or physiological aspects of sex; it does not extend to an awareness that sexual acts have probable serious consequences, such as pregnancy and birth, disease, infirmities, adverse psychological or emotional disorders, or possible adverse moral or social effects.⁹⁹

This is a rather minimal requirement of capacity, requiring volition but not an understanding of the consequences of sex.¹⁰⁰ This test would certainly allow a wide range of sexual activity by people with persistent cognitive impairments. However, it would place them at risk of significant welfare threats by permitting sexual activity merely if they said “yes,” even if they had no capacity to understand the consequences of the decision, such as pregnancy or sexually transmitted diseases.

Instead of narrowing the sexual incapacity inquiry to mere volition, many scholars have instead suggested widening the inquiry beyond the mental capacities of the subject when looking at persistent cognitive impairments.

⁹⁸ See Harlan Hahn, *Feminist Perspectives, Disability, Sexuality and Law: New Issues and Agendas*, 4 S. CAL. REV. L. & WOMEN'S STUD. 97, 118–24 (1994) (discussing the history of “asexual objectification”); see also Elizabeth F. Emens, *Intimate Discrimination: The State's Role in the Accidents of Sex and Love*, 122 HARV. L. REV. 1307, 1325 (2009) (discussing the hypersexualization of people with disabilities); Ralph Sandland, *Sex and Capacity: The Management of Monsters?*, 76 MODERN L. REV. 981, 982–83 (2013) (discussing how the “animal instincts” doctrine painted females with cognitive impairments as dangerous).

⁹⁹ *State v. Olivio*, 589 A.2d 597, 604–05 (N.J. 1991).

¹⁰⁰ It is not entirely clear how many courts, including in New Jersey, actually follow this approach. The statutory language in many states includes the term “nature of the conduct,” but few seem to follow *Olivio* explicitly, and some adopt a nature and consequences test in spite of more limited statutory language. See *State v. Mosbrucker*, 758 N.W.2d 663, 667 (N.D. 2008) (creating a nature and consequences test despite having “nature of his or her conduct” language in the relevant statute, N.D. CENT. CODE § 12.1-20-03(1)(e)); *People v. Whitten*, 647 N.E.2d 1062, 1067 (Ill. App. Ct. 1995) (same, although creating a totality of the circumstances test instead); Denno, *supra* note 15, at 345 n.188 (noting that other courts tend not to follow *Olivio* directly).

Professor Deborah Denno's test is emblematic and the most prominent of these approaches.¹⁰¹ Her "contextual approach" would assess not only the intellectual capacities of the subject, but also the "factual, moral, and contextual aspects of each case."¹⁰² The inquiry would be guided by the principle that people with persistent cognitive impairments should not be judged by a higher consent standard than those without these impairments.¹⁰³ This approach may be compatible with the case law of certain states, such as Illinois, which has adopted a broad "totality of the circumstances" test for sexual incapacity, allowing a consideration of a host of factors.¹⁰⁴

This open-ended flight to context poses its own difficulties. Without further specificity, all facts are potentially relevant to the capacity inquiry under the contextual approach.¹⁰⁵ The proffered limiting principle is helpful to the extent that it prohibits blanket restrictions on sexual activity due just to cognitive impairments, but it provides little guidance beyond that.¹⁰⁶ This has two negative effects. First, it provides no predictability to institutions that house people with persistent incapacities about whether they will be exposed to liability by permitting residents to engage in sexual activity. In fact, it may create more uncertainty than the current regime, as it widens the factual inquiry by the court. This will perhaps make institutions even more fearful of liability and cause them to restrict sexual environments further.

Second, it delegates to the courts the task of sorting out what factual, moral or contextual factors might be relevant to the capacity inquiry. Inviting judges to make somewhat unrestricted normative judgments in the area of capacity is a perilous endeavor, as the checkered history of incapacity doctrines demonstrates.¹⁰⁷ Putting judges in charge of sexual judgments will serve to promote certain types of mainstream sexual relationships and

¹⁰¹ See Denno, *supra* note 15, at 355–56.

¹⁰² *Id.* at 359.

¹⁰³ *Id.* at 355.

¹⁰⁴ See Whitten, 647 N.E.2d at 1067.

¹⁰⁵ The complexity of the decisional domain does not necessarily demand such an open-ended test. See Louis Kaplow, *Rules Versus Standards: An Economic Analysis*, 42 DUKE L.J. 557, 586–96 (1992) (distinguishing complexity from the choice of a rule or standard).

¹⁰⁶ The limit on blanket restrictions seems to be the focus of this principle in Professor Denno's applications. See, e.g., Denno, *supra* note 15, at 369–70 ("By implicitly presuming that Betty may not be able to consent to sexual intercourse under any circumstances, the court's ruling also ensured that she would be judged from a higher consent standard than her nonretarded counterpart."). Of course, one could argue that people with cognitive impairments are de facto being held to a higher consent standard by virtue of having their mental capacity evaluated by third parties at all. This further reinforces the point that the principle provides insufficient guidance in application.

¹⁰⁷ See Knauer, *supra* note 41, at 341–42 (noting that capacity doctrines have been used to oppress various groups in society). See generally Susan Stefan, *Silencing the Different Voice: Competence, Feminist Theory and Law*, 47 U. MIAMI L. REV. 763 (1993) (arguing that capacity has been used as a way of obscuring the power differentials that women face).

practices over other, more deviant ones.¹⁰⁸ In addition, the exercise of this judicial authority to prohibit certain forms of sexual expression will typically fall hardest on those with disfavored sexualities, such as women, racial minorities, people with disabilities, older adults, and sexual minorities.¹⁰⁹ In short, some context is needed to escape the problems of the nature and consequences test, but the contextual inquiry needs more structure to constrain judges in their judgments and to make those judgments more predictable.¹¹⁰

¹⁰⁸ See Gayle Rubin, *Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality*, in PLEASURE AND DANGER: EXPLORING FEMALE SEXUALITY 267, 281 (Carole S. Vance ed., 1984) (describing how society typically divides up “good sex” and “bad sex”).

¹⁰⁹ See MICHAEL GILL, ALREADY DOING IT: INTELLECTUAL DISABILITY AND SEXUAL AGENCY 17 (2015) (“Notions about the ability to be sexual are intertwined with gendered, classed, and racialized assessments of fitness.”); Luke A. Boso, *Urban Bias, Rural Sexual Minorities, and the Courts*, 60 UCLA L. REV. 562, 566 (2013) (describing how these biases can disadvantage rural sexual minorities); Elaine Craig, *Capacity to Consent to Sexual Risk*, 17 NEW CRIM. L. REV. 103, 108–13 (2014) (arguing that avoiding normative assessment of sex better serves women and sexual minorities); Helen Meekosha, *Body Battles: Bodies, Gender, and Disability*, in THE DISABILITY READER 163, 173–78 (Tom Shakespeare ed., 1998) (describing the regulation and surveillance of female disabled bodies); Ruthann Robson, *Judicial Review and Sexual Freedom*, 30 U. HAW. L. REV. 1, 19 (2007) (reviewing approaches critical of judicial methods of securing sexual freedom); Michael B. Shortnacy, *Sexual Minorities, Criminal Justice, and the Death Penalty*, 32 FORDHAM URB. L.J. 231, 231 (2005) (noting how such bias operates against sexual minorities, undercutting other legal victories).

¹¹⁰ The contextual models of other scholars are subject to similar objections. Professors Janine Benedet and Isabel Grant, writing from the Canadian perspective, propose that sexual capacity tests should focus on the contextual factors of the power dynamics of the relationship, coercion, and voluntariness. See Janine Benedet & Isabel Grant, *Hearing the Sexual Assault Complaints of Women with Mental Disabilities: Consent, Capacity, and Mistaken Belief*, 52 MCGILL L.J. 243, 279–87 (2007). While the authors’ focus on combating sexual abuse of women with disabilities is laudable, their test collapses the capacity and coercion inquiries, concentrating on the latter. This creates a robust coercion doctrine, which is valuable, especially in abuse of trust cases where a professional engages in sexual relations with a vulnerable client with disabilities. This approach, however, fails to provide a positive account of when people with persistent cognitive impairments can attain legal capacity and exercise their sexual capabilities. This truncated understanding of capacity creates an opening for judges to impose their own views about sexual morality in discriminatory ways.

Working in the context of adolescents, Professor Jennifer Ann Drobac has proposed an intriguing sexual capacity standard of legal assent. This is a form of consent that is voidable by the minor after the fact for tort law purposes if it is in the best interests of the subject to do so, while at the same time maintaining the possibility of independent criminal law prosecution. See Jennifer Ann Drobac, *A Bee Line in the Wrong Direction: Science, Teenagers, and the Sting to “the Age of Consent,”* 20 J.L. & POL’Y 63, 113–15 (2011). This test was developed in the context of the temporary extended incapacity of minority, and it might be a poor fit for more persistent forms of incapacity. Delegating the contextual analysis of “best interests” to the minor avoids the problem of judicial overreach, but a regime of voidable consent provides little predictability for institutions, caregivers, or sexual partners about how to proceed in the face of someone who has cognitive impairments and sexual desires. In addition, it does not touch on criminal law doctrines,

Part II defined the relevant terms for the argument in this Article and described how the law operates to restrict sexual activity through the liability it imposes and the social norms it reinforces. Finally, it set out the basic problem with the dominant nature and consequences test: it overly restricts the sexual lives of people living in contexts of persistent lifelong incapacity and persistent acquired incapacity. The alternatives have their own problems. The nature of the conduct test opens up the possibility of too many welfare threats, and the contextual approach gives too much leeway to judges to decide the sexual lives of people with disabilities and provides no predictability about liability exposure. The next part lays the groundwork for reforming sexual incapacity doctrine by evaluating the normative bases of the doctrine while also examining the lived experiences of people with persistent incapacities.

III. NORMATIVE FOUNDATIONS AND LIVED EXPERIENCES

The issues with adult sexual incapacity doctrines identified in Part II derive from both theoretical and practical sources. The theoretical source is the autonomy value that underlies and heavily influences the form of the current doctrine.¹¹¹ Cognitive capacity is cast as a necessary precondition of that autonomy, and thus a legal test that solely inquires into the cognitive capacities of the subject is seen as vindicating that value.¹¹² This understanding of autonomy has been critiqued for its exclusion of people who do not fit the ideal mold of independent cognitively unimpaired agents.¹¹³ Thus, it is not surprising that the legal test that derives from that value is

which are often the biggest driver of restrictive sexual environments for people with disabilities.

¹¹¹ See, e.g., ALLEN E. BUCHANAN & DAN W. BROCK, *DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING* 36–40 (1990) (discussing the importance of self-determination to informed consent); Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 *VILL. L. REV.* 1705, 1771–77 (1992) (discussing the role of autonomy in mental health law).

¹¹² See GERALD DWORKIN, *THE THEORY AND PRACTICE OF AUTONOMY* 20 (1988) (understanding autonomy as “a second-order capacity of persons to reflect critically upon their first-order preferences, desires, wishes, and so forth and the capacity to accept or attempt to change these in light of higher-order preferences and values”); FEINBERG, *supra* note 38, at 28 (describing autonomy as a capacity for self-government, which “is determined by the ability to make rational choices, a qualification usually so interpreted as to exclude infants, insane persons, the severely retarded, the senile, and the comatose, and to include virtually everyone else”).

¹¹³ See, e.g., Eva Feder Kittay, *The Ethics of Care, Dependence, and Disability*, 24 *RATIO JURIS.* 49, 51 (2011) (“I want to suggest that an ethics that puts the autonomous individual at the forefront, that eclipses the importance of our dependence on one another, . . . is not one to be preferred in the construction of an ethics of inclusion . . .”); see also MARILYN FRIEDMAN, *AUTONOMY, GENDER, POLITICS* 30–55 (2003) (summarizing critiques of autonomy and suggesting a reconfiguration of the concept rather than a wholesale rejection). One possibility for such a reconfiguration is the concept of relational autonomy, explored *infra* Part III.B.

subject to a similar critique. This creates a need for a new normative basis for the doctrine that is inclusive of people with persistent cognitive impairments.¹¹⁴

The practical source of the problem is the fact that the adult sexual incapacity doctrine is not calibrated for the variety of situations in which it is applied. These include both temporary transient incapacities like intoxication as well as persistent incapacities such as Down Syndrome and dementia. The decision-making contexts for persistent lifelong and persistent acquired incapacity are different, as they lack the quality of a reemerging self with mental capacity and often involve decision-making with the assistance of others. Any test of sexual incapacity that applies to these two contexts should take into account the lived experiences of people in those situations.

