WHEN "YES" MIGHT MEAN "NO": STANDARDIZING STATE CRITERIA TO EVALUATE THE CAPACITY TO CONSENT TO SEXUAL ACTIVITY FOR ELDERLY WITH NEUROCOGNITIVE DISORDERS

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The determination of consent among elders of diminishing mental capacity is subject to a great deal of uncertainty and discrepancy among the states. The lack of clear guidelines and standards leaves elders vulnerable to predation in some cases and incapable of sexual expression in others. Even the preliminary determinations of capacity are under extreme criticism, as they tend to be highly subjective and susceptible to the biases of those charged with their administration. Further, the social stigmas and taboos around elders' sexual habits prevent education about the associated rights, responsibilities, and risks.

By promoting open discussion of these issues and education of elders, their doctors, and society as a whole, it may be possible to create a more objective and functional approach to determinations of consent among those with neurocognitive disorders. Adoption of more uniform standards both in and among the states could make the consequences of these decisions clearer as well, facilitating informed decision-making. States should apply these effective, up-to-date standards in an effort to improve the predictability and fairness of their judicial systems, thus improving their protection of elders and their autonomy.

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I. Introduction

It was 8:30 p.m. on Christmas Day 2009.[1] Nurse Tiffany Gourley was summoned to a room at Windmill Manor nursing home, where she found a seventy-eight-year-old man, pulling up his pants, having just completed sexual intercourse with an eighty-seven-year-old woman.[2] The man, a former college professor, was divorced.[3] The woman, a retired secretary who enjoyed gardening, was married.[4] Both had dementia.[5] When the nursing home's staff tried to remove the woman from the room, she screamed, bit, and kicked them in an act of resistance.[6]

Incidents like this are becoming increasingly frequent, both inside and outside of nursing homes. The number of Americans age sixty-five and older currently constitutes 13.3% of the population of the United States, or over one in every eight Americans.[7] The aging Baby Boomers, many of whom lived through the sex-crazed era of the 1960s, will soon lead their families to face the same legal questions that the Windmill Manor staff confronted.[8] The question of capacity to consent to sexual relations should therefore be extended outside the institutional setting: Are elderly individuals who suffer from neurocognitive disorders able to protect themselves against rape in their own homes?

Individuals with neurocognitive disorders are often thought to lack capacity and are consequently deemed incapable of providing

1. Bryan Gruley, *Boomer Sex With Dementia Foreshadowed in Nursing Home*, BLOOMBERG (Jul. 21, 2013, 11:01 PM), http://www.bloomberg.com/news/2013-07-22/boomer-sex-with-dementia-foreshadowed-in-nursing-home.html.

2. *Id.*

3. Susan Scutti, *Age Of Consent: Should A Number Be Placed On the Upper Limit To Protect Elderly Patients With Dementia?*, MED. DAILY (Jul. 23, 2013,1:42 PM), http://www medicaldaily.com/age-consent-should-number-be-placed-upper-limit-protect-elderly-patients-dementia-247930.

4. Gruley, *supra* note 1.

5. *Id.*

6. *Id.*

7. ADMIN. ON AGING, A PROFILE OF OLDER AMERICANS: 2012 2 (2012), *available at* http://www.aoa.gov/Aging_Statistics/Profile/2012/docs/2012profile.pdf.

8. Gruley, *supra* note 1.

valid consent to any kind of sexual behavior.[9] Recent Health and Retirement Study data indicates that ten percent of people ages seventy and older have moderate to severe cognitive impairment.[10] Neurocognitive disorders are progressive conditions, meaning a person's capacity becomes increasingly limited with time.[11] This makes any legal action challenging when the condition is mild, and nearly impossible as the disorder worsens.[12] Moreover, governmental and societal attitudes reflecting general discomfort with the idea of cognitively impaired elders engaging in sexual activity have resulted in an overall lack of laws, regulations, and general guidelines on the subject.[13] However, states and legal scholars generally agree that when evaluating capacity, it is necessary to balance the cognitively impaired individual's right to sexual expression with the societal interest of prohibiting illegal sexual conduct.[14]

This issue has been addressed in the context of nursing homes, but elderly individuals in private homes need protection as well. Whereas nursing homes can implement standardized policies and procedures regarding sexual relations,[15] it is more challenging to adopt a uniform standard in the country outside this narrow percentage of the population. Only 3.6% of elderly Americans actually live in

9. *See* Kathleen S. Mayers, *Sexuality and the Demented Patient*, 16 SEXUALITY & DISABILITY 219, 223 (1998) ("If the patients involved in sexual activity are moderately to severely demented, the term 'consensual' cannot be applied to their sexual activity. A patient civilly committed under the supervision of the state may not have the mental capability to make a choice to engage in sexual activity.").

10. Scutti, *supra* note 3.

11. Andrew Casta-Kaufteil, *The Old & the Restless: Mediating Rights to Intimacy for Nursing Home Residents with Cognitive Impairments*, 8 J. MED. & L. 69, 76 (2004).

12. *Id.*

13. Paul F. Stavis, *Harmonizing the Right to Sexual Expression and the Right to Protection from Harm for Persons with Mental Disability*, 9 SEXUALITY & DISABILITY 131, 132 (1991).

14. *Id.*

15. *See*, *e.g.*, ROBIN DESSEL & MILDRED RAMIREZ, THE HEBREW HOME AT RIVERDALE, POLICIES AND PROCEDURES CONCERNING SEXUAL EXPRESSION AT THE HEBREW HOME AT RIVERDALE, (2013), *available at* http://www.hebrewhome.org/uploads/ckeditor/files/sexualexpressionpolicy.pdf (detailing a nursing home's policies and procedures concerning sexual relations between residents).

institutional settings such as nursing homes.[16] This means an overwhelming majority of the elderly population currently is not subject to institutional guidelines regulating their sexual activity.

An essential step in determining the legality of sexual relations is defining capacity to consent.[17] The importance of determining consent is most evident in criminal law because consent is the line that distinguishes whether sexual activity is a criminal act or a person's protected right.[18] Currently, there is significant variation between the statutory definitions and interpretations of capacity to consent to sexual activity, ranging from very conservative to very liberal tests.[19] As a result, cognitively impaired individuals have little guidance on how their claims would be evaluated if adjudicated.

This Note addresses the judicial approaches for determining the capacity of the cognitively impaired elderly to consent to sexual activity. Part II introduces background information regarding neurocognitive disorders, discusses the benefits and risks of sexual activity among the elderly, and provides a brief overview of potential ethical challenges facing lawyers who represent individuals with diminished capacity. Part III analyzes the different tests applied by courts in determining capacity to consent of elders with neurocognitive disorders and summarizes proposed solutions to help guide future litigants in pursuing sexual assault claims. Finally, Part IV advocates for the adoption of model assessment tools by states to increase predictability within and across states and discusses the potential for increasing the effectiveness of these tools through combining them with cultural considerations, mediation efforts, and elderly education programs.

16. ADMIN. ON AGING, *supra* note 7, at 5.

17. *Stavis*, *supra* note 13, at 138.

18. *Id.* at 133.

19. ABA COMM'N ON LAW & AGING & AM. PSYCHOL. ASS'N, ASSESSMENT OF OLDER ADULTS WITH DIMINISHED CAPACITY: A HANDBOOK FOR PSYCHOLOGISTS 63 (2008) [hereinafter 2008 HANDBOOK], *available at* http://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf.

II. Background

A. The Stigma Behind "Dementia"

The word "dementia" is commonly coupled with a negative stigma against elderly individuals.[20] The word originally stems from the Latin root meaning "madness," from *de-* "without" and *ment* "mind."[21] Throughout the early 1900s, people generally perceived those with dementia as a burden on society that should be isolated in institutions.[22] By the 1970s, countries worldwide started recognizing the rights of people with cognitive impairments and the need to integrate them into mainstream employment.[23] The 1990s signaled the development of the first drug treatments geared towards reversing deterioration of mental capacity, but researchers have yet to find a cure.[24] Furthermore, drug treatments remain largely unavailable in lower income countries and, in many countries, people who suffer from dementia are still either locked in institutions or hidden by relatives.[25] In the Netherlands, the Dutch recently developed "Dementiavillage," a neighborhood built exclusively to house patients with dementia.[26] Reporters speculate that American companies may soon parallel this design, possibly leading to similar isolation and added classification of those with dementia as people who cannot live with the rest of society.[27]

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20. James Siberski, *Dementia and DSM-5: Changes, Cost, and Confusion*, 5(6) AGING WELL 12, 12 (2012).

21. Marguerite Manteau-Rao, *Will New DSM-5 Diagnosis End 'Dementia' Stigma?*, HUFFINGTON POST (Apr. 5, 2012), http://www.huffingtonpost.com/marguerite-manteaurao/dsm-dementia_b_1404224.html.

22. NICOLE L. BATSCH & MARY S. MITTELMAN, ALZHEIMER'S DISEASE INT'L, WORLD ALZHEIMER REPORT 2012: OVERCOMING THE STIGMA OF DEMENTIA 7 (2012), *available at* http://www.alz.org/documents_custom/world_report_2012_final.pdf.

23. LAW REFORM COMM'N, SEXUAL OFFENCES AND CAPACITY TO CONSENT 9 (2013), *available at* http://www.lawreform.ie/_fileupload/Reports/r109.pdf.

24. BATSCH & MITTELMAN, *supra* note 22, at 7.

25. *Id.*

26. Kelsey Campbell-Dollaghan, *An Amazing Village Designed Just For People With Dementia,* GIZMODO (Feb. 20, 2014), http://gizmodo.com/inside-an-amazing-village-designed-just-for-people-with-1526062373?utm_campaign=socialflow_gizmodo_facebook&utm_source=gizmodo_facebook&utm_medium=socialflow.