This Part endeavors to address these theoretical and practical problems. Part A argues that the primary theoretical basis for sexual incapacity doctrines should be sexual capability, an inclusive alternative to sexual autonomy that still protects the historical importance of self-determination in the doctrine. Part B discusses the concept and practice of supported decision-making, the context in which many people with persistent cognitive impairments live their lives and practice self-determination. Understanding this lived experience generates the insight that self-determination, often cast as autonomy, is relational in nature.

A. *Sexual Capability*

The capabilities approach in economics and philosophy is a view of living as a combination of functionings, which are a series of “doings” and “beings.”¹¹⁵ These “doings” and “beings” are the various activities that one could engage in, or the various states of being that one could achieve.¹¹⁶ Examples of doing functionings include voting in an election, taking care of a child, or eating a nutritious meal. Examples of being functionings are being healthy, being educated, or being happy. A capability represents the ability to pursue these functionings, and one’s global well-being is based on whether one can achieve functionings that are valuable, like sex and sexuality.¹¹⁷

¹¹⁴ See Milton D. Green, *Public Policies Underlying the Law of Mental Incompetency*, 38 MICH. L. REV. 1189, 1205 (1940) (arguing for the importance of understanding the substantive policies that underlie capacity doctrine).

¹¹⁵ See Amartya Sen, *Capability and Well-Being*, in THE PHILOSOPHY OF ECONOMICS 270, 270–93 (Daniel M. Hausman ed., 3rd ed. 2008); see also AMARTYA SEN, *COMMODITIES AND CAPABILITIES* 25–32 (1985).

¹¹⁶ See SEN, *supra* note 17, at 39.

¹¹⁷ See MARTHA C. NUSSBAUM, *WOMEN AND HUMAN DEVELOPMENT* 78 (2000) (considering the capability to pursue “opportunities for sexual satisfaction” as one of the central human capabilities necessary for a flourishing life); SEN, *supra* note 17, at 40 (“Capability is, thus, a set of vectors of functionings, reflecting the person’s freedom to lead one type of life or another.”).

I define the value of sexual capability as the opportunity to pursue functionings associated with sex and sexuality.¹¹⁸ This could include having sexual pleasure, forming a sexual identity, or feeling sexy. The opportunities to achieve such functionings are not unlimited. In particular, one must respect the sexual capabilities of others.¹¹⁹ This justifies the requirement of consent, as it preserves the ability of others to make their own sexual choices.¹²⁰ Consent is also important because having sex without consent—i.e., experiencing rape—creates a host of other severely negative welfare effects, as the expansive literature on rape has documented.¹²¹ This can affect not only your own sexual capability but other human capabilities that are important.¹²²

The focus of sexual capability is on ensuring opportunities rather than on guaranteeing happiness, economic resources, or freedom from state interference.¹²³ However, capability can overlap significantly with these other measures of well-being. For example, a society that socializes its citizens to think that sex is dirty, that criminalizes non-marital sexual conduct, and that provides no protections against sexual violence, denies its citizens the capability for a healthy sexual life. Its citizens may also be less likely to be

¹¹⁸ While Nussbaum categorizes sexual satisfaction as a part of the fundamental capability of bodily integrity, *see* NUSSBAUM, *supra* note 117, at 78, it could also be a part of other fundamental capabilities, such as senses, imagination, and thought, emotions, practical reason, affiliation, and play. *See id.* at 78-80; *see also* DON KULICK & JENS RYDSTRÖM, LONELINESS AND ITS OPPOSITE 286 (2015) (connecting a right to sex with the fundamental capabilities of bodily integrity, emotions, and affiliation).

¹¹⁹ This is a key facet of liberal political theory. *See, e.g.*, BRUCE A. ACKERMAN, SOCIAL JUSTICE IN THE LIBERAL STATE 8–10 (1980); RONALD DWORKIN, A MATTER OF PRINCIPLE 191–92 (1985); JOHN RAWLS, A THEORY OF JUSTICE 325–28 (1971). *But see* JOSEPH RAZ, THE MORALITY OF FREEDOM 107–62 (1986); Edward L. Rubin, *Nazis, Skokie, and the First Amendment as Virtue*, 74 CALIF. L. REV. 233, 255 (1986) (“The progressive critique of classical, your-rights-end-at-my-nose liberalism is based precisely on the idea of social interdependence, and a vision of institutions that change continuously over time to provide individuals with increasingly greater rights and opportunities.”).

¹²⁰ Consent is best understood as “both a subjective decision and a social act.” Emily Sherwin, *Infelicitous Sex*, 2 LEGAL THEORY 209, 216 (1996). This social act has great power, which derives from personhood. *See* Heidi M. Hurd, *The Moral Magic of Consent*, 2 LEGAL THEORY 121, 123 (1996) (“[C]onsent can function to transform the morality of another’s conduct—to make an action right when it would otherwise be wrong. For example, consent turns a trespass into a dinner party; a battery into a handshake; a theft into a gift; an invasion of privacy into an intimate moment; a commercial appropriation of name and likeness into a biography.”).

¹²¹ *See, e.g.*, Rebecca Campbell et al., *An Ecological Model of the Impact of Sexual Assault on Women’s Mental Health*, 10 TRAUMA VIOLENCE & ABUSE 225 (2009) (describing the long-term negative effects of rape); Lynne N. Henderson, *What Makes Rape a Crime?*, 3 BERKELEY WOMEN’S L.J. 193 (1987–88) (describing rape as “negation of existence”); Robin L. West, *Legitimizing the Illegitimate: A Comment on Beyond Rape*, 93 COLUM. L. REV. 1442, 1448 (1993) (comparing rape to “spiritual murder”).

¹²² *See* MARTHA C. NUSSBAUM, FRONTIERS OF JUSTICE: DISABILITY, NATIONALITY, SPECIES MEMBERSHIP 76–78 (2006) (providing a list of ten central human capabilities).

¹²³ *See* Sen, *supra* note 115, at 271.

happy. Even if society does provide all that is necessary for a healthy sexual life, individual members of that society might, however, still pursue unhealthy sexual relationships or deny themselves sexual partners altogether, despite the desire for them. In other words, they might not take advantage of the opportunities to which they have access. Ultimately, it is the right of each individual to decide whether to pursue the functionings that are within reach.¹²⁴ Perhaps other functionings are perceived to be more important, or other commitments required sacrifices in the realm of sex and sexuality. In this way, sexual capability is agnostic as to peoples' sexual choices, as the focus is on creating the ability to have meaningful choice.¹²⁵

This points to a minimum threshold of capacity that should be required by any legal test embodying sexual capability: the ability to express volition. In other words, if one is so cognitively impaired that one cannot express affirmative desire with respect to sexual opportunities, then one cannot be a sexual agent.¹²⁶ This requirement of the ability to express will or intention represents a basic threshold that one must cross before one can be deemed capable of sexual consent.¹²⁷ This is a relatively minimal threshold, but it is necessary, not only to establish sexual consent in the first place, but also because it the only way to know what a person's internal mental states regarding sexual desires might be.¹²⁸

A given person's capabilities are a "product of her internal endowments, her external resources, and the social and physical environment in which she lives."¹²⁹ For example, in order to have the ability to drive to work, one must possess physical and mental capacities to drive, the resources to buy a vehicle to transport oneself, the legal entitlement of a driver's license, and adequately paved roads to get from point A to point B. This reflects the understanding that

¹²⁴ See NUSSBAUM, *supra* note 122, at 171–73.

¹²⁵ See MICHAEL L. PERLIN ET AL., COMPETENCE IN THE LAW 296–97 (2008) ("First, as a society, we accept the fact that persons without mental disabilities are free to make *terrible* decisions all the time without governmental or judicial intervention. . . . Yet, we have a different view with regard to the decision-making autonomy and capability of persons with mental disabilities. Why is that?" (footnote omitted)).

¹²⁶ See Robert Audi, *Volition, Intention, and Responsibility*, 142 U. PA. L. REV. 1675, 1680 (1994) (discussing the importance of volition as acts of will or as playing an "executory role in action").

¹²⁷ See Chunlin Leonhard, *The Unbearable Lightness of Consent in Contract Law*, 63 CASE W. RES. L. REV. 57, 67 (2012) (noting that volition is one of the necessary components of consent).

¹²⁸ See Donald Dripps, *For a Negative, Normative Model of Consent, with a Comment on Preference-Skepticism*, 2 LEGAL THEORY 113, 114 (1996) ("[C]onsent, is, at least in part, either a psychological state or some conduct that is presumed to provide evidence of a psychological state."); Drobac, *supra* note 110, at 80 (discussing the necessity of volition to both legal consent and assent).

¹²⁹ Elizabeth Anderson, *Justifying the Capabilities Approach to Justice*, in MEASURING JUSTICE: PRIMARY GOODS AND CAPABILITIES 81, 96 (Harry Brighouse & Ingrid Robeyns eds., 2010).

capabilities are not just a product of cognitive factors.¹³⁰ For example, sexual capability is the product of various factors, including one's cognitive impairments, social resources, and the legal treatment of those impairments and resources. Disability theorists have long emphasized that disabilities are not only created by the physical or mental impairments of the individual, but also by a society that refuses to accommodate these impairments.¹³¹ Put another way, the source of disability should be located both externally and internally.¹³²

This is where the distinction between mental and legal capacity is helpful. The former represents the cognitive capacities of the subject, and the latter represents how the law interprets those capacities.¹³³ To the extent that the law only considers mental capacities in evaluating legal capacity, it deprives many people with cognitive impairments of legal capacity. In the realm of sexuality, this has the effect of cutting people with persistent cognitive impairments off from this important aspect of the human experience. In other words, the legal doctrine can be a source of disability for people with cognitive impairments if it focuses narrowly on their mental capacities.

Sexual capability overlaps significantly with the value of sexual autonomy in its emphasis on self-determination. Whereas autonomy focuses on possessing the cognitive faculties to make choice, capability is more focused on creating the conditions necessary for self-determination, both internal and external to the subject. This more holistic understanding of self-determination makes the value inclusive of people with persistent cognitive impairments, but it does not represent a huge departure from the traditional normative bases of the sexual incapacity doctrines. This maintains doctrinal coherence with the

¹³⁰ See AMARTYA SEN, *DEVELOPMENT AS FREEDOM* 70–71 (2000) (describing the various heterogeneities in these different variables that contribute to overall capability).

¹³¹ See, e.g., MICHAEL OLIVER, *THE POLITICS OF DISABLEMENT: A SOCIOLOGICAL APPROACH* 11 (1990); Ron Amundson, *Disability, Handicap, and the Environment*, 23 J. SOC. PHIL. 105, 110 (1992) (“A handicap results from the interaction between a disability and an environment . . .”). But see Anita Silvers, *An Essay on Modeling: The Social Model of Disability*, in *PHILOSOPHICAL REFLECTIONS ON DISABILITY* 19, 19–21 (D. Christopher Ralston & Justin Ho eds., 2010) (critiquing the social model of disability for not representing the subjective and varied nature of the lived experience of people with disabilities).

¹³² See Lennart Nordenfelt, *Ability, Competence, and Qualification: Fundamental Concepts in the Philosophy of Disability*, in *PHILOSOPHICAL REFLECTIONS ON DISABILITY*, *supra* note 131, at 37, 39 (“Thus, there is no such thing as ability in isolation. And there is no such thing as an opportunity in isolation. A person’s ability must be judged in light of a certain set of circumstances. And a person’s opportunity must be judged in the light of a certain set of conditions internal to his or her body or mind.”).

¹³³ See Charles P. Sabatino, *Competency: Refining Our Legal Fictions*, in *OLDER ADULTS’ DECISION-MAKING AND THE LAW* 1, 2–4 (Michael Smyer et al. eds., 1996) (referring to legal capacity determinations as legal fictions).

interconnected legal regimes governing consent and sexual assault, which are premised to a large degree on the sexual autonomy value.¹³⁴

Like sexual autonomy, sexual capability is valuable not only because of the opportunity it represents to forge a sexual self, but also because it indirectly protects sexual welfare, or the effects of sex that contribute to well-being.¹³⁵ The welfare associated with sexual activity derives, first, from the subjective mental states that are involved in sex. These mental states are important because of the largely subjective nature of sex.¹³⁶ The first sense in which sex is subjective is that what is actually “sexual” will differ wildly between people and contexts.¹³⁷ Consider the recent controversy over the artist Sia’s music video for her song, “Elastic Heart.”¹³⁸ In it, Shia LaBeouf, a 28-year old male actor, performs an interpretive dance shirtless with Maddie Ziegler, a 12-year old dancer, who wears a full-body nude-colored costume. Sia intended and saw the dance as nonsexual; it represented a battle between two “Sia self-states.”¹³⁹ The outcry was immediate from fans, however, who considered the video to be sexualizing children and valorizing pedophilia,

¹³⁴ See *Coker v. Georgia*, 433 U.S. 584, 597 (1977) (plurality opinion) (“[Rape] is highly reprehensible, both in a moral sense and in its almost total contempt for the personal integrity and autonomy of the female victim and for the latter’s privilege of choosing those with whom intimate relationships are to be established. Short of homicide, it is the ‘ultimate violation of self.’” (quoting U.S. DEP’T OF JUSTICE, LAW ENFORCEMENT ASSISTANCE ADMINISTRATION REPORT, RAPE AND ITS VICTIMS 1 (1975))); STEPHEN J. SCHULHOFER, UNWANTED SEX 99 (1998). There are, of course, dissenting voices. See CATHERINE A. MACKINNON, FEMINISM UNMODIFIED 81–93 (1987) (arguing that systems of societal coercion render consent suspect); Kathryn Abrams, *From Autonomy to Agency: Feminist Perspectives on Self-Direction*, 40 WM. & MARY L. REV. 805, 806 (1999) (arguing for sexual agency); Jed Rubenfeld, *The Riddle of Rape-by-Deception and the Myth of Sexual Autonomy*, 122 YALE L.J. 1372, 1425–27 (2013) (arguing for self-possession).

¹³⁵ See BUCHANAN & BROCK, *supra* note 111, at 9–36 (discussing the importance of the value of well-being to the analysis of incapacity); Larry Alexander, *Pursuing the Good—Indirectly*, 95 ETHICS 315, 315 (1985) (discussing Mill’s views on the relationship between libertarianism and utilitarianism).

¹³⁶ See ABRAMSON & PINKERTON, *supra* note 30, at 8–10 (describing the subjective nature of sexual pleasure); see also Robin L. West, *The Difference in Women’s Hedonic Lives: A Phenomenological Critique of Feminist Legal Theory*, 15 WIS. WOMEN’S L.J. 149, 185 (2000).

¹³⁷ See Katherine M. Franke, *Putting Sex to Work*, 75 DENV. U. L. REV. 1139, 1146–47 (1998) (discussing whether the ritualized fellatio between Sambian males should be considered sexual or erotic); *id.* at 1157–58 (discussing whether the sodomy of Abner Louima by New York City police should be considered a sex crime).

¹³⁸ Sia, *Elastic Heart feat. Shia LaBeouf & Maddie Ziegler (Official Video)*, YOUTUBE (Jan. 7, 2015), <https://www.youtube.com/watch?v=KWZGAExj-es> [<http://perma.cc/EB5B=J3M5>].

¹³⁹ See Kory Grow, *Sia Apologizes for Controversial ‘Elastic Heart’ Video with Shia LaBeouf*, ROLLING STONE (Jan. 8, 2015), <http://www.rollingstone.com/music/news/sia-apologizes-for-controversial-elastic-heart-video-with-shia-labeouf-20150108> [<http://perma.cc/ZCW2-2T46>].

given the identities of the two performers and the juxtaposition of their bodies in a certain configuration.¹⁴⁰ What is sexual for one person might not be sexual for another.

Sex is also highly subjective in a second sense. Even when there is consensus about what is considered sexual, two people might disagree about whether some activity deemed sexual is desirable.¹⁴¹ This is the case with respect to sexual partners—neither a heterosexual male nor a lesbian will likely find sex with a male desirable. This is also the case with respect to sexual activities. Some people get off on being sexual exhibitionists, while others find the thought terrifying. Even within individuals, there may be a mix of emotions and desires with respect to a given sexual activity with a given partner.¹⁴² Thus, from an outside perspective, there is no clear and objective way to determine what is “good sex” and “bad sex.” Delegating sexual decisions to the individual represents the understanding that the individual is in the best position to perform their own sexual welfare calculus.¹⁴³

While sexual welfare might primarily be subjective, this subjectivity breaks down somewhat when we think of the physical consequences of sex. There are certain physical effects of sexual decisions, such as pregnancy and sexually transmitted diseases, which are knowable to third parties and quantifiable by medical professionals. These physical effects are also strongly related to other fundamental human capabilities such as life and bodily health.¹⁴⁴ Health occupies a special place in the capabilities framework, which warrants special attention to the health-related consequences of sexual expression.¹⁴⁵ The interpretation of these physical effects may still vary—

¹⁴⁰ See *id.*

¹⁴¹ See MICHAEL WARNER, *THE TROUBLE WITH NORMAL* 7 (1999) (“Having an ethics of sex, therefore, does not mean having a theory about what people’s desires are or should be. If the goal is sexual autonomy, then it will be impossible to say in advance what form that will take.”); see also EVE KOSOFSKY SEDGWICK, *EPISTEMOLOGY OF THE CLOSET* 25–26 (2008) (noting the various and radical ways in which sexuality differs in its subjective meaning for individuals).

¹⁴² See JANET HALLEY, *SPLIT DECISIONS: HOW AND WHY TO TAKE A BREAK FROM FEMINISM* 301–02 (2006) (“I think most of us experience sex (when it’s not routinized) as an alarming mix of desire and fear, delight and disgust, power and surrender, surrender and power, attachment and alienation, ecstasy in the root sense of the word and enraptured embodiedness.”).

¹⁴³ See JOHN STUART MILL, *ON LIBERTY* 55 (David Spitz, ed., W.W. Norton & Co. 1975) (1859) (“But it is the privilege and proper condition of a human being, arrived at the maturity of his faculties, to use and interpret experience in his own way. It is for him to find out what part of recorded experience is properly applicable to his own circumstances and character.”).

¹⁴⁴ See NUSSBAUM, *supra* note 122, at 76 (“1. *Life*. Being able to live to the end of a human life of normal length; not dying prematurely, or before one’s life is so reduced as to be not worth living. 2. *Bodily Health*. Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter.”).

¹⁴⁵ See CHRISTOPHER A. RIDDLE, *DISABILITY AND JUSTICE* 77–85 (2014) (arguing for the primacy of health in the ordering of capabilities).

imagine the contrasting reactions to an unwanted pregnancy and a pregnancy that results from several months of actively seeking that result. However, in situations of mental incapacity, there might be no clear understanding or interpretation of these physical effects from the individual with cognitive impairments. In these cases, there may be a role for third-party evaluation of such risks to protect the individual from welfare threats.¹⁴⁶

The third parties most likely to assist people with persistent cognitive impairments in their decision-making are their supportive networks. The next Part explores how many people with disabilities live in these capability-enhancing networks, which are unrecognized by the law in this area.

B. *Supported Decision-Making and Relational Autonomy*

Social supports play an important role in enabling people with cognitive impairments to exercise decision-making. In particular, people with persistent cognitive impairments can and often do exercise decision-making potential through supportive decision-making networks.¹⁴⁷ Supported decision-making is an emerging concept and formal practice, characterized by a situation in which “an individual with cognitive challenges is the ultimate decision-maker but is provided support from one or more persons who explain issues to the individual and, where necessary, interpret the individual’s words and behavior to determine his or her preferences.”¹⁴⁸

These networks can consist of a single caregiver, a set of family members, or an institution’s staff. The type of support provided will vary in accordance with the impairments the network is helping address. First, there are supports that “assist in formulating one’s purposes, to explore the range of choices and to make a decision.”¹⁴⁹ This involves communicating with the individual with cognitive impairments to discern what her sexual desires are and helping her make the connections between those interests and potential choices. If the person lacks the ability to communicate verbally, then this may involve observing the individual in context and paying attention to subtle cues of desire or displeasure.¹⁵⁰

¹⁴⁶ Such third-party evaluation of welfare threats might also be warranted for certain types of social consequences as well, if the subject cannot logically connect her actions to such consequences, but will still profoundly feel their effects.

¹⁴⁷ See Sara Honn Qualls, *Decision-Making Capacity: The Players*, in CHANGES IN DECISION-MAKING CAPACITY IN OLDER ADULTS, *supra* note 37, at 109, 109–18 (describing the different “players” that assist in decision-making).

¹⁴⁸ Nina A. Kohn et al., *Supported Decision-Making: A Viable Alternative to Guardianship?*, 117 PA. ST. L. REV. 1111, 1120 (2013).

¹⁴⁹ MICHAEL BACH & LANA KERZNER, A NEW PARADIGM FOR PROTECTING AUTONOMY AND THE RIGHT TO LEGAL CAPACITY 73 (Oct. 2010), <http://www.lco-cdo.org/disabilities/bach-kerzner.pdf> [<http://perma.cc/TL55-68JM>].

¹⁵⁰ See Stanley S. Herr, *Self-Determination, Autonomy, and Alternatives for Guardianship*, in THE HUMAN RIGHTS OF PERSONS WITH INTELLECTUAL DISABILITIES: DIFFERENT BUT EQUAL 429, 431–35 (Stanley S. Herr et al. eds., 2003) (describing the

Second, there are “supports to engage in the decision-making process with other parties.”¹⁵¹ This primarily involves communicative support, as people with cognitive impairments may have special forms of communicating their desires and concerns. Research on people with profound disabilities has shown that they are often capable of communication with the assistance of partners who know them and their methods well.¹⁵² Such persons can act as interpreters, just as a foreign language interpreter would for others.¹⁵³

Third, there are “supports to act on the decisions that one has made.”¹⁵⁴ This involves actualizing the decision, which may require arrangements for the sexual expression in question. This could include creating a safe space to engage in sexual expression, ensuring that the person with cognitive impairment is not at risk for physical harm. It may also require the creation of a private space for sexual expression, to the extent possible without compromising the physical safety of the person with cognitive impairments.¹⁵⁵

Supported decision-making broadens our understanding of the decision-making apparatus and of personhood from the individual and her body to the individual nested in a series of relationships that facilitate meaningful decision-making and flourishing.¹⁵⁶ It is also a recognition and exercise of relational autonomy.¹⁵⁷ As several feminist theorists have pointed out, our

system in Sweden, which appoints a “god man,” who acts as an assistant to the person with disabilities); Israel Doron, *Elder Guardianship Kaleidoscope—A Comparative Legal Perspective*, 16 INT’L J.L. POL’Y & FAM. 368, 376 (2002) (describing the “hojoniin,” or helper, in Japan for those who suffer from milder forms of intellectual disability, and with whom various decisions are jointly made with the ward).

¹⁵¹ See BACH & KERZNER, *supra* note 149, at 73.

¹⁵² See STEVEN CARNABY, *PEOPLE WITH PROFOUND AND MULTIPLE LEARNING DISABILITIES: A REVIEW OF RESEARCH ABOUT THEIR LIVES* 9–10 (2004) (summarizing the approaches and results of several studies); see also MALCOLM GOLDSMITH, *HEARING THE VOICE OF PEOPLE WITH DEMENTIA* 56–59 (1996) (discussing communication strategies for individuals with dementia); Karen Bunning, *Making Sense of Communication*, in *PROFOUND INTELLECTUAL AND MULTIPLE DISABILITIES: NURSING COMPLEX NEEDS* 46, 46 (Jillian Pawlyn & Steven Carnaby eds., 2009).

¹⁵³ See, e.g., Nancy M. Maurer, *Facilitated Communication: Can Children with Autism Have a Voice in Court?*, 6 MD. J. CONTEMP. LEGAL ISSUES 233, 248 (1995) (exploring the legal issues involved in facilitated communication for people with autism).

¹⁵⁴ See BACH & KERZNER, *supra* note 149, at 73.

¹⁵⁵ See Kristine S. Knaplund, *The Right of Privacy and America’s Aging Population*, 86 DENV. U. L. REV. 439, 442 (2009) (discussing the tension between sexual expression and privacy).

¹⁵⁶ See KULICK & RYDSTRÖM, *supra* note 118, at 16 (“If I need other people’s assistance to eat, dress, make lunch, scratch my itchy nose, convey meaning through my monosyllabic vocalizations, and engage in sexual relations with my equally disabled partner, then the locus of my personhood is dispersed—it resides not in my body, but across a network of relations that need to get coordinated in order to allow me to flourish as an individual.”).