27. *Id.*

Although the past century has seen increasing public awareness of dementia, many people are still unaware of the nature of its causes and progression.[28] The majority of people do not know that dementia is caused by a medical disorder, and that its symptoms stem from physical brain damage.[29] As a result, people make incorrect assumptions concerning dementia's effects and develop negative stereotypes about how a demented person will act.[30] Consequently, people with dementia often engage in social exclusion and are reluctant to seek help due to fear of rejection.[31] In a survey of 2,068 patients with dementia, twenty-four percent of participants reported concealing their diagnosis primarily due to the surrounding stigma.[32]

The general stigma surrounding old age worsens the stigma associated with dementia.[33] Often, the elderly are viewed as vulnerable and dependent on others.[34] Ageist views build popular perceptions that it is strange if an older individual is not cognitively impaired.[35] With this perception in mind, neither the elderly nor their close relatives are motivated to seek medical opinions and, if they do, many elders avoid discussing potential illnesses with their physicians until their symptoms become severe and apparent.[36] Even if the elderly patient seeks medical treatment, doctors may follow their impression of a patient driven by their stigmatic beliefs and assume the patient is incapable of making decisions simply based on his or her age.[37]

28. BATSCH & MITTELMAN, *supra* note 22, at 7.
29. *Id.*
30. *Id.* at 11.
31. *Id.* at 9.
32. *Id.* at 24.
33. *Id.* at 11.
34. *Id.*
35. *Id.* (referencing popular phrases such as "she is sharp for her age" and "she still has all her marbles" as social indicators of ageist beliefs).
36. *Id.*
37. *Id.*

B. Removing the Stigma: New Classification of Dementia Under the DSM-5

Partially to combat the surrounding stigma, the American Psychiatric Association published the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM-5") in May 2013. The DSM-5 eliminated the term "dementia" and subsumed it within the category of "Neurocognitive Disorders."[38] In accordance with the changes established in the DSM-5, this Note will use the broader term "neurocognitive disorders" in lieu of the term "dementia," except when referencing terminology as defined in specific scientific studies by the respective researchers. The DSM-5 suggests, as an advantage to this new categorization, that the definition of a major neurocognitive disorder is broader than that of "dementia."[39] This means that individuals with a major decline in one domain could receive this diagnosis where "dementia" would not have been previously used.[40] As an illustration, the former dementia terminology required a professional to find memory impairment for all dementia diagnoses.[41] However, researchers now recognize that, in several neurocognitive disorders, memory impairment is not necessarily the first domain affected.[42] In working towards a more encompassing diagnostic approach, the change in terminology will now require that all diagnosing healthcare professionals first establish the presence of a neurocognitive disorder and then determine whether the disorder is mild[43] or major.[44] Once a

38. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-5 591 (5th ed. 2013) [hereinafter DSM-5].

39. *Id.*

40. *Id.*

41. Siberski, *supra* note 20, at 12.

42. *Id.*

43. In DSM-5, a mild neurocognitive disorder is defined by the following: There is evidence of modest cognitive decline from a previous level of performance in one or more of the domains outlined above based on the concerns of the individual, a knowledgeable informant, or the clinician; and a decline in neurocognitive performance, typically involving test performance in the range of one and two standard deviations below appropriate norms (i.e., between the third and 16th percentiles) on formal testing or equivalent clinical evaluation. The cognitive deficits are insufficient to interfere with independence (e.g., instrumental activities of daily living, like more complex tasks such as paying bills or managing medications, are preserved), but greater effort, compensatory strategies, or accommodation may be required to maintain independence. The cognitive deficits do not occur exclusively in the context of a

professional determines the patient has a mild or major neurocognitive disorder, he will then decide on the etiological subtype of the disorder.[45]

One concern that arises from this new terminology is that when a patient is diagnosed with a mild neurocognitive disorder, he or she may assume it is a minor situation comparable to basic surgical procedures.[46] The patient may not comprehend the seriousness of the diagnosis in terms of how far the disease has progressed.[47] As a result, this may negatively affect a patient's behavior and decisions regarding care and living situations. For instance, patients may delay meeting with an elder care attorney to construct a will or determine arrangements for long-term care.[48] Alternatively, patients may choose to remain longer in private homes rather than seeking outside help.[49]

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delirium. The cognitive deficits are not primarily attributable to another mental disorder (e.g., major depressive disorder, schizophrenia).
DSM-5, *supra* note 38, at 605.

44. In DSM-5, a major neurocognitive disorder is defined by the following:
There is evidence of substantial cognitive decline from a previous level of performance in one or more of the domains outlined above based on the concerns of the individual, a knowledgeable informant, or the clinician; and a decline in neurocognitive performance, typically involving test performance in the range of two or more standard deviations below appropriate norms (i.e., below the third percentile) on formal testing or equivalent clinical evaluation. The cognitive deficits are sufficient to interfere with independence (i.e., requiring minimal assistance with instrumental activities of daily living). The cognitive deficits do not occur exclusively in the context of a delirium. The cognitive deficits are not primarily attributable to another mental disorder (e.g., major depressive disorder, schizophrenia).
DSM-5, *supra* note 38, at 602.

45. *Id.*, at 591 (listing the etiological subtypes of major and mild neurocognitive disorders:
Neurocognitive disorder due to Alzheimer's disease; vascular neurocognitive disorder; frontotemporal neurocognitive disorder; neurocognitive disorder due to traumatic brain injury, Lewy body dementia, Parkinson's disease, or HIV infection; substance-induced neurocognitive disorder; neurocognitive disorder due to Huntington's disease, Prion disease, or to another medical condition; and neurocognitive disorder not elsewhere classified.).

46. Siberski, *supra* note 20, at 12.

47. *Id.*

48. *Id.*

49. *Id.*

The new categorization could also affect whether elderly patients believe it is necessary to take prescribed medication to slow the progression of the disorder.[50] This may be especially detrimental since the medical community already widely criticizes the effectiveness of the medications available for treating neurocognitive disorders, such as Donepezil and Memantine.[51] There has been no definitive confirmation of the claims that these medications could actually alter the progression of brain cell deterioration associated with these disorders.[52] Potentially reversible cases of dementia are seen in nine percent of cases while only 0.6% of cases are actually reversed.[53] With these low success rates, even elderly patients who regularly take their medications may not experience any benefit.

The concern for potential inaction ties in with the general concern that the new terminology—particularly the additional subtypes—may prove confusing to the elders who are given these diagnoses.[54] It is therefore imperative that diagnostic professionals are trained in the new terminology and can explain the concepts and distinctions to elderly patients.[55]

50. *Id.*

51. *See*, *e.g.*, Ira Rosofsky, *When it comes to dementia, forget the drugs*, L.A. TIMES (Mar. 19, 2009), http://articles.latimes.com/print/2009/mar/19/opinion/oe-rosofsky19 ("[D]onepezil and memantine . . . together account for more than 90% of the anti-dementia drug market.").

52. *Id.* ("At best, these effects may be only marginally more effective against dementia than garlic was against the Black Death in the 14th century.").

53. A. Mark Clarfield, *The Decreasing Prevalence of Reversible Dementias*, 163 ARCHIVES INTERNAL MED., 2219, 2219-20, 2224 tbl.3 (2003).

54. Siberski, *supra* note 20, at 12.

55. *Id.*

C. The Need for Sex Among Elderly with Neurocognitive Disorders[56]

An underlying reason for the lack of a uniform standard for capacity to consent to sexual behavior may lie in the misperceptions concerning sexuality among the elderly.[57] Most commonly, elders are perceived as either asexual and disinterested in sex or hypersexual to the point of perversion.[58] Many younger people are repulsed by the thought of sexually active older adults.[59] Oftentimes, people believe that sex should be reserved for individuals who are cognitively intact, and some even think sexual activity in old age is immoral.[60] These beliefs lead to a general devaluation of the importance of sex to the elderly.[61] To the contrary, studies indicate that the elderly might need physical contact more than younger people.[62] Elderly individuals

56. It should be noted that the DSM-5 still acknowledges that because the word "dementia" is easily understood by everyone including elders, it will likely still be used in the foreseeable future. *See* Kim Warchol, *Major Neurocognitive Disorder: The DSM-5's New Term for Dementia*, CRISIS PREVENTION INST. (Jul. 30, 2013), http://www.crisisprevention.com/Blogs/Dementia-Care-Blog-Facilitating-Best-Abilities-an/July-2013/Major-Neurocognitive-Disorder-Dementia.

57. Kathleen S. Mayers & Dennis McBride, *Sexuality Training for Caretakers of Geriatric Residents in Long Term Care Facilities*, 16 SEXUALITY & DISABILITY 227, 230 (1998).

58. *Id.* (noting the stereotype of "dirty old man" and the "predatory old woman" as cultural symbols of hypersexual elderly).

59. Casta-Kaufteil, *supra* note 11, at 75; M. Ehrenfeld et al., *Sexuality Among Institutionalized Elderly Patients with Dementia*, 6 NURSING ETHICS 144, 144 (1999) ("Many younger people have a negative attitude toward sexuality among older people; some even view it as immoral and disgraceful.").

60. Dov Aizenberg et al., *Attitudes Toward Sexuality Among Nursing Home Residents*, 20 SEXUALITY & DISABILITY 185, 186 (2002); Casta-Kaufteil, *supra* note 11, at 73.

61. Ramzi R. Hajjar & Hosam K. Kamel, *Sexuality in the Nursing Home, Part 1: Attitudes and Barriers to Sexual Expression*, 4(3) J. AM. MED. DIRECTORS ASS'N 152, 154 (2003) ("In a youth-oriented culture, sexuality is attributed to the young, healthy, and beautiful, and the myth that the elderly are asexual beings predominates. Consequently, the sexual needs of the elderly are frequently overlooked and ignored.").

62. *See, e.g.*, Ehrenfeld, *supra* note 59, at 144.

have a greater fear of losing a loved one, and their need for comfort through physical contact may actually increase with age.[63]

With respect to sexual activity among the elderly as a whole, research shows that elderly Americans "value sexuality as an important part of life."[64] Doctor Stacy Lindau conducted the first detailed study of sexuality among older Americans and found that seventy-three percent of fifty-seven to sixty-four-year-old respondents, fifty-three percent of sixty-five to seventy-four-year-old respondents, and twenty-six percent of seventy-five to eighty-five-year-old respondents were sexually active.[65] These results have since been corroborated, yielding statistics which indicate that fifteen to forty percent of men and twenty-five percent of women in their eighties have intercourse at least once a month.[66] Furthermore, these percentages are likely to rise over the upcoming decades with the increasing availability and popularity of "sexual enhancement" medications such as Cialis and Viagra, coupled with the recent trend of online dating that allows single elders to connect with each other quickly and easily.[67]

The onset of neurocognitive disorders does not deter elderly individuals from engaging in sexual relations.[68] In fact, research demonstrates that fourteen percent of dementia patients reported they actually had an increased libido.[69] One study of forty married couples with one partner who suffered from mild to moderate dementia found over twenty percent of couples were still sexually active.[70] Among the sexually active couples, all the partners of patients suffering from dementia reported satisfaction with their sexual relationships and be-

63. *Id*. (explaining that an elderly person is aware of the possible loss "of the object of their love" so it is "not surprising that the human need for touch, hugs and kisses increases with age in both men and women").

64. *See* Stacy Tessler Lindau et al., *A Study of Sexuality and Health Among Older Adults in the United States*, 357(8) NEW ENG. J. MED. 762, 767 (2007).

65. *Id.* at 762.

66. Casta-Kaufteil, *supra* note 11, at 70-71.

67. *The dramatic rise of STDs among senior citizens*, THE WEEK (Feb. 6, 2012), http://theweek.com/article/index/2241 00/the-dramatic-rise-of-stds-among -senior-citizens.

68. *See* C. G. Ballard et al., *Sexual Relationships in Married Dementia Sufferers*, 12 INT'L J. GERIATRIC PSYCHIATRY 447, 450 (1997).

69. *See* DEBBIE CHRISTIE ET AL., INTIMACY, SEXUALITY, AND SEXUAL BEHAVIOUR IN DEMENTIA: HOW TO DEVELOP PRACTICE GUIDELINES AND POLICY FOR LONG TERM CARE FACILITIES 6 (2002).