¹⁵⁷ See Marilyn Friedman, *Relational Autonomy and Independence*, in *AUTONOMY, OPPRESSION, AND GENDER* 42, 42 (Andrea Veltman & Mark Piper eds., 2014) (defining

sense of self and autonomy is experienced and interpreted relationally.¹⁵⁸ As children, we construct a sense of self in relation to our parents or other loved ones who might surround us.¹⁵⁹ They help us to develop our capacities for individuality and choice, and this process continues as we age. Consider the example of student autonomy in a classroom. How a teacher structures a classroom impacts that autonomy, including the capacity for critical thinking:

Classes can be structured so that students are expected to memorize material from lectures and texts and to parrot back professors' views on exams. Class discussion can encourage respectful disagreement among students and with the professor or it can be characterized by harsh criticism or failure to take alternative views seriously. . . . Again, the power hierarchy (and the students' dependence on the professor for grades) remains. The question is whether it is structured to create relations conducive to autonomy.¹⁶⁰

Thus, our social relationships can enhance the exercise of our autonomy or hinder it. We may enter the classroom with a set of mental capacities that will either thrive or wither, depending on the social environment. This basic dynamic is true of people with cognitive impairments as well, whose more limited cognitive capacities will either thrive or wither depending on the circumstances.

Thus, we must rely on others to exercise our autonomy. This dependency, however, can come in two different forms. Some degree of dependency is a necessary feature of the human condition.¹⁶¹ For example, as children, everyone has undeveloped capacities for rational thought that must be nurtured, and everyone is at risk of becoming disabled, whether by accident or disease. Some amount of dependency, however, is "rooted in unjust and potentially remediable social institutions."¹⁶² This type of surplus dependency

relational autonomy as "emphasizing the social nature of the self and the social relations and conditions that are necessary for the realization of autonomy").

¹⁵⁸ See JENNIFER NEDELSKY, *LAW'S RELATIONS: A RELATIONAL THEORY OF SELF, AUTONOMY, AND LAW* 3 (2011) ("The individual self is, then, constituted in an ongoing, dynamic way by the relationships through which each person interacts with others."); Catriona Mackenzie & Natalie Stoljar, *Introduction: Autonomy Refigured*, in *RELATIONAL AUTONOMY: FEMINIST PERSPECTIVES ON AUTONOMY, AGENCY, AND THE SOCIAL SELF* 3, 3–31 (Catriona Mackenzie & Natalie Stoljar eds., 2000) (summarizing the different feminist critiques of autonomy while arguing for a reconfiguration, rather than abandonment, of the concept for feminist theory).

¹⁵⁹ See Holning Lau, *Pluralism: A Principle for Children's Rights*, 42 HARV. C.R.-C.L. L. REV. 317, 329–32 (2007) (describing identity formation among children).

¹⁶⁰ See NEDELSKY, *supra* note 158, at 40.

¹⁶¹ See Martha Albertson Fineman, *Cracking the Foundational Myths: Independence, Autonomy, and Self-Sufficiency*, 8 AM. U. J. GENDER SOC. POL'Y & L. 13, 18 (2000) ("All of us were dependent as children, and many of us will be dependent as we age, become ill, or suffer disabilities.").

¹⁶² Nancy Fraser & Linda Gordon, "Dependency" *Demystified: Inscriptions of Power in a Keyword of the Welfare State*, 1 SOC. POL. 4, 24 (1994).

inhibits capability, and often is the result of unjust laws or allocations of resources. Fortunately, it is likewise amenable to reform through legal or policy interventions.

In order for the adult sexual incapacity doctrine to realize the possibility of sexual capability, it must recognize the existence of supportive decision-making networks.¹⁶³ The law should recognize an individual who employs a supported decision-making network as having legal capacity on par with individuals who do not need such support.¹⁶⁴ This will serve to remove one of the disabling features of the social environment for people with disabilities, and it will have the added benefit of bringing the law in line with international law norms in this area.¹⁶⁵

* * *

This Part first identified the sources of the problems with the dominant approach to adult sexual incapacity doctrine. The first problem is a theoretical one, as current doctrine rests on a narrow understanding of self-determination embodied by a non-relational autonomy value. The second problem is a practical one, as current doctrine does not take account of the decision-making structures of people with persistent cognitive impairments. The Part then proceeded to provide a stronger normative basis for sexual incapacity doctrine—sexual capability—which accounts for the internal as well as

¹⁶³ See Terry Carney, *Participation and Service Access Rights for People with Intellectual Disability: A Role for Law?*, 38 J. INTELL. & DEVELOPMENTAL DISABILITY 59, 60 (2013) (noting that these structures already exist, waiting to be recognized by the law); Leslie Salzman, *Guardianship for Persons with Mental Illness—A Legal and Appropriate Alternative?*, 4 ST. LOUIS U. J. HEALTH L. & POL'Y 279, 307 (2011).

¹⁶⁴ See Nandini Devi, *Supported Decision-Making and Personal Autonomy for Persons with Intellectual Disabilities: Article 12 of the UN Convention on the Rights of Persons with Disabilities*, 41 J.L. MED. & ETHICS 792, 800–03 (2013) (describing more generally the range of decision-making statuses that people with disabilities could occupy).

¹⁶⁵ See U.N. Secretary-General, *Final Report of the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities*, art. 12(2), U.N. Doc. A/61/611 (Dec. 6, 2006), <http://daccess-dds-ny.un.org/doc/UNDOC/LTD/N06/645/30/PDF/N0664530.pdf?OpenElement> [<http://perma.cc/X8MD-2EBJ>] (“States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.”); Robert D. Dinerstein, *Implementing Legal Capacity Under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road from Guardianship to Supported Decision-Making*, 19 HUM. RTS. BRIEF 2, 8 (2012) (suggesting a move to supported decision-making may be necessary); Eilionóir Flynn & Anna Arstein-Kerslake, *The Support Model of Legal Capacity: Fact, Fiction, or Fantasy?*, 32 BERKELEY J. INT’L L. 124 (2014) (arguing that only supported decision-making models are permissible under the Convention on the Rights of Persons with Disabilities Article 12). But see Sheila Wildeman, *Challenges to Global Mental Health Policy in Light of the Conventions on the Rights of Persons with Disabilities*, 41 J.L. MED. & ETHICS 48, 58 (2013) (describing CRPD Article 12 as a skeletal attack on the existing regime of capacity, without necessarily having plausible alternatives yet).

external threats to self-determination. It then went on to discuss the role of supportive networks in assisting those with persistent cognitive impairments in pursuing decision-making, reflecting the relational nature of autonomy. The next Part operationalizes the insights of this Part, describing what an adult sexual incapacity doctrine informed by these insights might look like.

IV. COGNITION-PLUS

The cognition-plus test represents the legal implementation of the sexual capability value for people with persistent cognitive impairments. It derives its name from a joint focus on the mental capacities of the subject (cognition) and the recognition that some individuals achieve sexual decision-making capacity through the assistance of a decision-making support network (plus). The test proceeds in three general steps. The first step is to gauge whether the individual has the threshold capacity to express volition with respect to a sexual decision. Without this manifestation of desire, one cannot proceed to be a sexual agent. If the first step is satisfied, the second step is to assess whether the individual has the necessary mental capacities to understand and reason about the nature and consequences of a given sexual decision. If one meets this requirement, then one has sexual consent capacity without the need for assistance. If one does not, however, the third step is to evaluate whether there is an adequate decision-making support network in place. Assessment of the system would be contextual in nature, guided by the principles of loyalty and care from fiduciary law. Thus, courts would evaluate whether the system is free from conflicts of interest, has adequate knowledge of the individual and the sexual decision, and has taken reasonable steps to protect the individual with cognitive impairments from the threat of sexually transmitted diseases and pregnancy. If the system is adequate, then the individual possesses sexual consent capacity.

Part A discusses the key features of the test, compares it to the other approaches discussed in Part II, and notes its limitations. Part B applies the test to the case of older people with dementia, a group that has received little attention in legal scholarship.

A. The Cognition-Plus Test

1. The Three-Step Legal Test

The first step of the cognition-plus test is to examine whether an individual with persistent cognitive impairments still has the capacity to express volition. This volition is traditionally expressed as verbally saying “Yes” to sex. People with cognitive impairments, however, may have difficulty with standard communication. In this case, volition might be inferred in a variety of ways, which will often be specific to the person. It might come in the form of initiation and active pursuit of sexual expression. Alternatively,

it might require an interpretation of cues by someone familiar with the person's communication methods, which could include nonverbal signals or facial expressions.¹⁶⁶ If one is not capable of even this basic level of communication of volition, then one lacks the legal capacity for sexual consent. In this case, liability should flow to her sexual partner or to institutions that have a responsibility for safeguarding her.

The second step is to assess the variety of cognitive abilities that one might need to reason about a given sexual decision and its consequences. At a minimum, this requires an understanding that the person has the power to make a choice, to consent or not. Beyond this, the capacity to understand and judge consequences is necessary to perform a subjective welfare calculus for oneself. Thus, at an abstract level, the set of consequences of sex that one should have the capacity to understand should start large, encompassing both its physical and nonphysical effects. This starting point is justified by the fact that sex has many meanings and many effects, any of which might be relevant to a given decision-maker. One might want to achieve pleasure with sex, forge a specific identity, solidify social relationships with others, or all of the above.¹⁶⁷

This relatively large set of consequences must then be calibrated to the particular sexual situation. In other words, because capacity is determined on a functional basis, one must consider each sexual decision at a particular point in time under a particular set of circumstances. Physical and nonphysical consequences vary significantly with sexual behavior; thus, the type and quantity of consequences that one must be capable of understanding should vary as well. For example, holding hands and kissing do not involve significant risks of negative physical consequences, while penile-vaginal

¹⁶⁶ See, e.g., *People v. Miranda*, 132 Cal. Rptr. 3d 315, 339 (Ct. App. 2011) (“A person can have the ability to give consent even though he or she responds to questions with one or two-word answers and with physical gestures.”).

¹⁶⁷ This set of consequences, however, should not include the “moral” consequences of sex, as required by the New York test. First, it is not clear that there is a consensus on the moral quality of different sexual acts in society, making a determination of that consensus an impossible cognitive task. Some states have rejected the morality test precisely because of this vagueness problem. See *State v. Sullivan*, 298 N.W.2d 267, 272 (Iowa 1980) (striking down as unconstitutionally vague a statute requiring “the mental capacity to know the right and wrong of conduct in sexual matters”). Second, since sexual activities are often more private than other activities, the moral views of society as a whole would not be a relevant consequence for most individuals engaged in sexual relations. See *Anderson v. Morrow*, 371 F.3d 1027, 1043 (9th Cir. 2004) (Berzon, J., dissenting) (“[W]hile the state surely has a very strong, legitimate interest in ensuring that the consent of a mentally disabled individual is knowledgeable and truly voluntary, and in disregarding that consent in situations where the alleged victim does not understand either the circumstances and consequences of sexual conduct or the extent of her ability to refuse sex, the state has no legitimate interest in imposing sexual mores on retarded individuals or their consensual partners.”). Moral disapproval by others might be a relevant *social* consequence of sexual activity that one might have to have the capacity to understand at some level, if one would actually experience welfare effects from others’ moral disapproval.

intercourse poses more significant risks of pregnancy or sexually transmitted diseases. Since there are more consequences at issue, the latter will likely require a higher level of cognitive capacities than the former.¹⁶⁸ In sum, the context of the sexual encounter must be examined to determine which consequences are actually present for a given sexual decision-maker.

If a person with persistent cognitive impairments does not have the requisite mental capacities alone to reason about a specific sexual decision and its consequences, then the court must proceed to the third step and broaden the inquiry to determine if an adequate decision-making support system is in place. This support system can take many forms, including friends, family, or institutional staff. The network will often include people who have been legally appointed to make decisions for a person with cognitive impairments, such as a guardian or attorney-in-fact.¹⁶⁹ That legal authorization to act as a surrogate decision-maker, however, is not sufficient to establish that a valid decision-making support system is in place.¹⁷⁰ In other words, a decision-making support system does not exist to make the sexual decision as a surrogate for the person with cognitive impairments, but instead to facilitate her wishes and desires.

¹⁶⁸This is in some respects similar to the risk-relativity approach in health care decision-making. See BUCHANAN & BROCK, *supra* note 111, at 51–57. In assessing capacity, its proponents argue, one must consider the probabilities of benefit and harm from a given health care treatment, considering the alternatives. The more risky the course of action, the higher the level of capacity required to engage in it. This creates an asymmetrical set of capacity requirements—one for accepting a known beneficial treatment (low), and one for refusing said treatment (high). *Id.* The approach here is different in that it would not weight positive and negative consequences differently; the presence of either would raise the required level of capacity. Thus, the cognition-plus test avoids some of the critiques of the risk-relativity approach. See, e.g., David Checkland, *On Risk and Decisional Capacity*, 26 J. MED. & PHIL. 35, 36 (2001) (criticizing the asymmetrical nature of the test as confusing the capacity question and the well-being question). But see Ian Wilks, *Asymmetrical Competence*, 13 BIOETHICS 154, 158–59 (1999) (defending asymmetrical capacity). Avoiding asymmetry makes sense in the sexual domain because of the subjectivity of sex. Ex ante, it is difficult both to predict the mental and social consequences of sexual activity and to know whether any sexual consequence will be experienced positively or negatively. This, in turn, makes it impossible to create a repository of sexual knowledge akin to the repository of medical knowledge about the likely trajectories of treatment.

¹⁶⁹See LAWRENCE A. FROLIK, *THE LAW OF LATER-LIFE HEALTH CARE AND DECISION-MAKING* 171–82 (2006) (describing the process of appointing a guardian or selecting an attorney-in-fact).

¹⁷⁰This is especially true in the United States, with its reliance on plenary guardianship and its under-use of more tailored guardianship. See Lawrence A. Frolik, *Guardianship Reform: When the Best is the Enemy of the Good*, 9 STAN. L. & POL'Y REV. 347, 348–50 (1998) (noting how statutory changes in limited guardianships have not led to their widespread adoptions). In other countries, supported decision-making principles are embedded in the law. See, e.g., Makoto Arai, *Guardianship in Japan Under the Adult Guardianship Law of 2000*, in *COMPARATIVE PERSPECTIVES ON ADULT GUARDIANSHIP* 167, 170–71 (A. Kimberley Dayton ed., 2014).

It is possible that there will be many individuals who are potential members of the decision-making support system, and they might disagree on how best to actualize the sexual desires of a person with cognitive impairments. Ideally, such disagreements will be worked out before the sexual activity takes place. However, it is not the role of the court to determine the one true decision-making support system. This is the case for two reasons. First, this shifts the focus from the person with cognitive impairments to those around her, but it is the person with cognitive impairments whose desires and volition should be the focus of the analysis.¹⁷¹ To the extent that she is aided in actualizing those desires by a supportive network, the court's only task is to determine whether that particular network was adequate. Thus, this approach implicitly favors the supportive network that wishes to actualize the wishes of the person with impairments, centering the analysis on that person.

Second, as a practical matter, the court need not decide between two supportive networks that have different opinions about which sexual choice is best. As it would be deciding the case *ex post* in a civil or criminal proceeding, it need only analyze whether the supportive network or portion of the network that facilitated the sexual relations in question was adequate under the criteria discussed in this Part. In other words, it need not resolve the dispute of who represents the "better" network in a more general sense, as the presence of some other potential supportive network would not be relevant to determining whether the operative network was actually adequate.¹⁷²

Whatever individuals comprise the decision-making support system, that support system must also participate in the making of the relevant sexual decision in order to prevent liability from flowing to sexual partners or supervising institutions. For example, consider the following case in which a support network existed but was not involved in the decision.¹⁷³ On February 20, 2011, a twenty-six year old woman with moderate intellectual disabilities was left alone in her mother's apartment. While highly sociable, her reasoning and communication skills were significantly impaired. Her caregiver did not

¹⁷¹ See A. Frank Johns, *Person-Centered Planning in Guardianship: A Little Hope for the Future*, 2012 UTAH L. REV. 1541, 1547–49 (describing a person-centered philosophy in the context of guardianship).

¹⁷² A court might have to make this determination in other types of proceedings, such as guardianship. See, e.g., FLA. STAT. ANN. § 744.3215 (West 2010) (noting that the right to "make decisions about his or her social environment or other social aspects of his or her life" might be removed from a person and given to a guardian). The degree to which a guardian could legally limit a ward's "social environment" could not be absolute, given mandates that guardianship be adopted in its least restrictive form. See, e.g., *id.* § 744.344 ("The order appointing a guardian must be consistent with the incapacitated person's welfare and safety, must be the least restrictive appropriate alternative, and must reserve to the incapacitated person the right to make decisions in all matters commensurate with the person's ability to do so."). Of course, in practice, some guardians may exert such influence in spite of the law's mandates.

¹⁷³ This narrative is adapted from *State v. Inzunza*, 316 P.3d 1266, 1269 (Ariz. Ct. App. 2014).

show up that day, and so she left her mother's apartment and wandered into the open door of Miguel Inzunza's apartment, also in the apartment complex. While there, she did not say anything, but she did eat a plate of food Miguel gave her, watched television, listened to music, and followed Miguel into his bedroom. At 2 a.m. the next morning, the police found them asleep together on Miguel's bed. She had hickeys on her neck and breast, Miguel's DNA was found on her breast, and her DNA was found on his penis. Miguel claimed that the sexual activity was consensual.

In this example, the young woman was disconnected from her caregivers as she wandered into a stranger's apartment. While a support network might have existed for her in another context, it was not supporting her decision to engage in sexual activity with Miguel Inzunza. A person lacking a network at the time of the sexual decision must be assessed according to the mental capacities she has alone. If these are insufficient, liability must flow to her sexual partner and the institution with a responsibility for taking care of her. It is important to note that involvement of a network in supporting sexual decision-making by a person with persistent cognitive impairments does not mean that members of the supportive network necessarily need to be physically present for the sexual acts. For some severely disabled individuals, this may be the case, and there is a tradeoff between privacy and sexual expression in these situations. For most others, involvement of the supportive network may require something more like appropriate sex education, provision of contraception, and vetting of the sexual partner in question.¹⁷⁴

After verifying the involvement of a decision-making support system, the court should assess its quality to ensure that it is adequate. This is essentially an inquiry into the health of the decision-making apparatus as a whole, similar to the inquiry into the individual's mental capacities. The principles governing fiduciary relationships provide useful guideposts for conducting this fact-intensive and contextual inquiry. A fiduciary is an individual who is in a position of power and trust with respect to another person, putting that other person at risk if the fiduciary does not act in her interests.¹⁷⁵ Members of the decision-making support system are in this type of relationship with the person with cognitive impairments, who relies on them to assist in decision-making tasks.¹⁷⁶

¹⁷⁴ See, e.g., KULICK & RYDSTRÖM, *supra* note 118, at 106–12 (discussing the role of contracts, group discussions, and roleplays in structuring the sexual education and sexual activities of people with cognitive impairments); *id.* at 200–05 (discussing how Danish “sexual advisors” assist people with persistent cognitive impairments with engaging sex workers).

¹⁷⁵ See TAMAR FRANKEL, FIDUCIARY LAW 4 (2011) (“While the definitions of fiduciaries are not identical, all definitions share three main elements: (1) entrustment of property or power, (2) entrustors’ trust of fiduciaries, and (3) risk to the entrustors emanating from the entrustment.”).

¹⁷⁶ This is not to say that the decision-making support system should necessarily be considered a fiduciary entity under law, but instead to suggest that fiduciary principles are helpful for determining whether the decision-making support system is adequate to the

Because of their position of power and trust, fiduciaries have certain duties.¹⁷⁷ The primary fiduciary duty is one of loyalty: the duty to act in the interests of the person for whom you are a fiduciary.¹⁷⁸ This primarily means avoiding conflicts of interest.¹⁷⁹ In application to the sexual realm, this suggests that courts should be skeptical of members of a supportive network who are also engaging in sexual expressions with the person who has cognitive impairments. This indicates a conflict of interest that could potentially reflect that the sexual decisions being made do not reflect the preferences of the person with cognitive impairments.

The no-further-inquiry rule traditionally governs such situations.¹⁸⁰ Under it, a fiduciary is prohibited from engaging in self-dealing, even if these conflicted transactions are well-meaning.¹⁸¹ Applied in this context, such a rule would have the effect of deeming conflicted supportive networks *per se* inadequate, imposing civil or criminal liability on all sexual partners who were also members of the decision-making support network.

Such a harsh rule and outcome is unwarranted in this context. Members of the decision-making support system will often be spouses or other loved ones, who may be primary targets of sexual interest by the person with cognitive impairments.¹⁸² To rule out all sexual encounters with members of supportive networks may restrict the desirable sexual options of people with cognitive impairments completely. At the same time, conflicted networks should not get a pass; they should be subjected to a rebuttable presumption of network inadequacy, which can be overcome if sufficient evidence of loyalty and care

task. Legal scholars have applied similar principles to other noneconomic relationships. *See, e.g.*, Elizabeth S. Scott & Robert E. Scott, *Parents as Fiduciaries*, 81 VA. L. REV. 2401, 2401–02 (1995).

¹⁷⁷ There are several different theories justifying the imposition of these fiduciary duties. *See* Robert Cooter & Bradley J. Freedman, *The Fiduciary Relationship: Its Economic Character and Legal Consequences*, 66 N.Y.U. L. REV. 1045, 1045–49 (1991) (performing a law and economics analysis of fiduciary relationships); Deborah A. DeMott, *Beyond Metaphor: An Analysis of Fiduciary Obligation*, 1988 DUKE L.J. 879, 908–15 (discussing voluntary assumption, entrusting, and descriptive theories).

¹⁷⁸ *See* RESTATEMENT (THIRD) OF AGENCY § 8.01 (AM. LAW INST. 2006) (“An agent has a fiduciary duty to act loyally for the principal’s benefit in all matters connected with the agency relationship.”).

¹⁷⁹ *See* *Strickland v. Washington*, 466 U.S. 668, 688 (1984) (“Counsel’s function is to assist the defendant, and hence counsel owes the client a duty of loyalty, a duty to avoid conflicts of interest.”).

¹⁸⁰ *See, e.g.*, *Wood v. McDonald*, 124 N.E.2d 264, 265 (Mass. 1955); *Hartmann v. Hartle*, 122 A. 615, 615 (N.J. Ch. 1928).

¹⁸¹ *See* RESTATEMENT (THIRD) OF TRUSTS § 78 (AM. LAW INST. 2007) (“[T]he trustee is strictly prohibited from engaging in transactions that involve self-dealing or that otherwise involve or create a conflict between the trustee’s fiduciary duties and personal interests.”).

¹⁸² *See* MARY JOY QUINN, *GUARDIANSHIPS OF ADULTS: ACHIEVING JUSTICE, AUTONOMY, AND SAFETY* 73 (2005) (noting that nearly seventy percent of guardians are family members).

is supplied to the court. This is consistent with recent scholarly commentary suggesting a move away from the no-further-inquiry rule for traditional fiduciary relationships.¹⁸³ It is also a recognition that one conception of loyalty may not be appropriate for all types of fiduciary relationships, especially in domains such as this one, which contain a high frequency of structural conflicts of interest.¹⁸⁴

For the duty of loyalty, the goal in sifting through the evidence is to ascertain whether members of the supportive network have tried to avoid conflicts and whether they have adopted an orientation of selflessness towards the person with cognitive impairments at the center of the network.¹⁸⁵ The evidence would be particularly important to overcome the presumption of network inadequacy in situations of conflicts of interest. One valuable type of evidence would be whether the person with cognitive impairments put trust in the loyalty of individuals who might be in the supportive network. This could include her acceptance of an individual as a marital partner or her appointment of someone as an agent for decision-making through a health care or financial durable power of attorney.¹⁸⁶ Other evidence might be testimonial or documentary in nature, indicating whether or not the person was acting in a trustworthy and loyal way towards the person with cognitive impairments.¹⁸⁷

¹⁸³ See John H. Langbein, *Questioning the Trust Law Duty of Loyalty: Sole Interest or Best Interest?*, 114 YALE L.J. 929, 980–82 (2005) (describing such a rule). *But see generally* Melanie B. Leslie, *In Defense of the No Further Inquiry Rule: A Response to Professor John Langbein*, 47 WM. & MARY L. REV. 541, 543 (2005).

¹⁸⁴ See Andrew S. Gold, *The Loyalties of Fiduciary Law*, in PHILOSOPHICAL FOUNDATIONS OF FIDUCIARY LAW 176, 191 (Andrew S. Gold & Paul B. Miller eds., 2014) (“Different types of relationship [sic] may implicate different types of trust, as we see for example when we compare director–shareholder relationships, employer–employee relationships, parent–child relationships, or husband–wife relationships.”); Langbein, *supra* note 183, at 935–37 (describing how the pervasiveness of conflicts of interest may justify the switch to a best interests rule).

¹⁸⁵ See Irit Samet, *Fiduciary Loyalty as Kantian Virtue*, in PHILOSOPHICAL FOUNDATIONS OF FIDUCIARY LAW 125, 139–40 (Andrew S. Gold & Paul B. Miller eds., 2014) (“In this thin sense of loyalty, the duty to be loyal embodies a ‘juridical’ moral duty, ie, [sic] a duty to act in a certain way which can be legitimately enforced by the state. The other ‘thick’ sense of loyalty implies a specific emotional and intellectual orientation towards one’s principals. It is an attitude in which selfless action comes easily, and exploitation of weakness is unthinkable.”).