70. Ballard, *supra* note 68, at 448.

lieved their partners were also satisfied.[71] Among the non-sexually-active couples, nearly forty percent were dissatisfied with the absence of a sexual relationship, and all but one of those dissatisfied partners believed their partners were also dissatisfied.[72] From these results, researchers concluded that elders who suffered from neurocognitive disorders likely wanted to continue having sexual relations despite their disorders,[73] and still found sex fulfilling even when these disorders reached more advanced stages.[74]

This conclusion was supported by a study in which elderly individuals reported that maintaining an active sex life served as a source of support and comfort to couples dealing with one spouse's deteriorating mental condition.[75] One spouse insisted, "[U]p until [my husband] could no longer walk, he seemed to know me and always would accept me in our bed in his old familiar way. This was such a comfort to me as his endearments never stopped and though they were whispered in 'gibberish' I knew what he meant!"[76] This account suggests that, in addition to reported continued physical pleasure between couples in old age,[77] there is also continued emotional pleasure derived from intimacy.[78] Statistics further indicate that that passionate love, companionship, and satisfying sexual intimacy strongly corresponded with participants' reported life satisfaction, confidence, and overall psychological health.[79] Sexual intimacy has even been found to prolong consciousness in some cases and make the conscious moments of an elderly individual more meaningful.[80]

71. *Id.* at 449.
72. *Id.*
73. *Id.* at 450.
74. Casta-Kaufteil, *supra* note 11, at 73.
75. Edna L. Ballard, *Attitudes, Myths, and Realities: Helping Family and Professional Caregivers Cope with Sexuality in the Alzheimer's Patient*, 13 SEXUALITY & DISABILITY 255, 259 (1995).
76. *Id.*
77. *Id.* (citing an account of an eighty-year-old husband who wrote, "[T]here is the physical pleasure, even at our advanced age.").
78. *Id.* (quoting an eighty-year-old man who explained the emotions behind sex: "Then there is the recognition of the bond between us: 'no matter what, we've got each other.'").
79. Casta-Kaufteil, *supra* note 11 , at 73.
80. *Id.* at 82.

Elderly individuals with neurocognitive disorders, like everyone else, want to assert their individuality and autonomy.[81] For these individuals, "[s]exual 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."[82] Elders with cognitive impairments should not be deprived of their chance to enter into these emotionally-supportive relationships.

D. Health Benefits of Sexual Activity

Despite the taboo associated with elderly sexual relations, sexual intimacy yields subjectively and objectively-felt benefits for both physical and mental health.[83] Several studies specifically examine the perceived benefits of sexual activity among elderly individuals.[84] Research conducted on the sexual relations of older Americans found that being sexually active was positively associated with self-reported health.[85] Similarly, another study discovered that people who suffer from arthritis claimed they experienced several hours of pain relief after sexual encounters and, in general, sexually active elders reported an increase in heart and breathing rates, and improved bodily functions.[86]

The self-reported benefits perceived in these studies are supported by research examining objective measurable health benefits due to sexual activity. Research demonstrates that individuals who

81. Erica F. Wood, *Dispute Resolution and Dementia: Seeking Solutions*, 35 GA. L. REV. 785, 790 (2001) ("'People with dementia want to exert their personhood and autonomy . . . .").

82. Sally M. Roach, *Sexual Behaviour of Nursing Home Residents: Staff Perceptions and Responses*, 48 J. ADVANCED NURSING 371, 378 (2004).

83. *See* Rob Stein, *Elderly Staying Sexually Active*, WASH. POST (Aug. 23, 2007), http://www washingtonpost.com/wp-dyn/content/article/2007/08/22/AR2007082202000.html.
(quoting Stacy Tessler Lindau: "'Individuals who remain sexually active gain the benefit of the physical exercise that comes with sex . . . the hormones–the endorphins released by orgasms–give a general sense of well-being that could be beneficial. The psychological benefits of being loved and cared for may also trickle over to physical health.'").

84. *See, e.g.*, C. G. Ballard, *supra* note 68, at 449; Casta-Kaufteil, *supra* note 11, at 71; Lindau, *supra* note 64, at 762.

85. Lindau, *supra* note 64, at 765 tbl. A.

86. Casta-Kaufteil, *supra* note 11, at 72.

are sexually active benefit from, a reduced risk of heart disease, reduced depression, better overall fitness, and even less frequent colds and flus.[87] One such study found that elderly individuals with intimate relationships have a longer life expectancy and a lower risk of contracting cancer or cardiovascular disease.[88] These potential benefits can be particularly advantageous to older individuals who are at a higher risk of suffering from these diseases.[89]

E. Risks Associated with Sexual Activity Between Cognitively Impaired Elders

To analyze the issue of capacity to consent to sex among elders with neurocognitive disorders, it is important to balance the rights of an elderly individual to engage in sexual expression with the need to protect the individual as a member of a group that may be vulnerable to abuse.[90] To balance these rights, one must consider the potential risks of elderly individuals with cognitive impairments engaging in sexual activity. These risks include vulnerability to psychological or physical abuse and sexually-transmitted diseases.[91]

1. Reporting Problems for Elderly Abuse

States most commonly use the definition of elderly abuse set forth by the National Center on Elder Abuse (NCEA) as a guideline for their adopted definitions.[92] The NCEA defines elderly sexual abuse as "non-consensual sexual contact of any kind with an elderly person" or "[s]exual contact with any person incapable of giving consent."[93] Nevertheless, there is large variation in specificity of defini-

87. Alan Farnham, *Is Sex Necessary?*, FORBES (Oct. 8, 2003), http://www.forbes.com/2003/1 0/08/cz_af_1 008health.html.

88. Tiina-Mari Lyyra & Riitta-Liisa Heikkinen, *Perceived Social Support and Mortality in Older People*, 61 J. GERONTOLOGY: SOC. SCI. S147, S147 (2006).

89. *See Understanding Cancer Risk*, CANCER.NET (Feb. 2013), http://www.cancer.net/all-about-cancer/risk-factors-and-prevention/understanding-cancer-risk.

90. Stavis, *supra* note 13, at 132.

91. 2008 HANDBOOK, *supra* note 19, at 66.

92. Robert A. Hawks, *Grandparent Molesting: Sexual Abuse of Elderly Nursing Home Residents and its Prevention*, 8 MARQ. ELDER'S ADVISOR 159, 161 (2006).

93. NCEA, *Types of Abuse*, U.S. DEP'T OF HEALTH AND HUMAN SERVS., http://www.ncea.aoa.gov/FAQ/Type_Abuse/index.aspx.

tions between states, making it likely that sexual abuse is grossly underreported.[94] The Administration on Aging, under the U.S. Department of Health and Human Services, suggested that approximately 450,000 elders are abused every year and, for every case that is reported, up to five cases go unreported.[95]

Underreporting may come from fear of punishment, embarrassment, and the legal consequences of reporting abuse.[96] In a non-institutional context, family members or caregivers commit the majority of elder abuse.[97] Therefore, the abused often brave the abuse out of fear of losing the benefits the abuser provides, including protection and autonomy from not being moved into a nursing home.[98] Further, victims may not want to call the police because they are scared their loved ones may be sent to jail[99] and they feel too ashamed to report the abuse.[100]

2. Vulnerability to Abuse

Generally, the elderly are more vulnerable to sexual abuse.[101] People over sixty years old constitute eighteen percent of all sexual assault victims.[102] The elderly may be in a heightened vulnerable state due to diminished abilities, including hearing impairments, weakened muscular strength to resist these acts, and limited mobility.[103] Memory and other cognitive deficiencies add to these factors, thereby increas-

94. *See* Hawks, *supra* note 92, at 161.

95. THE NAT'L CTR. ON ELDER ABUSE AT THE AM. PUBLIC HUMAN SERVS. ASS'N & WESTAT, INC., ADMIN. ON AGING, THE NATIONAL ELDER ABUSE INCIDENCE STUDY 4-3 (1998), *available at* http://www. http://aoa.gov/AoA_Programs/Elder_Rights/Elder_Abuse/docs/ABuseReport_Full.pdf.

96. Hawks, *supra* note 92, at 167.

97. LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW IN A NUTSHELL 407 (West 5th ed. 2010).

98. *Id.* at 408.

99. *Id.*

100. *See id.* (stating that in one instance an aunt feared entrance into a nursing home following a nephew's incarceration).

101. Jamie Demers, *Elderly especially vulnerable to sexual abuse*, SUN-JOURNAL, Jun. 10, 2012, http://www.sunjournal.com/news/columns-analysis/201 2/06/10/jamie-demers-elderly-especially-vulnerable-sexual/1206557.

102. *Id.*

103. *Id.*

ing vulnerability of the cognitively impaired elderly.[104] A 2004 study of 120 adults, consisting of sixty individuals with intellectual disabilities and sixty without, found that the intellectually impaired adults were "significantly less knowledgeable about almost all aspects of sex and appeared significantly more vulnerable to abuse, having difficulty at times distinguishing abusive from consenting relationships."[105] These results suggest that elderly individuals with diminished capacity are particularly at risk for sexual abuse.

3. Health Risks for Sexually Active Elderly

Rates of sexually-transmitted diseases (STDs) are steadily increasing amongst the elderly in the United States.[106] Much of the elderly population became sexually active before the "safe-sex revolution" and, consequently, is predominantly uneducated about the spread of STDs.[107] The majority of sexually active elders believe that, because post-menopausal women cannot get pregnant, they do not need to use contraceptives.[108] This lack of education is illustrated through findings of a 2010 National Survey of Sexual Health and Behavior, which found that only six percent of people sixty-one years and older use condoms when engaging in sexual activity.[109] In 2005, the Centers for Disease Control (CDC) reported that people over age fifty constituted fifteen percent of new HIV/AIDS diagnoses.[110] It is anticipated that by 2015, the majority of HIV carriers will be over fifty

104. *Id.*

105. Glynis H. Murphy & Ali O'Callaghan, *Capacity of Adults with Intellectual Disabilities to Consent to Sexual Relationships*, 34 PSYCHOL. MED. 1347, 1355 (2004).

106. Ezekiel J. Emanuel, *Sex and the Single Senior*, N.Y. TIMES (Jan. 18, 2014), http://www.nytimes.com/2014/01/19/opinion/sunday/emanuel-sex-and-the-single-senior html?_r=0.

107. Lara Belonogoff, *Sex in Nursing Homes—The Debate Continues*, CARING.COM (Mar. 23, 2007), http://www.caring.com/articles/sex-in-nursing-homes.

108. Stan Grossfeld, *AIDS: A Threat to Elderly, Too Many Disregard Hazards of Unprotected Sex--Doctors Often Fail to Warn Them*, THE BOSTON GLOBE, June 4, 2001, *available at* http://www.cbs.com/cbs_cares/topics/show/77327.