¹⁸⁶ See Alexander A. Boni-Saenz, *Personal Delegations*, 78 BROOK. L. REV. 1231, 1267 (2013) (“Such advance planning is desirable because the principal is in the best position to select a trustworthy agent who is knowledgeable about the principal’s beliefs and preferences.”). This is not to say that spouses, health care proxy agents, or attorneys-in-fact will always act loyally, but that the person who selected them has already put her trust in them, which is significant.

¹⁸⁷ See Daniel P. Collins, *Summary Judgment and Circumstantial Evidence*, 40 STAN. L. REV. 491, 494 (1988) (“Direct evidence is either documentary . . . or first-hand testimony of a person who actually perceived, through one or more of the senses, the disputed historical fact.”).

The other primary duty is one of care. The decision-making support system should “perform their services with prudence, attention, and proficiency.”¹⁸⁸ This requires knowing the subject they are assisting and providing a safe space for the actualization of sexual desire. In this context, due care involves having information about the person’s history, preferences, and forms of communication. Thus, evidence of care could include the degree of familiarity with the subject and the amount of time that members of the supportive network have known her, assuming that knowledge was put to good use. Sufficient care ensures that the supportive network can actualize the subjective elements of the sexual experience for the person with cognitive impairments. For an institution, an inquiry into the level of care should seek to determine whether it performed a thorough analysis of the resident’s capacity, whether it gathered information about the resident’s history, preferences, and forms of communication, and whether it kept adequate records of these efforts to be reviewed by the court if necessary.¹⁸⁹

In addition to acquiring and operationalizing knowledge about the individual, care also involves providing a safe space for sexual expression to take place and taking reasonable steps to protect the individual with cognitive impairments from physical harm. This guarantees that the supportive network has recognized and dealt with the consequences of sex that entail more objective welfare threats, such as sexually transmitted diseases and unwanted pregnancy. Evidence of care with respect to these objective welfare effects could include efforts to enact various consequence-diminishing interventions, such as birth control to protect against pregnancy or Truvada to protect against HIV infection.¹⁹⁰ Supportive networks can take precautions with respect to the physical environment as well, to prevent risk of fall or physical injury during sexual activity.¹⁹¹ In sum, the evidentiary inquiry on the care axis would focus on whether members of the supportive network have acted as a reasonable or prudent person or institution would have.¹⁹²

¹⁸⁸ FRANKEL, *supra* note 175, at 169.

¹⁸⁹ See Fay Rozovsky, *Informed Consent as a Loss Control Process*, in 2 RISK MANAGEMENT HANDBOOK, *supra* note 71, at 77, 92–97 (Sylvia M. Brown ed.) (describing the importance of these types of procedures in the context of informed consent generally).

¹⁹⁰ See *State v. Dudley*, 64 So. 3d 746, 748 (Fla. Dist. Ct. App. 2011) (en banc) (describing how the mother of the person with cognitive impairments put her daughter on Depo-Provera, a form of birth control); Donald G. McNeil, Jr., *Are We Ready for H.I.V.’s Sexual Revolution?*, N.Y. TIMES (May 23, 2014), <http://www.nytimes.com/2014/05/24/opinion/sunday/ready-for-hivs-sexual-revolution.html> [<http://perma.cc/24ZJ-LV3N>] (describing the use of Truvada by many gay men as an effective pre-exposure prophylactic against HIV infection).

¹⁹¹ See Marshall B. Kapp, *Resident Safety and Medical Errors in Nursing Homes Reporting and Disclosure in a Culture of Mutual Distrust*, 24 J. LEGAL MED. 51, 59–60 (2003) (discussing the problem of falls in nursing homes).

¹⁹² See Robert H. Sitkoff, *The Economic Structure of Fiduciary Law*, 91 B.U. L. REV. 1039, 1043 (2011) (“The duty of care prescribes the fiduciary’s standard of care by establishing a ‘reasonableness’ or ‘prudence’ standard in which the meaning of

This is a familiar standard for institutions, and it provides them with more certainty and predictability in dealing with resident sexuality and the liability it might create. The current highly restrictive sexual policies are the result of a rational risk management strategy focused on exposure avoidance.¹⁹³ The strategy is rational because it is a response to a legal regime that would impose liability for allowing any sexual activity by people with persistent cognitive impairments. In contrast, the cognition-plus test provides a clear route for supportive networks, particularly institutions, to avoid unnecessary legal liability. They only need to pursue adequate procedures that are consistent with the fiduciary duties of loyalty and care, such as thorough assessment, provision of safety in sexual spaces, and recordkeeping.

In other words, by treating sexual expression similarly to other issues that are already routinely managed, such as falls, pressure ulcers, or medical treatment, institutions can move away from an exposure avoidance strategy and towards a loss prevention or loss reduction strategy that might currently apply in those other areas.¹⁹⁴ This is not to say that all institutions will always do this; many fail in these other areas so it would be surprising if there were no failures in this domain as well. In that case, liability will continue to flow, but institutions now at least have a route towards reducing liability exposure.

Having reviewed the types of evidence that would be relevant to the capacity analysis, it is important to note the types of evidence that would not be relevant in a cognition-plus test. Certain facts that are integral to the sexual encounter would not be *per se* relevant to the capacity analysis. Examples include the sex of a subject's sexual partner or the particular sex act engaged in with said partner. Similarly, other contextual facts that could trigger moral evaluation of the sexual situation, such as whether the person with cognitive impairments is engaging in adultery, or whether the motives of the sexual partner are benign, would likewise be irrelevant to the capacity analysis unless some specific link to a relevant step of the cognition-plus test could be established.

There are at least two plausible routes to relevance. First, it is possible for such facts to enter the inquiry in a limited way in step two of the cognition-plus test. This step requires assessing the relevant consequences of a particular sexual decision, as those consequences will dictate the level of mental capacities needed to process them. For example, the sex of the partner coupled with particular sexual acts may create the risk of a pregnancy consequence. Or

reasonableness or prudence is informed by industry norms and practices. This standard of care is objective, measured by reference to a reasonable or prudent person in like circumstances.”)

¹⁹³ See Glenn T. Troyer & LeeAnne R. Coons, *Corporate Compliance: A Risk Management Framework*, in 3 RISK MANAGEMENT HANDBOOK, *supra* note 71, at 123, 140 (describing this strategy).

¹⁹⁴ See Andrew Weinberg, *Risk Management and Quality-of-Care Concerns in Long-Term Care*, in 7 ETHICS, LAW, AND AGING REVIEW 101, 102–03 (Marshall B. Kapp ed., 2001).

the fact that the sex is adulterous may create the risk of fracturing an important relationship with a spouse-caregiver. Thus, these types of facts may enter the analysis because they affect the relevant consequences that one must have the capacity to consider.

Second, certain facts could be relevant in step three of the cognition-plus test, which requires a deeper assessment of the loyalty of members of the supportive network in situations of conflict of interest. Thus, the motives of a conflicted member of supportive network could be relevant to the loyalty inquiry. In short, these types of facts only enter the analysis in a limited way for purposes of analyzing consequences or network adequacy, rather than for purposes of moral judgment. This excludes normative judgments about sex from the formal analysis of capacity in the legal test, and thus permits people with persistent cognitive impairments to pursue the wide range of sexual relationships and practices that those without impairments are entitled to pursue. For this reason, the cognition-plus test is at least nominally “sex-positive.”¹⁹⁵

2. Comparisons with Existing Approaches

To understand how the cognition-plus test differs from other approaches to sexual consent capacity, it is worth considering the points of convergence and divergence among the tests. First, there is the nature of the conduct test, which focuses on volition. Whereas this is the beginning and end of the analysis for this test, it only represents the beginning for the cognition-plus test. For simple expressions of sexuality that have few or no consequences, such as holding hands, the two tests will converge. The nature of the conduct test only requires volition, and the cognition-plus would only require volition in this case because there are no significant consequences that need to be understood and contemplated, with or without a decision-making support system.

The two tests will diverge when sexual contact has significant physical or nonphysical consequences. Here, a person who can show volition to engage in sexual contact will automatically achieve legal capacity with the nature of the conduct test. Whether she does so with the cognition-plus test depends on whether she has the ability to contemplate the sexual decision on her own or can do so with the help of an adequate decision-making support system. The nature of the conduct test would thus permit a far wider range of sexual conduct, without concern for whether the person consenting could contemplate the consequences of the action, alone or assisted. People with severe and persistent cognitive impairments who act without a network are far more vulnerable to negative welfare threats under a nature of the conduct test as opposed to under the cognition-plus test.

¹⁹⁵ See Margo Kaplan, *Sex-Positive Law*, 89 N.Y.U. L. REV. 89, 91 (2014) (“A ‘sex-positive’ approach that values sexual pleasure in itself requires lawmakers and legal scholars to undertake a more honest assessment of what we choose to regulate, what we fail to regulate, and our justifications for these choices.”).

The nature and consequences test focuses on mental capacity. It converges with the cognition-plus test in situations when a person with cognitive impairments can still understand and process the sexual decision's consequences, either because the impairments are not so severe, or because the consequences are not so complex. It diverges in cases of people with persistent cognitive impairments who do not have the mental capacities on their own to process a sexual decision. The cognition-plus test would allow those who fall into this situation to experience sexual expression if they have an adequate decision-making support system in place. In other words, the nature and consequences test would impose complete bans on sexual expression for many individuals with persistent cognitive impairments, whereas the cognition-plus would allow a route to a sexual life, provided adequate safeguards in the form of a supported decision-making network exist.

The contextual approach focuses on all the facts and circumstances surrounding the sexual act. It converges with the cognition-plus test in that it considers more than just the mental capacities of the subject and does not permit blanket prohibitions on sexual conduct just because of cognitive impairment. It diverges in the amount of contextual information that is considered to be relevant and in the amount of normative guidance that is provided in assessing the information in a given case. The contextual approach is openly normative and could examine the nature of the sexual relationship and even possibly the nature of the sexual acts involved. In contrast, the cognition-plus test keeps a narrow focus on the quality of the decision-making machinery, inclusive of the individual's mental capacities and decisional network. Facts that might trigger moral evaluation only enter the analysis to the extent that they are relevant to some other step of the test. In sum, the contextual approach considers too much, running the risk of inhibiting sexual capability among populations whose sexuality is already societally disfavored, whereas the cognition-plus test removes such judgments from the purview of the judge.

The cognition-plus test represents an improvement on existing sexual incapacity doctrines for people with persistent cognitive impairments. It strikes the correct balance between protection and restriction, has a sound theoretical basis, guards against courts dictating which sexual acts are appropriate, and provides more predictability to institutions in formulating resident sexual policies and practices.

3. Limitations

Despite its significant advantages, the cognition-plus test does have some limitations. The first limitation is one that is confronted by any sexual incapacity doctrine, which is the fact that the cognition-plus test will not be able to prevent all sexual assault or exploitation of those with cognitive impairments. Justice Holmes's "bad man" will find a way around any sexual

incapacity test that we might construct.¹⁹⁶ Thus, the question is not whether all sexual danger has been avoided, as that is impossible. It is whether we have found the best practical ways to reduce its prevalence, taking into account the costs of doing so in the form of restricting sexual opportunities.¹⁹⁷ Current doctrines have failed to reduce sexual violence completely, and they have come at the great cost of creating restrictive sexual environments for people with persistent incapacities.

Much of the discussion in this Article has centered on finding ways for people with persistent cognitive impairments to achieve sexual lives, but it is important to note that liability will still flow to sexual partners or institutions in situations with which many might be concerned. Liability will flow when the subject is incapable of expressing volition.¹⁹⁸ Unlike situations of temporary transient incapacity, the court can examine whether such a volitional capacity was present at the time of the sexual encounter because the conditions causing the incapacity are more stable. Liability will flow when she is unaided by a supportive network and cannot understand the nature and consequences of the sexual decision or that there is a choice to be made. Thus, perpetrators who prey on isolated people with cognitive impairments have no legal recourse. Liability will flow when she cannot understand the nature and consequences of the sexual decision and her supportive network is inadequate. If perpetrators are part of a supportive network themselves, which might unfortunately be the case in many instances, they face a presumption of network inadequacy they must overcome to avoid liability. Together, these cover a wide range of the problematic situations of abuse and exploitation that are reachable by the law, at much lower cost to the sexual lives of people with persistent cognitive impairments. Of course, the prosecution of such claims will still be plagued by evidentiary problems, problems of non-enforcement of sexual assault law, and the like, but these are problems common to all doctrines in this space.¹⁹⁹

Second, even if everyone had adequate supportive networks in place, the cognition-plus test alone cannot and will not force decision-making networks to be supportive of sexual expression. While local decision-making networks may be superior to removed judges in understanding the sexual context of

¹⁹⁶ See Oliver Wendell Holmes, *The Path of the Law*, 10 HARV. L. REV. 457, 459 (1897).