109. Emanuel, *supra* note 106 (comparing this rate of about forty percent of sexual encounters).

110. *STD Tests for the Elderly*, SEX HEALTH MATTERS (May 4, 2011), http://www.sexhealthmatters.org/sex-health-blog/std-tests-for-the-elderly.

years old.[111] Further, the CDC found that between 2007 and 2011, chlamydia infections increased by thirty-one percent and syphilis by fifty-two percent amongst Americans age sixty-five and older.[112]

More alarming still, research indicates that sexual abuse may hasten a victim's mortality. One study demonstrated that over half of sexual abuse victims died within twelve months of a sexual abuse incident.[113] The Bureau of Justice reported that 2.6% of rape victims over sixty were actually murdered during the rape.[114] Other adverse health consequences that have also been associated with sexual abuse include depression, chronic diseases, psychological distress, and increased likelihood of heart attacks.[115] Elderly females are particularly susceptible to infection because their vaginal lining becomes thinner and more fragile with age and can be more easily torn during sex and open the body up to bacterial infections.[116] Beyond the physical consequences of sexual abuse, many victims who suffer from neurocognitive disorders often display post-rape emotional distress, including "disorganized or agitated behaviors, sleep disturbance, and extreme avoidance of [others]."[117]

The negative taboo surrounding elderly sexuality may deter doctors from providing the necessary help to elders who suffer physical and mental injuries from abuse. In a Florida survey, researchers asked a group of seventy older men and women to raise their hands if their doctors had ever asked them if they were sexually active.[118] No one raised their hand.[119] When asked why this was, Sue Saunders, a

111. Deborah Kotz, *Sex Ed for Seniors: You Still Need Those Condoms*, U.S. NEWS & WORLD REP. (Aug. 5, 2007), http://health.usnews.com/usnews/health/articles/070805/13senior.htm.

112. Emanuel, *supra* note 105.

113. Pamela B. Teaster & Karen A. Roberto, *Sexual Abuse of Older Adults: APS Cases and Outcomes*, 44 THE GERONTOLOGIST 788, 789 (2004).

114. Demers, *supra* note 101.

115. ADMIN. ON AGING, DEP'T OF HEALTH AND HUMAN SERVS. FY 2011 REPORT TO CONGRESS 32 (2011).

116. *See* David E. Soper, *Overview of Vaginal Infections,* THE MERCK MANUAL (Mar. 2013), http://www.merckmanuals.com/home/womens_health_issues/vaginal_infections_and_pelvic_inflammatory_disease/overview_of_vaginal_infections.html.

117. Elizabeth A. Capezuti & Deborah J. Swedlow, *Sexual Abuse in Nursing Homes*, 2 MARQ. ELDER'S ADVISOR 51, 52 (2000).

118. Grossfield, *supra* note 108.

119. *Id.*

sixty-nine-year-old grandmother, conjectured, "[a] lot of these doctors see these women like their mothers. The idea of wrinkled people having sex just throws them for a loop. They can't imagine it. They think we are dead from the neck down."[120] Because of physicians' incorrect assumptions that senior patients are not sexually active, their infections may go untreated for longer, which may in turn result in unnecessary complications.[121] Alternatively, physicians' general lack of understanding and negative judgment may sway elderly patients to restrain from sexual activity regardless of their desires.[122]

F. Ethical Concerns of Representing Elderly with Diminished Mental Capacity

Mentally impaired elderly victims may face problems when first trying to establish an attorney-client relationship for representation. Rule 1.14 of the ABA Model Rules of Professional Conduct directs an attorney to maintain "as far as reasonably possible" a normal attorney-client relationship with a client whose ability to make "adequately considered decisions in connection with a representation is diminished."[123] Comment 6 to this Rule tries to guide lawyers by giving them leeway to seek guidance from "an appropriate diagnostician."[124] However, this comment does not specify how specialized this professional should be or what avenues the professional should take to determine competence.

Further, Rule 1.14(b) gives a lawyer the discretion to take protective action if he finds: (1) existence of client's diminished capacity, (2) risk of substantial harm to the client, and (3) an inability for a client to act in his or her own interest.[125] Although lawyers routinely assess a client's risks and interests, they are typically not trained to evaluate diminished capacity and consequently may opt not to take any protective action.[126] This grant of additional discretion warrants seeking

120. *Id.*
121. Belonogoff, *supra* note 107.
122. Aizenberg, *supra* note 60, at 188.
123. MODEL RULES OF PROF'L CONDUCT R. 114 (a) (2014).
124. MODEL RULES OF PROF'L CONDUCT R. 114 cmt. 6 (2014).
125. MODEL RULES OF PROF'L CONDUCT R. 114 (b) (2014).
126. ABA COMM'N ON LAW & AGING & AM. PSYCHOL. ASS'N, ASSESSMENT OF OLDER ADULTS WITH DIMINISHED CAPACITY: A HANDBOOK FOR LAWYERS 2 (2005), *available at* http://www.apa.org/pi/aging/resources/guides/diminished-capacity.pdf.

remedies to alleviate the burden on lawyers so they can more effectively represent and protect their clients.

G. Challenges Facing Mentally Impaired Elderly in the Criminal Justice System[127]

Elders with neurocognitive disorders face two main obstacles when trying to bring a claim through the criminal justice system: first, reporting the abuse; and second, finding a way to prosecute the abuse.[128] As discussed in Part E of this Section, sexual abuse is severely underreported by the elderly. The onset of cognitive decline further reduces the likelihood of reporting.[129] Several factors may explain this. First, people with disabilities often do not know how to report a crime like rape and have no means of obtaining support to assist them.[130] Second, mentally disabled individuals may fear the criminal justice system with regards to reporting. They may think that their report will not be taken seriously given their mental impairment, or they may believe that their report will result in the loss of their independence if taken seriously.[131] Third, cognitively impaired individuals may not remember the details of the abusive incident, thus diminishing their credibility.[132] Finally, victims of sexual abuse may be uncertain as to whether a particular incident constitutes a crime at all and do not want to waste their time reporting.[133]

Even when cases are reported, a low percentage of them are actually prosecuted.[134] Only fourteen to eighteen percent of reported

127. Throughout this Section, the author will mainly focus on adjudicating sexual abuse claims through the criminal justice system given criminal statutes' heavy reliance on the concept of consent. However, it is important to highlight that sexual abuse victims may also seek remedies through civil tort law. *See generally* Stavis, *supra* note 13, at 136.

128. *See* LAW REFORM COMM'N, *supra* note 23, at 88-89.

129. LAW REFORM COMM'N, *supra* note 23, at 88.

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.*

134. U.K. CTR. FOR RESEARCH ON VIOLENCE AGAINST WOMEN, TOP TEN THINGS ADVOCATES NEED TO KNOW, 4 (2011), *available at* https://opsvaw.as.uky.edu/sites/default/files/Top_Ten_Things_Advocates_Need_to_Know.pdf.

sexual assaults are prosecuted.[135] This may be due in part to police officers' attitudes regarding these reports and the victims themselves.[136] Specifically, police officers may hold negative perceptions concerning a mentally impaired victim's credibility and reliability.[137] This might in turn influence their assessment of the information provided by the victim, their decision to investigate further, and the extent of any further investigation.[138] These barriers to reporting and prosecution of abuse deter many elderly individuals from pursuing sexual abuse claims.

III. Analysis

A. Judicial Determination of Capacity of Elderly to Consent to Sexual Activity

All states recognize sexual intercourse with a person who does not have the "mental capacity" to consent as a criminal offense.[139] All courts hold a general presumption that an individual has the requisite capacity to engage in a sexual act once he or she reaches the age of consent.[140] The burden is therefore on the party claiming the impairment to prove the victim lacked the requisite capacity at the time of the sexual act.[141] All states employ a functional approach when determining capacity to consent that is based on a victim's ability to understand information related to the sexual act.[142] However, courts differ in their interpretation of what "understanding" entails. Due to the lack of a uniform standard, a court may find that an individual has the

135. *Id.*

136. A. Bailey et. al., *Police attitudes towards people with intellectual disability: an evaluation of awareness training*, 45(4) J. INTELLECT. DISABIL. RES. 344, 346 (2001).

137. Cheryl Guidry Tyiska, *Working with Victims of Crime with Disabilities*, OFFICE FOR VICTIMS OF CRIME, https://www.ncjrs.gov/ovc_archives/factsheets/disable.htm.

138. Bailey, *supra* note 136, at 345.

139. PETER F. BUCKLEY, SEXUALITY AND SERIOUS MENTAL ILLNESS 37 (Psychology Press 2013).

140. LAW REFORM COMM'N, *supra* note 23, at 148.

141. *Sexual Assault Defenses*, FINDLAW (2014), http://criminal.findlaw.com/criminal-charges/sexual-assault-defenses.html.

142. LAW REFORM COMM'N, *supra* note 23, at 10 (defining a "functional approach" for capacity determinations).

requisite capacity to consent to sexual activity in one state, but not in another.[143]

Most jurisdictions recognize three factors that must be analyzed in determining legal capacity to consent to sexual activity: (1) knowledge of the relevant facts concerning the decision to be made; (2) the mental capacity and intelligence to realize and rationally process the risks and benefits of engaging in sexual activity; and (3) voluntariness to engage in conduct without coercion.[144] Despite identification of these three elements, courts disagree on the degree to which these factors must be determined.[145] This has resulted in a range of state standards to define the mental incapacity that renders a person incapable of understanding the nature of his conduct.[146]

A majority of states require an understanding of both the sexual nature of the act and the voluntary nature of participation in the act.[147] In thirteen states, courts require an additional understanding of the nature of the sexual act and the associated potential consequences, such as contracting sexually transmitted diseases.[148] Seven states impose a further requirement of understanding the moral quality of engaging in sexual activity.[149] In nine states, courts contemplate "evidence of a disability" that may impact an individual's ability to consent to the sexual activity.[150] Finally, the courts of Georgia and Minnesota use a test to determine whether individuals can exercise their judgment in consenting to a sexual activity.[151]

143. *Id.*

144. 2008 HANDBOOK, *supra* note 19, at 19; Stavis, *supra* note 13, at 138.

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

146. *Id.*

147. LAW REFORM COMM'N, *supra* note 23, at 159 (listing the states that employ this test: California, Delaware, Florida, Kentucky, Louisiana, Maine, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oregon, Rhode Island, South Carolina, Texas, and Utah).

148. *Id.* (listing the states that employ this test: Alaska, Arizona, Arkansas, Indiana, Iowa, Kansas, New Mexico, Oklahoma, Pennsylvania, Tennessee, Vermont, Virginia and Wyoming).

149. *Id.* (listing the states that employ this test: Alabama, Colorado, Hawaii, Idaho, Illinois, New York, and Washington).

150. *Id.* (listing the states that employ this additional consideration: Connecticut, Maryland, Massachusetts, Michigan, Mississippi, Missouri, South Dakota, West Virginia, and Wisconsin).

151. *Id.*

These standards demonstrate the lack of consensus on the tipping point of when a state's interest in protection from sexual abuse should override the sexual freedom of an elderly individual. The wide divergence in standards highlights a key reason why elderly victims may be deterred from pursuing litigation: uncertainty of success. Moreover, six states still have not adjudicated a case applying a particular test, and several states employ multiple tests, leading to high levels of speculation as to the outcome of any given rape case.[152]

1. The Lowest Threshold for Capacity to Consent: Understanding and Voluntariness of Sexual Acts

The lowest threshold a court employs to find that someone has the capacity to consent requires only an understanding of the sexual nature of the act and voluntary consent to the act.[153] The voluntariness requirement of this standard simply requires that an individual can make a decision regarding sexual activity that is not a result of coercion, unfair persuasion, or inducements.[154]

In *State v. Olivio*, the Supreme Court of New Jersey held that victims are unable to consent if, at the time the sexual activity occurred, their mental defects rendered them "unable to comprehend the distinctively sexual nature of the conduct" or "incapable of understanding or exercising the right to refuse to engage in such conduct with another."[155] This means there is no requirement that the victim understand the risks and consequences of the sexual conduct.[156] Due

152. Deborah W. Denno, *Sexuality, Rape, and Mental Retardation*, 1997 U. ILL. L. REV. 315, 424 cmt. to tbl. 4.

153. *See*, *e.g.*, State v. Howard, 172 Cal. Rptr. 539, 540-41 (Cal. Ct. App. 1981); Salsman v. Commonwealth, 565 S.W.2d 638, 640 (Ky. Ct. App. 1978); State v. Peters, 441 So.2d 403, 409 (La. Ct. App. 1983); State v. Ricci, 507 A.2d 587, 588 (Me. 1986); State v. Doremus, 514 N.W.2d 649, 652 (Neb. Ct. App. 1994); State v. Call, 650 A.2d 331, 332 (N.H. 1994); State v. Olivio, 589 A.2d 597, 599 (N.J. 1991); State v. Oliver, 354 S.E.2d 527, 537 (N.C. Ct. App. 1987); State v. Zeh, 509 N.E.2d 414, 418 (Ohio 1987); State v. Anderson, 902 P.2d 1206, 1207 (Or. Ct. App. 1995); Commonwealth v. Thomson, 673 A.2d 357, 359 (Pa. Super. Ct. 1996); State v. Schuster, 502 N.W.2d.565, 568 (S.D. 1993); Wootton v. State, 799 S.W.2d.499, 501 (Tex. Ct. App. 1990); State v. Archuleta, 747 P.2d 1019, 1022 (Utah 1987).

154. Martin Lyden, *Assessment of Sexual Consent Capacity*, 25 SEXUAL DISABILITIES 3, (2007).

155. *Olivio*, 589 A.2d at 599.

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

to the minimal requirements of this threshold, this approach has been criticized for encroaching upon the sexual autonomy of individuals with mental disabilities.[157]

The test, as applied, has also proven unnecessarily vague. For example, the *Olivio* court charged the jury to consider circumstances of the sexual activity that would have rendered the victim "temporarily or permanently incapable of understanding the nature of his conduct."[158] In so instructing the jury, the court failed to explain what these circumstances should be and failed to provide any guidance to the prosecuting attorneys.[159]

2. An Intermediate Threshold: The "Nature and Consequences" Test

Thirteen jurisdictions require an additional understanding of the potential health risks and consequences of the sexual conduct.[160] This approach is viewed as a compromise in balancing states' interests in protecting individuals from sexual exploitation against the individuals' rights to sexual autonomy.[161] For example, in *Jackson v. State*, the Alaska Court of Appeals found that a victim was incapable of understanding a sexual act when she could demonstrate a sexual act using dolls, but did not understand birth control or the practical consequences of pregnancy.[162]

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157. LAW REFORM COMM'N, *supra* note 23, at 88.

158. *See Olivio*, 589 A.2d at 600 (referencing to N.J. STAT. ANN. §2C:1 4-1(h) (West 1983)).

159. *See* Denno, *supra* note 152 , at 354 n. 247 (quoting Assistant Passaic County Prosecutor Steven Braun: "[w]hen the [*Olivio*] case was tried we had nothing to work with. I can see judges giving [jurors] an instruction on capacity to consent and telling them the factors they consider are the following, A, B, C, D, etc., which would have to be hammered out with both attorneys before the jury is charged.")

160. *See, e.g.*, Jackson v. State, 890 P.2d 587, 592 (Alaska Ct. App. 1995); State v. Johnson, 745 P.2d 81, 84 (Ariz. Ct. App. 1987); People v. Washington, 520 N.E.2d. 1160, 1162 (Ill. App. Ct. 1st Dist. 1988); Stafford v. State, 455 N.E.2d 402, 406 (Ind. Ct. App. 1983); State v. Chancy, 391 N.W.2d 231, 235 (Iowa 1986); Keim v. State, 777 P.2d 278, 280 (Kan. Ct. App. 1989); Slaughterback v. State, 594 P.2d 780, 781 (Okla. Crim. App. 1979); Sanford v. Commonwealth, 678 S.E.2d 842, 846 (Va. Ct. App. 2009); Righter v. State, 752 P.2d 416, 420 (Wyo. 1988).

161. LAW REFORM COMM'N, *supra* note 23, at 139.

162. *Jackson*, 890 P.2d at 592.

This approach is closest to that contemplated by the American Law Institute when drafting the Model Penal Code.[163] The commentary to the Model Penal Code explains that criminal liability under the Code is limited to sexual intercourse with a "mentally incompetent woman [with] severe defect or impairment precluding ability to understand the nature of the act itself."[164] Compared to the other employed thresholds, this test also most closely mirrors the medical Informed Consent doctrine, which requires that a patient understand the nature and consequences of a given medical procedure.[165] An advantage to this approach, therefore, may be an increased comprehension among elders who are already familiar with medical consent but may not otherwise understand a state test for capacity to consent to a sexual act. However, mental health professionals still criticize this test for vagueness, arguing that determining a victim's understanding of the nature and consequences of the act is "far more ambiguous" than determining that victim's understanding of volition in the lower-threshold test.[166]

3. The Highest Threshold: Understanding the Moral Quality of Sexual Conduct

Several states add the requirement of understanding the "moral quality" of the sexual conduct to evaluations of victims' capacity.[167] This requires individuals to be "mentally capable of understanding the social mores of sexual behavior."[168] In the illustrative case of *People v. Easley*, the New York Court of Appeals held that appraisal of conduct involves not merely understanding the physiological elements of sex, but also includes understanding "the moral quality" of the con-

163. AM. LAW INST., MODEL PENAL CODE AND COMMENTARIES PART II §§ 2100 – 13.6322 (1980).

164. *Id.*

165. Jamie P. Morano, *Sexual Abuse of the Mentally Retarded Patient: Medical and Legal Analysis for the Primary Care Physician*, 3(3) J. CLIN. PSYCHIATRY 126, 132 (2001).

166. Tracee Parker & Paul R. Abramson, *The Law Hath Not Been Dead: Protecting Adults with Mental Retardation from Sexual Abuse and Violation of Their Sexual Freedom*, 33(4) MENTAL RETARDATION 257, 262 (1995).

167. *See*, *e.g.*, Brooks v. State, 555 So.2d 1134, 1136–37 (Ala. Crim. App. 1989); People v. Gross, 670 P.2d 799, 801 (Colo. 1983); State v. Gonsalves, 706 P.2d 1333, 1337 (Haw. Ct. App. 1985); People v. Easley, 364 N.E.2d 1328, 1332 (N.Y. 1977); State v. Erika D.W., 934 P.2d 704, 706 (Wash. Ct. App. 1997).

168. Lyden, *supra* note 154, at 5.

duct "in the framework of the societal environment and taboos to which a person will be exposed."[169] The court found that the key question was to ask whether the victim had the capacity to evaluate the nature of the stigma: the ostracism or other noncriminal sanctions that society imposes for conduct it deems immoral.[170]

This approach may too strongly favor the state's "protection from harm" interest. This standard infringes on people with both mild and major neurocognitive disorders by presuming that these individuals are both unable to control their sex drives and unable to cope with the consequences of sex.[171] The court in *State v. Sullivan* asserted that this approach was improper for determining capacity to consent, reasoning that regardless of how carefully a judge writes a jury instruction, a jury's conviction under this test will be "based not on [its] view of the facts, but on its view of the morality of certain sexual conduct."[172] The sentiment expressed by the *Sullivan* court reflects the general caution of allowing judges or juries to determine consent based on their personal morals rather than on facts and law.[173]

Another criticism of this approach is that "morality" is an ambiguous concept, and adding this requirement is not workable on a larger scale to impose criminal liability.[174] The American Law Institute criticized this approach on these grounds, noting that "one can imagine many instances in which a [person] is not mentally incompetent . . . but . . . is incapable of appreciating fully the community's notions of intercourse as an event of moral or ethical significance."[175] To address these criticisms, states that use this test only require an individual to understand that society holds these views, not necessarily to be-

169. *Easley*, 364 N.E.2d at 1332.

170. *Id.* at 1333.

171. Robert L. Hayman, Jr., *Presumptions of Justice: Law, Politics, and the Mental Retarded Parent*, 103 HARV. L. REV. 1202, 1246 (1990) ("[T]he mentally retarded person—no more and no less a sexual being than his non-labeled counterpart—is largely deprived of legitimated sexual expression by social and legal attitudes.")

172. State v. Sullivan, 298 N.W. 2d 267, 271 (Iowa 1980).

173. Denno, *supra* note 152, at 350.

174. State v. Olivio, 589 A.2d 597, 603 (N.J. 1991) (quoting the Attorney General: "Such a concept seriously muddies the water and does not help formulate a workable definition or standard.")

175. LAW REFORM COMM'N, SEXUAL OFFENCES AGAINST THE MENTALLY HANDICAPPED 15 (1990), *available at* www.lawreform.ie/_fileupload/Reports/rSexualOffencesMentally.htm.

lieve them him or herself.[176] The court in *People v. Cratsley* addressed this concern directly by cautioning that "care must be taken not to restrict the freedom of persons" in cases where this test is applied.[177] Furthermore, courts employing this test reason that setting a threshold that is too low may risk failing to protect people with mental disabilities from sexual exploitation in the first place.

Through its case law, Illinois developed its own variation of the morality test, commonly referred to as the "Totality of the Circumstances" test.[178] This test expands the "nature and consequences" portion of the morality test, finding that looking only at "the act, its nature, and [its] consequences" is insufficient to address a victim's situation or the abuser's intent.[179] While this test has been lauded in theory, it has not been extensively litigated and, in its current state, is insufficiently descriptive to guide elderly victims of sexual abuse.[180]

4. The Evidence of Mental Disability Test

Courts that employ the "evidence of mental disability" test to determine a victim's capacity consider evidence of mental disability that affects a victim's ability to consent to sexual activity.[181] For exam-

176. Janine Benedet & Isabel Grant, *Hearing the Sexual Assault Complaints of Women with Mental Disabilities: Consent, Capacity, and Mistaken Belief*, 52 MCGILL L. J. 243, 272 (2007).