¹⁹⁷ See Katherine M. Franke, *Theorizing Yes: An Essay on Feminism, Law, and Desire*, 101 COLUM. L. REV. 181, 182 (2001) (arguing that legal feminism has problematically reduced discussions of sexuality to either dependency or danger).

¹⁹⁸ While this is technically separate from the sexual incapacity doctrine, if the law were to incorporate an affirmative consent standard, and there are good arguments that it should, liability will flow if she does not affirmatively consent in a way that is appropriate to her forms of communication. See generally Lois Pineau, *Date Rape: A Feminist Analysis*, 8 LAW & PHIL. 217 (1989) (arguing for an affirmative consent standard).

¹⁹⁹ See Katharine K. Baker, *Why Rape Should Not (Always) Be a Crime*, 100 MINN. L. REV. 221, 221–22 (describing the difficulties the criminal law has with successfully preventing sexual assault).

people with disabilities, they may in fact hold some of the same societal biases that historically plague judges in implementing incapacity doctrines.²⁰⁰ Members of these networks may prevent sexual expression before it can happen due to stereotypes they might hold about people with disabilities. Since sexual incapacity doctrines only apply in situations in which sexual activity has taken place, they will not be able to ameliorate these types of situations. This reveals the limits of the law in this area, and perhaps generally. Without more intrusive sexual regulation of all local decision-making behavior, which would be undesirable for other reasons, the best that can be hoped for is that doctrines allow those networks that wish to facilitate the sexuality of people with persistent cognitive impairments the ability to do so. A less stigmatizing set of laws in this area might be able to exert positive expressive pressure on social norms around the sexuality of people with disabilities in the long run as well.

Finally, the cognition-plus test represents only a partial solution to realizing the sexual capabilities of people with persistent cognitive impairments. The law is only one of many disabling features of the social environment.²⁰¹ In addition to the biased attitudes already noted, many people with persistent cognitive impairments might not be embedded in an adequate supportive network in the first place, whether due to social isolation, lack of funding for long-term care facilities and staff, or overburdened caregivers.²⁰² Thus, changing the legal test for sexual incapacity is a necessary, but not sufficient, condition for realizing the sexual capability of people with persistent cognitive impairments. It needs to be part of a multi-pronged approach that includes pursuing litigation in related areas, allocating more resources to these issues, and pursuing policy and regulatory reforms.²⁰³

²⁰⁰ See Julian C. Hughes et al., *Sexuality in Dementia*, in THE LAW AND ETHICS OF DEMENTIA 227, 229 (Charles Foster et al. eds., 2014) (noting family member discomfort with their relatives with dementia having sexual intercourse and staff discomfort with same-sex sexual expression in residential facilities).

²⁰¹ See TOM SHAKESPEARE ET AL., THE SEXUAL POLITICS OF DISABILITY: UNTOLD DESIRES 16–43 (1996) (discussing the various barriers to being sexual among people with disabilities).

²⁰² See MARGARET C. JASPER, HOSPITAL LIABILITY LAW 86 (2d ed. 2008) (“More than one-half of American nursing homes are below the suggested minimum staffing level for nurse’s aides, and more than one-third of nursing homes fell below the suggested minimum staffing level registered nurses. Of total licensed staff, nearly one-fourth of all nursing homes routinely fall below the suggested minimum staffing level.”); John V. Jacobi, *Federal Power, Segregation, and Mental Disability*, 39 HOUS. L. REV. 1231, 1234 (2003) (calling for action on the isolation of people with mental disabilities); Richard L. Kaplan, *Retirement Planning’s Greatest Gap: Funding Long-Term Care*, 11 LEWIS & CLARK L. REV. 407, 409 (2007) (discussing the problems in the funding of long-term care); Donna R. Lenhoff, *LTC Regulation and Enforcement: An Overview from the Perspective of Residents and Their Families*, 26 J. LEGAL MED. 9, 11 (2005) (noting the problem of understaffing in long-term facilities).

²⁰³ See DOUGLAS WORNELL, SEXUALITY AND DEMENTIA 159 (2014) (noting how sex workers may have a role to play in addressing the sexual needs of older adults with

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With the principles and mechanics of the test in place, and an understanding of how it differs from other approaches and has its limits, the next Part explores its application in more detail to the population of older adults with cognitive impairments. Specifically, it applies the cognition-plus test to the case of Henry and Donna Rayhons, a context of persistent acquired incapacity in the form of dementia.

B. *Application to Older Adults with Dementia*

The opening narrative of Henry and Donna Rayhons is an example of the situation of many older adults with cognitive impairments, but it is not the only one.²⁰⁴ It reveals some key points about the context of persistent acquired incapacity, particularly with older adults. First, as a demographic matter, dementia is rising in importance due to the aging of the population. Over 5 million people currently suffer from dementia in the United States, most of them over the age of 65.²⁰⁵ By 2050, it is estimated that over 13 million people will have Alzheimer's Disease, the most common cause of dementia.²⁰⁶ This condition causes deficits in communication, attention, reasoning, and judgment.²⁰⁷ The disease's hallmark, however, is its effect on memory.²⁰⁸ It worsens both semantic memory, which relates to general knowledge, and

dementia); David F. Bragg, *Dealing with Nursing Home Neglect: The Need for Private Litigation*, 39 S. TEX. L. REV. 1, 4 (1997) (noting the importance of private litigation to keep nursing homes from neglecting residents); Marilyn Denny, "This Is Who I Am, Don't Let Them Move Me:" *Autonomy in Nursing Homes*, 2 QUINNIPIAC HEALTH L.J. 203, 223–24 (1999) (discussing the need to fund ombudsmen to safeguard the autonomy of individuals in long-term care facilities); Marshall B. Kapp, *Nursing Home Restraints and Legal Liability: Merging the Standard of Care and Industry Practice*, 13 J. LEGAL MED. 1, 16 (1992) (discussing policy and litigation responses to the improper use of restraints by nursing homes).

²⁰⁴ See, e.g., Marie-Therese Connolly, *When the Mind Falter, Is Sex a Choice?*, WASH. POST (Sept. 20, 2009), http://www.washingtonpost.com/wp-dyn/content/article/2009/09/18/AR2009091801144_pf.html [<http://perma.cc/SS2W-BBHN>] (collected stories); Melinda Henneberger, *An Affair to Remember*, SLATE (June 10, 2008), http://www.slate.com/articles/life/family/2008/06/%20an_affair_to_remember.html [<http://perma.cc/P7KR-5WCP>] (telling the tragic story of a ninety-five-year-old man and eighty-two-year-old woman who found romance in an assisted living facility and then were separated by staff and a family member of the man).

²⁰⁵ See Alzheimer's Ass'n, *2014 Alzheimer's Disease Facts and Figures*, 10 ALZHEIMER'S & DEMENTIA e47, e54 (2014).

²⁰⁶ See Hebert et al., *supra* note 22, at 1120.

²⁰⁷ See Peter V. Rabins, *Dementia and Alzheimer's Disease: An Overview*, 35 GA. L. REV. 451, 452 (2001).

²⁰⁸ See Andrea Schaffner, *Understanding Dementia*, 23 QUINNIPIAC PROB. L.J. 372, 373 (2010) ("Memory deficit is one of the hallmarks of dementia.").

episodic memory, which deals more with autobiographical knowledge.²⁰⁹ Typically, dementias progressively worsen over time, though in the short term they may include fluctuating levels of capacity.²¹⁰

Second, sexuality does not disappear with age, even very old age.²¹¹ The form of sex, however, may change from being more genital in nature to taking on other forms of intimacy.²¹² Sexuality may even take on greater importance for people with degenerative cognitive conditions such as Alzheimer's Disease, as it can help provide a sense of connection to other people. This is particularly important for people who lose social relationships as they age, especially if they enter institutions.²¹³ Alzheimer's Disease may also cause disinhibition in sexual behaviors, leading people with the condition to seek out sex more than they did in the past.²¹⁴

Third, many people with these conditions live in the context of institutions.²¹⁵ These institutions are not generally sex-positive, as staff either

²⁰⁹ See Taylor Kuhn & Russell M. Bauer, *Episodic and Semantic Memory Disorders*, in HANDBOOK ON THE NEUROPSYCHOLOGY OF AGING AND DEMENTIA 401, 402 (Lisa D. Ravin & Heather L. Katzen eds., 2013).

²¹⁰ See ALAN JACQUES & GRAHAM A. JACKSON, UNDERSTANDING DEMENTIA 53–65 (3d ed. 2000).

²¹¹ See Stacy Tessler Lindau et al., *A Study of Sexuality and Health Among Older Adults in the United States*, 357 NEW ENG. J. MED. 762, 762 (2007) (noting that fifty-three percent of those aged sixty-five to seventy-four and twenty-six percent of those seventy-five to eighty-five were still having sex); see also Alexander Warso, *Something Catchy: Nursing Home Liability in the Senior Sexually Transmitted Disease Epidemic*, 22 ELDER L.J. 491, 500–01 (2014) (discussing the problem of sexually transmitted diseases among older adults).

²¹² See Ramzi R. Hajjar & Hosam K. Kamel, *Sex and the Nursing Home*, 19 CLINICS GERIATRIC MED. 575, 576 (2003) (“[T]here is a shift from genital sex to intimacy, and other means to express lifelong sexual desires, as people age.”).

²¹³ See Steven H. Miles & Kara Parker, *Sexuality in the Nursing Home: Iatrogenic Loneliness*, 1999 GENERATIONS 36, 37 (describing iatrogenic loneliness); Sally M. Roach, *Sexual Behaviour of Nursing Home Residents: Staff Perceptions and Responses*, 48 J. ADVANCED NURSING 371, 378 (2004) (“Sexual sensations are among the last of the pleasure-giving biological processes to deteriorate, and are an enduring source of gratification at a time when pleasures are becoming fewer and fewer.” (citing Kaplan H.S., *Sex, Intimacy, and the Aging Process*, 18 J. AM. ACAD. PSYCHOANALYSIS 185 (1990))).

²¹⁴ See Leslie M. Lothstein et al., *Risk Management and Treatment of Sexual Disinhibition in Geriatric Patients*, 61 CONN. MED. 609, 609 (1997) (noting the phenomenon and discussing treatment options for such behaviors). *But see* Antonette M. Zeiss, *An Observational Study of Sexual Behavior in Demented Male Patients*, 51A J. GERONTOLOGY M325, M329 (1996) (concluding that sexual disinhibition is less frequent than assumed).

²¹⁵ See Andrew Casta-Kaufteil, *The Old & the Restless: Mediating Rights to Intimacy for Nursing Home Residents with Cognitive Impairments*, 8 J. MED. & L. 69, 70 (2004) (“Alzheimer's disease is responsible for half of the nursing home residencies in this Country.” (citing LAWRENCE FROLIK & MELISSA C. BROWN, ADVISING THE ELDERLY OR DISABLED CLIENT: LEGAL, HEALTH CARE, FINANCIAL AND ESTATE PLANNING (2d ed. 2003))); Hajjar & Kamel, *supra* note 212, at 575.

ignore resident sexuality or try to actively prevent it due to biases against older adult sexuality or fear of legal liability.²¹⁶ Nursing homes are frequently targets for lawsuits, and permitting sexual contact with a resident who cannot consent opens another font of potential liability.²¹⁷ Perhaps in recognition that resident sexuality is something that cannot be swept under the rug anymore, the American Medical Directors Association recently called on nursing homes to formulate policies on the sexual behavior of residents, as only one in four nursing homes had one.²¹⁸

With that background on the importance and characteristics of the aging population with cognitive impairments, we now turn to how the cognition-plus test might apply to this group, using the Rayhons example. The first step in applying the cognition-plus test is to analyze whether there is volition. In the case of Donna, the criminal case against Henry rested not on some claim that Donna *did not* say yes, but that she *could not* say yes.²¹⁹ Nonetheless, this first step may raise issues in similar contexts. First, the ways in which a person with persistent cognitive impairments communicates volition may vary significantly. For example, Henry described Donna as the one to initiate sex, and she would do so by saying “Shall we play a bit?”²²⁰ Assuming the accuracy of this statement, this is not something one would know without

²¹⁶ See Ann Christine Frankowski & Leanne J. Clark, *Sexuality and Intimacy in Assisted Living: Residents' Perspectives and Experiences*, 6 SEXUALITY RES. & SOC. POL'Y 25, 31 (2009) (noting the minimal policies on sexuality among residents); Hosam K. Kamel & Ramzi R. Hajjar, *Sexuality in the Nursing Home, Part 2: Managing Abnormal Behavior—Legal and Ethical Issues*, 4 J. AM. MED. DIR. ASS'N, 203, 204 (2003) (noting fears of liability among nursing home staff); Marshall B. Kapp, *Legal Anxieties and End-of-Life Care in Nursing Homes*, 19 ISSUES L. & MED. 111, 122 (2003) (“A certain amount of generalized fear and loathing of anything connected to the law, lawyers, or the legal process is innate among all health care providers, especially in the [end-of-life] context.”); Belinda Kessel, *Sexuality in the Older Person*, 30 AGE & AGEING 121, 121 (2001) (describing how people generally see older adult sexuality as either nonexistent, funny, or disgusting); Kathleen S. Mayers & Dennis McBride, *Sexuality Training for Caretakers of Geriatric Residents in Long Term Care Facilities*, 16 SEXUALITY & DISABILITY 227, 230 (1998) (noting how it is simply easier to ignore resident sexuality).