177. People v. Cratsley, 653 N.E.2d 1162, 1165 (N.Y. 1995).

178. Denno, *supra* note 152, at 345.

179. *Id.*

180. *See* People v. Whitten, 647 N.E.2d 1062, 1067 (Ill. App. Ct. 1995) The *Whitten* court provided litigants with the most recent iteration of the "totality of the circumstances" test:

> [W]e believe that the courts should broaden their inquiry in cases involving the inability to give knowing consent to more than just focusing on the IQ or mental ability of the alleged victim. All of the circumstances, including those facts that demonstrate control and its misuse by defendant over the exercise of complainant's free will, are germane to the issue of whether a particular complainant gave knowing consent.

Id.

181. *See*, *e.g.*, State v. Wyman, 173 A. 155, 156 (Conn. 1934); Edmondson v. State, 185 A.2d 497, 497 (Md. 1962); Commonwealth v. Roderick, 586 N.E. 967, 969 (Mass. 1992); People v. Baker, 403 N.W.2d 479, 480 (Mich. Ct. App. 1986); Martin v. State, 415 So. 2d 706, 707 (Miss. 1982); State v. Robinson, 136 S.W. 2d

ple, in the South Dakota case of *State v. Willis*, the court found that the evidence strongly showed the defendant "schemed and took advantage of the victim's mental incapacity of giving consent."[182] Like the other tests, this test is criticized for failing to give either guidance or direction regarding the details of a given case.[183] The test requires a party to introduce evidence of a mental impairment, but sets no guidelines as to what is sufficient and what type of evidence a court is seeking. Sample jury instructions from courts that employed this test offer little extra guidance to future litigants. In *Willis*, the trial court judge offered the following instruction on consent as a defense: "If from all the evidence you have a reasonable doubt whether the defendant reasonably and in good faith believed she voluntarily consented to engage in sexual intercourse, you must give the defendant the benefit of the doubt and acquit him of said charge."[184] This test fails, as the others do, to set concrete criteria to guide future litigants when proceeding to trial.

5. The Judgment Test: Georgia and Minnesota's Approach

Georgia and Minnesota apply a slightly different approach than the other states, in that they look instead at whether a victim can exercise judgment to consent to sexual activity.[185] In *Ely v. State*, the Georgia Court of Appeals found a victim incapable of consenting to sexual activity where, due to her high degree of mental impairment, she was unable to give intelligent assent and exercise judgment regarding the sexual activity.[186] The court in *State v. Willenbring* did little to clarify this unclear standard, stating that a victim lacked capacity to consent where she "lack[ed] the judgment to give reasoned consent to sexual contact or to sexual penetration."[187] This test, like the others, does not allow either victims or attorneys to gauge their potential for success at trial.[188] With attorneys and scholars criticizing all of these

1008, 1009 (Mo. 1940); State v. Willis, 370 N.W.2d 193, 199 (S.D. 1985);State v. Burks, 267 S.E. 2d 752, 753 (W. Va. 1980).

182. *Willis*, 370 N.W.2d at 200.

183. Denno, *supra* note 152, at 355.

184. *Willis*, 370 N.W.2d at 200.

185. Morano, *supra* note 165, at 132.

186. Ely v. State, 384 S.E.2d 268, 271-72 (Ga. Ct. App. 1989).

187. State v. Willenbring, 454 N.W.2d 268, 270 (Minn. Ct. App. 1990) (citing MINN. STAT. § 609.344 (1988)).

188. Denno, *supra* note 152, at 355.

capacity tests as being overly vague and ambiguous, it becomes evident why past and future victims hesitate to bring claims when they are sexually assaulted.

B. Determination Methods Used by Courts to Apply State Capacity Tests

When applying and gathering evidence for any of the above tests, the two most common methods courts use to determine the capacity of an individual to consent to sex are the clinical determination method and the judicial determination method.[189] A court that employs the clinical determination of competency asks for determinations of a qualified psychiatrist, psychologist, or physician.[190] Alternatively, a court that uses a judicial determination method directly evaluates a victim's competence by evaluating evidence and expert testimony.[191] Typically, clinical determinations are made pursuant to any existing law and applicable standards of the respective profession.[192] Judicial determinations, in contrast, are often reserved for cases where there is a genuine question about the person's competency, or about a clinical determination once it is made.[193] Both of these methods are criticized for disempowering the victim and being unnecessarily costly.[194] With the uncertainty regarding both what determination method and what test a court will use in a given case, a victim will likely be more inclined to do nothing, rather than pursue litigation.[195]

C. Proposed Solutions

1. Guardianship

Several authors propose giving a legal guardian the right to consent to sexual behavior on behalf of the individual with a neurocognitive disorder. This right is within the scope of the National Guardianship Association's Standards of Practice, which outline, "the guardian shall ensure that the [ward] has information about and ac-

189. Elizabeth J. Reed, *Criminal Law and the Capacity of Mentally Retarded Persons to Consent to Sexual Activity*, 83 VA. L. REV. 799, 813 (1997).
190. *Id.*
191. *Id.*
192. Stavis, *supra* note 13, at 138-39.
193. *Id.* at 139.
194. Casta-Kaufteil, *supra* note 11, at 77.
195. *Id.*

cess to accommodations necessary to permit sexual expression . . . to the extent the [ward] possesses the capacity to consent to the specific activity."[196] Further, when making a major decision concerning legal rights of a ward, scholars argue that serious deference should be given to all reasonable guardian input.[197] However, there are several problems in implementing this solution.

First, the chance that an appointed guardian would be immediately available to make a decision concerning their ward's sexual activity would be very small. Although guardians are given major decision-making powers on behalf of a ward, they are not required to stay in close proximity to the ward so they may not be available for quick decisions every time the individual wants to engage in sex.[198] Second, oftentimes appointed guardians are family members who, as discussed above, disapprove of elderly sexual activity or are the abusers themselves.[199] Therefore, in order to maintain an older person's sexual autonomy, guardianship may need to be coupled with education to help guardians understand that sexual behavior is normal and beneficial—perhaps even essential—for the elderly individual's health and well-being.[200]

2. Imposing an Upper Limit for Age of Consent

Another proposed solution is the adoption of an upper limit for age of consent, similar to the lower limit imposed in statutory rape cases.[201] Adopting an upper limit follows the idea that the "developmentally young" should be equated with the chronologically young. Specifically, that a person who suffers from cognitive impairments, who possesses the "social maturity of a seven or eight year old,"[202] may also be vulnerable and incapable of consenting to sexual relations.

196. NAT'L GUARDIANSHIP ASS'N STANDARDS OF PRACTICE 8 (3d ed. 2007), *available at* http://www.guardianship.org/documents/Standards_of_Practice.pdf.

197. Stavis, *supra* note 13, at 139.

198. NAT'L GUARDIANSHIP ASS'N, *supra* note 195, at 7.

199. *See generally* Section II.C of this Note.

200. Hosam Kamel & Ramzi R. Hajjar, *Sexuality in the Nursing Home, Part 2: Managing Abnormal Behavior- Legal and Ethical Issues*, 4(4) J. AM. MED. DIR. ASS'N 203, 205 (2003).

201. Scutti, *supra* note 3.

202. State v. Olivio, 123 N.J. 550, 562 (N.J. 1991).

This suggestion is supported by case law in which courts looked at the "functional age" of a rape victim as a factor in determining capacity to consent, regardless of what capacity test a particular state applies.[203] For example, in *Keim v. State*, the Kansas Court of Appeals—a court that applies the nature and consequences test—noted that a thirty-year-old woman with Down's Syndrome had a functional age of between four and six years old when determining her capacity to consent.[204] Similarly, in *Edmondson v. State*, the Supreme Court of Maryland—a court that uses the evidence of mental disability test—considered evidence pointing to a girl being the chronological age of eighteen but having a mental age of four years old.[205]

The idea of using a mental age, as opposed to chronological age, is also employed in determining whether age should be a mitigating factor in capital sentencing proceedings.[206] Therefore, the idea of courts looking at both the actual age of a victim and whether that age accurately reflects the victim's mental capacity would not be a novel idea for courts. However, as with any state determining a lower threshold for age of consent, it would be challenging for any state to adopt a "functional age of consent" and to develop a uniform standard as to how to determine a given victim's "functional age."[207]

3. Mediation Between Parties

Proponents of mediation recommend it as a means of understanding the sexual interests and determining the capacity of a victim.[208] During a given mediation session, a mediator could act as a

203. *See, e.g.*, Brooks v. State, 555 So. 2d 11 34, 11 36 (Ala. Crim. App. 1989) (finding a victim lacked capacity to consent where he did not understand the nature of sexual conduct "in adult terms."); Keim v. State, 777 P. 2d 278, 278 (Kan. Ct. App. 1989); Edmondson v. State, 185 A.2d 497, 497 (Md. 1962).

204. *Keim*, 777 P.2d at 278.

205. *Edmondson*, 185 A.2d at 497.

206. Lebron v. State, 982 So. 2d 649, 660 (Fla. 2008) ("[E]vidence that a defendant's 'mental, emotional, or intellectual age was lower than his . . . chronological age' would support the finding of age as mitigation.").

207. As of the date of publication, there is still no uniform age of consent for statutory rape laws across the United States, which may foreshadow a negative outcome for trying to determine an uniform upper age limit for rape laws. *See generally* Paul Lines, *The Age of Consent in US Criminal Law*, LEGAL SOURCE 360 (Jan. 22, 2008), http://www.legalsource360.com/index php/the-age-of-consent-in-us-criminal-law-2-5955/.

208. Wood, *supra* note 81, at 809.

neutral third-party facilitator who could guide interested parties (possibly including both the parties and their families) to a voluntary consensus.[209] The mediator could assess the victim's capacity to consent to sexual activity on a case-by-case basis, looking at factors such as a victim's ability to avoid sexual exploitation and the victim's awareness of the potential risks of sexual activity.[210] Mediation offers the advantage of empowering the victim to make independent decisions, thereby encouraging observance of the mediated terms.[211]

On the other hand, cognitively impaired individuals may lack the necessary skills needed to engage in effective mediation.[212] Namely, those who suffer from major neurocognitive disorders often cannot remember a specific sexual act, articulate concerns related to the act, evaluate settlement options, or, most importantly, adhere to—or even remember—terms of an agreement.[213] Therefore, successful mediation may be limited to those victims who are in the early stages of cognitive decline.[214] Nevertheless, some scholars argue that even patients who have "lost the ability to talk can express desire or dismay through sounds, facial expressions, and hand gestures."[215] This suggests that even in cases where victims cannot express their opinions through speech, non-verbal cues may help guide the mediator in determining that person's desire to engage in sexual activity.

4. Education of Doctors and Cognitively Impaired Elderly

To foster understanding of the risks surrounding the sexual needs of the elderly, authors advocate for education of both physicians and elders with diminished capacity. This is premised on the

209. *Id*. at 801.

210. Casta-Kaufteil, *supra* note 11, at 80 (citing suggested criteria a mediator should consider when negotiating a voluntary settlement between parties).

211. *Id.* at 79.

212. *Id.* at 77.

213. *Id.*

214. *See id.* at 80 (applying use of mediation in an example of a patient with early dementia).

215. *See, e.g.*, Daniel Engber, *Naughty Nursing Homes*, SLATE (Sept. 27, 2007), http://www.slate.com/id/2174855.

idea that sexual education would help cognitively impaired elders distinguish consensual acts from sexual abuse.[216]

A. Education of Physicians

Physicians should accept that older patients might still enjoy sex and openly discuss potential risks with them. Currently, physicians find it difficult to talk about sex with any patient, and this is exacerbated when discussing sex with an older patient.[217] Many physicians feel unequipped to have these discussions and consequently do not actively pursue the topic with their older patients.[218] Physicians should seek training to understand sexuality in older age and learn ways to improve communication skills with patients.[219] Training can help physicians gain awareness of their own prejudices and seek methods to ensure these prejudices do not affect their sensitivity to patients' sexual needs.[220] In turn, patients will feel more comfortable engaging in dialogue about safe and consensual sex with their physicians.[221]

There may be several barriers blocking the effectiveness of this proposal. First, physicians' hesitation to discuss sexual matters with their patients is not always due to lack of training, but at times, due to personal moral beliefs. Often, physicians do not discuss information about morally controversial issues.[222] That is, if they do not believe it is right for their older patients to be sexually active in the first place, they may refuse to discuss the issue at all.[223] Second, older patients

216. Paul R. Abramson, Tracee Parker & Sheila R. Weisberg, *Sexual Expression of Mentally Retarded People: Educational and Legal Implications*, 93 AM. J. ON MENTAL RETARDATION 328, 329 (1988).

217. Abi Taylor & Margot A. Gosney, *Sexuality in older age: essential considerations for healthcare professionals*, AGE AND AGING 3 (Jul. 11, 2011), *available at* http://ageing.oxfordjournals.org/content/early/2011/07/19/ageing.afr049.full.pdf+html.

218. *Id.*

219. *Id.*

220. *Id.* at 5.

221. *Id.*

222. Farr A. Curlin et al., *Religion, Conscience, and Controversial Clinical Practices*, 356 NEW ENG. J. MED. 593, 593 (2007).

223. Taylor & Gosney, *supra* note 217, at 3.

typically attend doctors' visits with other family members.[224] Patients therefore may, out of personal discomfort or embarrassment, refuse to talk about their sexual activity in front of their family even if a doctor asks them.

B. Education of Elderly with Neurocognitive Disorders

Programs across the country sponsor educational seminars for elders to learn about sex-related risks.[225] Even amongst elders without cognitive impairments, Marilyn Brand, an HIV/AIDS health educator observed, "They don't realize that protection is the way they can avoid the HIV virus. They think that if they can't become pregnant, they don't need devices. And then they get tested for everything but HIV."[226] As a result, the elderly do not understand safe-sex practices and may unintentionally expose themselves to danger when they engage in sexual activity.[227] In the nursing home setting, one study indicated that the majority of residents expressed "positive attitudes toward open discussion of sexual matters and willingness to accept therapeutic interventions when needed."[228] This suggests that the elderly may be open to the idea of sexual education outside the institutional setting as well. One potential barrier to this solution is the degenerative nature of neurocognitive disorders.[229] For individuals with major neurocognitive disorders, education about the risks of sexual activity would likely have little or no impact on their capacity assessments.[230]

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224. GERONTOLOGICAL SOC'Y OF AM., COMMUNICATING WITH OLDER ADULTS: AN EVIDENCE-BASED REVIEW OF WHAT REALLY WORKS 16 (2012), *available at* http://www.agingresources.com/cms/wp-content/uploads/2012/10/GSA_Communicating-with-Older-Adults-low-Final.pdf.

225. *See generally* Vianna Davila, *For Today's Seniors, It's Never Too Late for Sex Education*, CHI. TRIB., Mar. 27, 2009, http://www.chicagotribune.com/features/sns-health-seniors-sex-education,0,281090.story; Corey Kilgannon, *Greatest Generation Learns About Great Safe Sex*, N.Y. TIMES, Feb. 14, 2007, http://www.nytimes.com/2007/02/14/nyregion/14sex.html?_r=0.

226. Grossfeld, *supra* note 108.

227. Melissa White, *The Eternal Flame: Capacity to Consent to Sexual Behavior Among Nursing Home Residents with Dementia*, 18 ELDER L.J. 133, 155 (2010).

228. Aizenberg, *supra* note 60, at 185 (finding twenty-three of thirty-one residents expressed willingness to receive medical consultation for sexual dysfunction).

229. Casta-Kaufteil, *supra* note 11, at 76.

230. White, *supra* note 227, at 155.

5. Adoption of Model Assessment Tools for Judicial Determination

For years, lawyers have looked to psychologists for their opinions on the decision-making capacity of older adults, due to their training and expertise in evaluating patients' cognitive and functional abilities.[231] In the past, psychologists came to conclusions concerning a patient's capacity through clinical interviews or general mental status evaluations.[232] Researchers and scholars criticized these methods as being unreliable and overly subjective.[233] To correct for these biases, researchers have worked to develop standardized psychological tools to improve reliability by presenting clinicians with concrete assessment criteria.[234]

Following this trend, authors have advocated for the adoption of a standardized model assessment tool for courts to use when evaluating capacity to consent to sexual activity.[235] This tool would balance the competing interests the law faces between the elderly individual's needs for sexual freedom and protection from harm.[236] Moreover, implementing a uniform standard would help those elderly victims concerned that they lack the monetary means to sue by helping them assess the possibility of success at trial.[237]

The courts should look for several characteristics when evaluating a model assessment tool for capacity determinations. First, a tool should only require the demonstration of minimum levels of knowledge, intelligence, and voluntariness, so as not to infringe too much on an individual's right to sexual activity.[238] Also, tools should be kept up-to-date to account for new discoveries regarding neurocognitive disorders and indicators of cognitive abilities.[239] Finally, in order to be most effective in achieving the goal of uniformity across

231. 2008 HANDBOOK, *supra* note 19, at 9.
232. *Id.* at 12.
233. *Id.*
234. *Id.*
235. Reed, *supra* note 189, at 817.
236. *Id.*
237. Casta-Kaufteil, *supra* note 11, at 76 (arguing few victims have the financial means to be involved in litigation).
238. Reed, *supra* note 189, at 825.
239. Interview with Paul S. Appelbaum, MD, Columbia University College of Physicians and Surgeons (Feb. 2, 2014).

jurisdictions, the evaluation must be objective to reduce test-taker bias.[240]

Several studies have examined the positive impact of using structured assessments for elderly decision-making in other areas dealing with capacity to consent. Specifically, in a study on capacity assessments for medical consent, researchers found that five physicians who reviewed videotapes of capacity assessments and rated the competence of patients achieved a rate of agreement that was no better than chance.[241] In contrast, researchers found that providing physicians with specific legal standards to guide their judgments increased inter-rater agreement three-fold.[242] Moreover, another study found that when physicians and nurses all used a systematic set of questions for competence assessments, it led to a high rate of agreement between expert judgments.[243] This indicates that adopting similar criteria in courts to determine competence may help standardize judgments across jurisdictions through higher rates of agreement.

IV. Recommendation

To best balance the interests of the elderly with those of the states, states should develop and adopt a model assessment tool that employs a clinical perspective to evaluate a person's capacity to consent to sexual activity. Model assessment tools provide courts with a clear and objective standard, which would increase predictability and uniformity of court decisions.[244] Moreover, identifying specific cognitive functions that need to be assessed would constitute a major step forward in those states that have not yet done so.[245] This Note advocates for the use of two tests: 1) the Socio-Sexual Knowledge and Atti-

240. *See*, *e.g.*, Reed, *supra* note 189, at 827.

241. Daniel C. Marson et al., *Consistency of physician judgments of capacity to consent in mild Alzheimer's disease*, 45 J. AM. GERIATR. SOC. 453, 455 (citing a kappa statistic of 0.14).

242. Paul S. Appelbaum, *Assessment of Patients' Competence to Consent to Treatment*, 357 NEW ENG. J. MED. 1834, 1837 (2007).

243. E. Etchells, et al., *Assessment of patient capacity to consent to treatment*, 14 J. GEN. INTERN. MED. 27, 30 (1999).

244. *See* John M. Niederbuhl & C. Donald Morris, *Sexual Knowledge and the Capability of Persons with Dual Diagnoses to Consent to Sexual Contact*, 11 SEXUALITY & DISABILITY 295, 305 (1993).

245. Interview with Paul S. Appelbaum, *supra* note 239.

tudes Test (SSKAT)[246] and 2) Cognistat.[247] Authors have previously argued for the adoption of the SSKAT to assess sexual capacity to consent among mentally retarded patients.[248] The American Bar Association and American Psychological Association cited use of Cognistat to assess cognitive capacity to consent to sexual activity among hypothetical patients with diminished capacity.[249]

There are several important considerations to bear in mind concerning this recommendation. First, because situations of alleged incompetents, and therefore, decisions with which they are faced, are unique between cases, too great a level of specificity may be counterproductive.[250] Second, designation of specific instruments that must be used may potentially stymie development and application of better instruments.[251] Therefore, these proposed tests are primarily meant to serve as suggested models for the types of criteria courts should consider implementing to increase predictability across judgments. Further, several state sex offender commitment statutes already designate specific instruments that must be used, indicating a growing acceptance of states to adopt specific tools through legislation.[252] Finally, the results gathered from using a model assessment tool are not meant to be dispositive at trial. However, they would provide increased guidance to mentally impaired elderly victims and courts that would otherwise rely on the vague terminology and arbitrary standards currently implemented in states.

A. Socio-Sexual Knowledge and Attitudes Test (SSKAT)

The SSKAT consists of questions meant to assess knowledge and attitudes about sexuality with separately scored sections.[253] The

246. *See, e.g.*, Niederbuhl & Morris, *supra* note 244, at 297; Reed, *supra* note 189, at 827.

247. 2008 HANDBOOK, *supra* note 19, at 70.

248. *See, e.g.*, Niederbuhl & Morris, *supra* note 244, at 297; Reed, *supra* note 189, at 827.

249. 2008 HANDBOOK, *supra* note 19, at 70.

250. Interview with Paul S. Appelbaum, *supra* note 239.

251. *Id.*

252. *Id.*; COUNCIL OF STATE GOV'TS, SEX OFFENDERS 1 (2010), *available at* http://www.csg.org/policy/documents/TIA_FF_SexOffenders.pdf ("At least 35 states use risk-based assessment tools that can aid in sentencing and release decisions, levels of supervision, monitoring and treatment, appropriate application of registration and communication notification laws.").