²¹⁷ See, e.g., Katie Thomas, *Facing Suits, a Nursing Home in California Seeks Bankruptcy*, N.Y. TIMES (Feb. 17, 2015), <http://www.nytimes.com/2015/02/18/business/facing-suits-a-nursing-home-seeks-bankruptcy.html> [<http://perma.cc/7KB8-WW7W>] (noting the rise in bankruptcies among nursing homes, due in part to lawsuits).

²¹⁸ See Bryan Gruley, *Sex Among Seniors with Dementia Spurs Call for Policies*, BLOOMBERG (Oct. 27, 2013), <http://www.bloomberg.com/news/articles/2013-10-28/sex-among-demented-spurs-group-to-call-for-policies> [<http://perma.cc/P74W-2G6R>].

²¹⁹ In fact, in many cases of older adults in institutions seeking sexual pleasure, volition is not an issue, as they seek ways of expressing sexuality in the face of hostility from staff. See, e.g., Carole Archibald, *Sexuality and Dementia: The Role Dementia Plays When Sexual Expression Becomes a Component of Residential Care Work*, 4 ALZHEIMER'S CARE Q. 137, 139–40 (2003) (telling the story of Will and Wilma who “were adamant they wanted to continue their relationship and this was obvious by the different means they used to outwit staff”).

²²⁰ See *supra* text accompanying note 2.

extensive knowledge of the person with the impairment. Second, whether or not there was volition could be an issue in another case. The well-documented evidentiary issues around expressed consent in non-incapacity sexual assault cases are also lurking in the background of incapacity cases.²²¹

The second step is to assess the mental capacities of the subject in light of the relevant consequences.²²² Here, we do not know the exact mental faculties of Donna, but we do know she was cognitively impaired. To establish whether the cognitive abilities she had were sufficient for the sexual decisions she was making, we would need to know more about the types of sex in which Donna and Henry might have engaged. There are several reasons why the universe of consequences may be less complicated for Donna and Henry, though, and perhaps for many other similarly situated older adults with dementia. First, the pregnancy consequence will often not be present, as women have aged past the period of fertility.²²³ Less is known about male fertility, but it is commonly assumed to last longer, even if it might decline with age.²²⁴ Thus, older men who have access to fertile female partners may still have to deal with the potential consequences of pregnancy. Same-sex sexual expressions will never lead to pregnancy, exempting sexual contacts between members of the same anatomical sex from the pregnancy consequence altogether. Thus, typically older women, older men who have older women as sexual partners, and those who exclusively pursue same-sex partners need not have the capacity to consider this physical consequence, which may result in a lower level of required mental capacities to process the decision.²²⁵

²²¹ See, e.g., Kim Lane Scheppelle, *Just the Facts, Ma'am: Sexualized Violence, Evidentiary Habits, and the Revision of Truth*, 37 N.Y.L. SCH. L. REV. 123, 123 (1992) (“Cases of sexualized violence often evolve into a ‘he said, she said’ battle of competing narratives in which the ‘he,’ who is the defendant, wins by default simply because the evidence is contested.”). There are also genuine issues of sexual assault in nursing home contexts. See Lisa Tripp, *The Medico-Legal Aspects of Dementia-Driven Sexual Abuse in Nursing Homes*, 12 MARQ. ELDER’S ADVISOR 363, 377–78 (2011) (discussing the problem of dementia-driven sexual abuse in nursing homes).

²²² Several tools of cognitive assessment have been proposed. See Martin Lyden, *Assessment of Sexual Consent Capacity*, 25 SEXUALITY & DISABILITY 3, 10 (2007); Stephanie L. Tang, Note, *When “Yes” Might Mean “No”: Standardizing State Criteria to Evaluate the Capacity to Consent to Sexual Activity for Elderly with Neurocognitive Disorders*, 22 ELDER L.J. 449, 484–87 (2015) (reviewing various tests).

²²³ See Vera Bittner, *Menopause and Cardiovascular Risk*, 47 J. AM. C. CARDIOLOGY 1984, 1984 (2006) (noting the average age of onset of menopause as 51.4).

²²⁴ See Mohamed A. M. Hassan & Stephen R. Killick, *Effect of Male Age on Fertility: Evidence for the Decline in Male Fertility with Increasing Age*, 79 FERTILITY & STERILITY 1520, 1525–26 (2003).

²²⁵ This understanding of the capacity test will likely not pose significant constitutional difficulties. See *Michael M. v. Superior Court of Sonoma Cty.*, 450 U.S. 464, 472–73 (1981) (plurality opinion) (upholding a statutory rape law that differentially treated men and women due to the different pregnancy risks involved); *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 313–14 (1976) (per curiam) (adopting a life course perspective by holding that distinctions based on age do not pose constitutional difficulties). The distinction drawn

Second, the impairment itself may affect what the relevant consequences are. If one cannot retain the psychological effects of sexual expression, the mental and social consequences are far less relevant for a given person. For example, someone who would experience negative feelings about engaging in sexual activities outside marriage, but who is not capable of remembering doing so, will not experience the negative psychological consequences of engaging in this activity.²²⁶ In this case, it is not necessary that the individual have the ability to process such a consequence in order to engage in that activity. In contrast, delirium creates short bursts of significant impairment followed by periods of lucidity. This situation should be treated similarly to other temporary impairments such as intoxication, as a less-impaired self will reemerge who will have to deal with the mental and social consequences of the sexual behavior.

Third, as noted earlier, people with cognitive impairments may undertake various consequence-diminishing interventions, such as birth control or Truvada, to protect themselves from the negative consequences of sexual contact, with the assistance of a supportive network. These types of interventions will reduce the number of relevant consequences one needs to be able to process to have legal capacity. This, in turn, should reduce the required level of capacity. Of course, just because one can intervene does not mean one should. Requiring STD testing or safer sex practices of potential sexual partners are interventions that may not only reduce the sphere of privacy that an individual enjoys, but may also reduce the overall availability of sexual partners. This restriction of partner choice thus limits the sexual opportunities of people with cognitive impairments. The correct course of action in these circumstances would need to be resolved on a case-by-case basis, with as much input from the person with impairments as possible.

Thus, for some in this population, the consequences of sexual expression will be fewer than if they had sexual relations at an earlier age without impairments and without consequence-diminishing interventions. For Donna, it is possible that she did not face a wide variety of relevant consequences because of her age, condition, and context, and she might thus satisfy the second step of this test. If this was not the case, then the third step of assessing the decisional support system comes into play.

between gays and lesbians and straight men and women may pose difficulties, depending on whether the Court applies strict scrutiny to sexual orientation. *See generally* Edward Stein, *Immutability and Innateness Arguments About Lesbian, Gay, and Bisexual Rights*, 89 CHI.-KENT L. REV. 597 (2014) (discussing the arguments put forth in the briefs of recent same-sex marriage cases).

²²⁶ This situation is not unheard of; Justice Sandra Day O'Connor experienced this with her husband, who had Alzheimer's and developed a relationship with another woman in the nursing home. *See* Kate Zernike, *Love in the Time of Dementia*, N.Y. TIMES (Nov. 18, 2007), http://www.nytimes.com/2007/11/18/weekinreview/18zernike.html?page-wanted=all&_r=0 [<http://perma.cc/6J37-92UP>].

Donna was in the fortunate situation of having many individuals who provided care for her, including her husband Henry, her daughters, and nursing home staff. These individuals varied in their assessments of her mental capacity to have sex. The daughters did not believe she had capacity, and a relatively cursory medical examination of her cognitive capacities led a doctor at the nursing home to agree. Henry Rayhons clearly had a different opinion. Ideally, all those individuals and institutions that surrounded Donna would have acted together to try to respect and facilitate Donna's sexual desires.²²⁷ This, however, did not happen. In applying the legal test, a court need not decide which part of the supportive network should "win out." It need only assess the decision-making support network that is at issue in a particular sexual decision.

In this case, the only individual who was facilitating Donna's sexual activity was Henry, and thus he is the supportive network that must be evaluated for its adequacy. Because Henry is in a conflicted position by virtue of being Donna's alleged sexual partner, there is a rebuttable presumption that Henry, as the supportive network, is inadequate. In assessing whether he can overcome this presumption, one must evaluate the evidence of his loyalty and care. On the axis of loyalty, we might look to Donna and Henry's relationship for evidence of whether he acted in her interests, apart from his conflicted position with respect to sex. We know that they were married, which indicates that at least at some level Donna trusted Henry as a partner. Delving deeper into what we know of Donna and Henry's relationship, it appears that it was a mutually supportive and loving, including after her diagnosis.

On the axis of care, a court would examine Henry's competence to act as a supportive network. This includes whether he had knowledge of Donna's history, preferences, and forms of communication, which he likely did based on his close relationship with her. Also important is whether he created a safe space for the sexual activity to take place, reducing the risk of objective welfare threats derived from sex. While pregnancy is not a concern, sexually transmitted disease may have been depending on Henry's health status. A further concern might have been the quality of the physical space in which they might have had sex, as risk of falling is a primary concern for older adults due to the risk of hip fractures.²²⁸

Although it might be helpful to know a little more in order to fully assess whether Henry Rayhons could overcome the presumption of network

²²⁷This is actually the optimal strategy for the nursing facility in terms of risk management as well. See TOM FLEWETT, CLINICAL RISK MANAGEMENT 38 (2010) ("Best practice in the assessment and management of risk is to include the patient and family at all stages wherever possible.").

²²⁸In an interview after his acquittal, Henry stated that one of the reasons that he did not have sex with her in the nursing home was because the bed was too small. See Pam Belluck, *An Intimacy that Outlasted Dementia*, N.Y. TIMES (Apr. 27, 2015), http://www.nytimes.com/2015/04/28/health/an-intimacy-that-outlasted-dementia.html?_r=0 [<http://perma.cc/923H-322F>].

inadequacy created by his sexual conflict of interest, it appears that there is significant evidence that he was acting as an adequate support network for Donna. If this was indeed the case, then Donna would be deemed to have legal capacity under the third step of the cognition-plus test, if she had not already passed it under the second step. More importantly, perhaps, the prosecution might not have pressed charges for a relatively weak case, basing it solely on the mental capacities of Donna, as required by current law.

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The relative position of older adults with cognitive impairments is improved through the adoption of a cognition-plus test. Provided that there is volition, some of these individuals may satisfy the test simply because several of the consequences of sexual expression may not be present in this population, reducing the level of cognitive capacities needed to process the sexual decision. Age removes the possibility of pregnancy for many in this group, and sexually transmitted diseases can be screened by caregivers. Some of the mental and social consequences of sex may also not register due to the memory impairments that are characteristic of dementia. Others may satisfy the test despite exposure to these consequences due to the presence of a supportive network of family members or nursing home staff, provided that they adequately actualize individual sexual desires in a safe environment. This helps to make it easier for institutions to deal with legal liability, moving from an exposure avoidance strategy of risk management to a loss prevention or loss reduction framework.

V. CONCLUSION

Both sexuality and incapacity are inescapable features of the human condition. They need not be mutually exclusive, but current sexual incapacity doctrines make them so for many, by creating unduly restrictive sexual environments and contributing to pernicious social norms. This Article has offered a way forward by reconfiguring sexual incapacity doctrines so that they are not a disabling force for people with persistent cognitive impairments. First, it has offered a novel theoretical basis for the doctrine—sexual capability—which accounts for the internal as well as external threats to self-determination. Second, it has proposed a new legal test—cognition-plus—which is grounded in the lived experiences of people with persistent cognitive impairments. This approach strikes the correct balance between protection and restriction, has a sound theoretical basis, guards against courts dictating which sexual acts are appropriate, and provides more predictability to institutions in formulating resident sexual policies and practices.