253. Niederbuhl & Morris, *supra* note 244, at 297-98.

respondent has the flexibility to answer these questions by pointing to the correct response or by indicating "yes" or "no" through words or gestures.[254] This flexibility is beneficial to the elderly victims who can no longer speak coherently but can still indicate capacity through hand motions. The test is performed using a team of evaluators in order to reduce bias and arbitrary decision-making.[255] After the evaluation, the team discusses a victim's ability to avoid unwanted sexual conduct and a victim's knowledge of the sexual conduct.[256]

Compared to alternative evaluation methods, the SSKAT proves advantageous in that it produces an objective and numeric score, it is quick to administer, and individuals are interested in completing the test and are therefore cooperative.[257] Team review ensures that an individual's SSKAT score is a better representation of her ability to consent.[258] Moreover, the test results can pinpoint areas where the individual needs further training or education.[259] Overall, the SSKAT provides "a documented decision regarding consensual ability which is defensible in court."[260]

There are a few drawbacks to this model. It is not normed, so it would be extremely difficult to compare an individual's sexual knowledge with that of his mentally defective peers.[261] Additionally, the SSKAT is based on New York law, which includes the "morality" prong.[262] Thus, the test would have to be modified to fit within laws in jurisdictions that do not include the "morality" requirement.[263] Finally, the test is criticized for its high costs, given the fact that it involves the hiring of professionals for its administration.[264] However, the costs of the tests could be reduced significantly by making the capacity to consent assessment part of a person's routine evaluations.[265]

254. *Id.* at 298. *See* Part III.C.5.
255. Reed, *supra* note 189, at 823.
256. Niederbuhl & Morris, *supra* note 244, at 298.
257. *Id.* at 303.
258. *Id.*
259. *Id.*
260. *Id.*
261. *Id.* at 303-04.
262. *See* Part III.A.3 (discussing the specifics of the morality test); Reed, *supra* note 189, at 824.
263. *Id.*
264. *Id.*
265. *Id.*

B. Cognistat

The Cognistat is a standardized test designed to rapidly assess neurocognitive functioning in three general areas: level of consciousness, orientation, and attention; and five major ability areas: language, constructional ability, memory, calculation skills, and reasoning/judgment.[266] The test takes fifteen to thirty minutes to administer for cognitively-impaired individuals, and the test is readily accessible by paper or online.[267] This relatively quick administration time is beneficial, given the degenerative nature of neurocognitive disorders. This means the test can be used in follow-up appointments to track an individual's cognitive changes over time.

Compared to the SSKAT, the results of the Cognistat are normed and yield results in standard deviations.[268] A diagnostician must find that a patient lies two or more standard deviations below appropriate norms in order to find that he or she has a major neurocognitive disorder.[269] Using a test that has normative data eliminates the extra cost of changing the test to adapt to the new DSM-5 definitions.[270] Additionally, the over 225 peer-reviewed articles on Cognistat speak to the test's assessment reliability.[271]

There are a couple of concerns with adopting this test. First, the test is limited in scope in that it does not measure social[272] or medical history.[273] But, compared to cognitive functioning, an individual's social or medical history is much easier to obtain through witness testimony, medical records, or other pre-existing documentation that the courts already use. The test has also been criticized for lacking norms specifically tailored for older adults, as would be desired in this

266. Cognistat, *What Cognistat Tests*, http://www.cognistat.com/what-cognistat-tests.

267. *Id.*

268. 2008 HANDBOOK, *supra* note 19, at 70.

269. Siberski, *supra* note 20.

270. *Id.* (suggesting that adapting cognitive tests such as the commonly-used Mini Mental State Examination and Montreal Cognitive Assessment to yield results in standard deviations will add to patient cost).

271. Cognistat, *About the Exam (FAQ)*, http://www cognistat com/about-exam-faq.

272. 2008 HANDBOOK, *supra* note 19, at 68 (describing "social history" as employment history and marital and family history).

273. 2008 HANDBOOK, *supra* note 19, at 164 ("This screening test examines language, memory, arithmetic, attention, judgment, and reasoning.").

case.[274] However, researchers have recently developed normative data for Cognistat specifically for older adults.[275] If adopted, these data will improve the diagnostic utility of the test for the elderly.[276]

C. Future Expansion and Combination With Other Solutions

Once a court adopts a particular assessment tool, states will be able to explore new developments to address the limitations of tools, broaden the cultural scope of tools, and mix the tools with other solutions to increase their reach and effectiveness.

1. Development of Forensic Assessment Tools for Sexual Consent Capacity

As mentioned above, the proposed tools are meant to serve as models for potential criteria that would increase standardization across capacity assessments. Further, these tests were chosen given the lack of availability of any standardized instruments to specifically assess sexual consent capacity at the time of publication.[277] A recent notable advancement in assessment tests for other types of capacity evaluations is the development of "forensic assessment instruments."[278] These instruments are specifically designed to assess the functional abilities relevant to a particular legal capacity.[279] For example, researchers have adopted at least nine separate assessment tools specifically tailored to gauge capacity for medical consent.[280] These tools utilize standardized vignettes and structured questions designed to assess an individual's understanding, appreciation, and reasoning abilities with regard to consenting to healthcare decisions.[281] Following this example, researchers could potentially develop a tool for the evaluation of an elderly individual's sexual capacity to consent that would conduct a direct assessment of functions necessary to engage in

274. D.L. Drane, R L Yuspeh, J S Klinger, L K , & K M Hendry *Older Adult Norms for the Cognistat (NCSE)*, 14(1) ARCH. CLIN. NEUROPSYCHOL. 47, 47-48 (1999).
275. *Id*.
276. *Id.*
277. 2008 HANDBOOK, *supra* note 19, at 68.
278. *Id.* at 12.
279. *Id.* at 56-57.
280. *Id.* at 57.
281. *Id.*

sexual conduct; namely knowledge, intelligence, and voluntariness.[282] The development of a test specifically tailored to determining capacity to sexual acts may allow for even greater predictability across state lines. State courts should therefore be diligent in watching for development of more specialized tests once they adopt an initial assessment tool.

2. Cultural Considerations

In ruling on sexual matters, courts should adjust for and consider the culture and views of a person and the person's close family.[283] One problem that faces the majority of assessment tools or forms in general is accommodating the vast array of cultural backgrounds exhibited among American citizens.[284] Many cultural variables could affect the applicability of a test to a given individual.[285] Psychologists who administer these tests must therefore understand the possible test bias, fairness, and cultural equivalence of a given assessment tool.[286] In 2002, the American Psychological Association attempted to advance this understanding by publishing specific guidelines on multicultural training and research for psychologists to follow.[287] Among its recommendations is that psychologists should consider both the test's reference population and the potential limitations of the tool with other populations.[288] By bearing in mind these cultural differences, a psychologist will be better able to determine appropriate adjustments to increase the effectiveness of assessment tools in capacity determinations.

282. *See id.* at 19 (providing an example of a "forensic assessment instrument" for capacity determinations in independent living).

283. Stavis, *supra* note 13, at 140 (1991) ("[O]ur laws have for thousands of years consistently recognized that consideration should be given to the culture and views of a person's family where there is a genuine caring relationship.").

284. 2008 HANDBOOK, *supra* note 19, at 11.

285. *Id.*

286. *Id.*

287. *See generally* AM. PSYCHOL. ASS'N, GUIDELINES ON MULTICULTURAL EDUCATION, TRAINING, RESEARCH, PRACTICE, AND ORGANIZATIONAL CHANGE FOR PSYCHOLOGISTS (2002), *available at* www.apa.org/pi/oema/resources/policy/multicultural-guideline.pdf.

288. *Id.* at 48.

3. Using Model Assessment Tools to Guide Mediation Efforts

Developing a set of standardized criteria would also help mediators reach an agreement between sides before trial. As mentioned previously, effective mediation requires the mediator to assess a party's capacity to consent to sexual activity on a case-by-case basis.[289] However, mediators currently have only general guidelines as to what questions to ask during these mediation sessions.[290] As a result, mediation evaluations are often extremely subjective and subject to bias based on the mediator's own personal beliefs. By providing a set of standardized criteria for all courts, mediators can better guide parties in how courts will rule on their capacity to consent to sexual relations.

4. Combining Model Assessment Tools with Elder Education

A model assessment tool would also provide insight as to which areas of sexual education would be most beneficial to the individual being evaluated. For example, assistive devices can be provided if the individual is found to have sensory deficits or physical disabilities.[291] Elders can attend seminars teaching problem-solving skills to increase their abilities to identify potentially coercive or inappropriate situations, create effective approaches to address these situations, and to select among alternatives created in these situations.[292] Finally, elders could roleplay common scenarios to help them avoid or escape situations where they are confronted with undesired sexual contact.[293] Therefore, the adoption of any assessment tool should be accompanied by systematic sexual education that is tailored to the specific cognitive abilities of the individuals. This way, the tool can serve as a customizable preventative measure to maximize protection of the elderly from unwanted sexual contact.

289. *See* Part III.C.3.
290. *See, e.g.*, Christie, *supra* note 69, at 6.
291. 2008 HANDBOOK, *supra* note 19, at 66.
292. *Id.*
293. *Id.* (recommending learning "rules of thumb" for typical sexual abuse situations)

V. Conclusion

Many people cannot bear to imagine what their lives would be like if they lost their cognitive abilities. In fact, national U.S. reports indicate dementia is among the most feared diseases[294] and the majority of "cognitively normal" individuals that reported they would choose to die rather than live with even mild dementia.[295] Across the world, countries use the slogan "no means no" to signify a person's express denial of consent to sexual acts.[296] In the case of cognitively impaired elders, this clear line becomes blurred. They often consent to sex without the necessary capacity to do so. For those individuals who lack that capacity, it is necessary to create a uniform standard to weigh individuals' rights to sexual expression against the states' desire to protect them from abuse. The tests currently employed by the states are all overly vague and provide little guidance to elderly victims of sexual abuse as to the possibility of success at trial. By adopting a model assessment tool to evaluate capacity using objective criteria, states will increase predictability of judicial determination for future litigants. Furthermore, the results from these evaluative tools will allow states to pinpoint areas where elderly individuals would benefit from further sexual education and help mediators to make objective determinations of capacity. Together, these benefits will help states strike the optimal balance between protecting elderly from sexual abuse and respecting their rights and desires for sexual freedom.

294. HARRIS INTERACTIVE FOR METLIFE FOUNDATION, WHAT AMERICA THINKS: METLIFE FOUNDATION ALZHEIMER'S SURVEY (2011), *available at* https://www.metlife.com/assets/cao/contributions/foundation/alzheimers-2011.pdf (finding that the fear of getting a dementia diagnosis is greater than the fear of developing cancer, heart disease, diabetes, or stroke).

295. Elysa R. Koppelman, *Dementia and Dignity: Towards a New Method of Surrogate Decision Making*, 27 J. MED. & PHIL. 65, 71 (2002) ("In a recent study of 'cognitively normal' people, about three-fourths indicated that they would not want life-sustaining treatment . . . if they were mildly demented. And 95% would not want such treatment if they were severely demented.").

296. *See generally* NO MEANS NO WORLDWIDE, http://nomeansnoworldwide.org/ (last visited Sept. 21, 2014).