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Assessment of Sexual Consent Capacity

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Abstract This article discusses assessment of sexual consent capacity, its ethical and legal mandates, and a rationale for the assessment of capacity to have a sexual relationship. It reports current assessment practices used by the authors as well as a summary of relevant literature. There is a review and discussion of New York laws, National and State court cases, and policies of National and international authorities relevant to sexual relations between persons who have intellectual disabilities. Technical information about a tool for assessing capacity to give consent for sexual relationships is described. A proposed clinical standard for use in assessing the capacity of a person with cognitive impairments to have a sexual relationship is presented.

Keywords Disabilities · Sexual · Consent · Capacity

Overview

This article presents a summary of relevant literature as well as assessment practices that have been used at the Center for Disability Services. The Center for Disability Services is a not-for-profit community agency in the Albany, NY area.

Rights of persons with disabilities

There is a presumption in American law that an individual has the prerequisite capacity to engage in a sexual relationship once he/she reaches the age of consent [1, 2].

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An adult is entitled to all of his or her rights and privileges under the law, unless limitations are imposed by a court of law or by a professional judgment acceptable under the law [3]. However, there are consent capacity questions about an individual with cognitive impairments [4, 5]. Cognitive impairments can include intellectual disabilities and other conditions such as dementia, traumatic brain injury, and a developmental disability. New York Penal Law Section 130 [6] points out that persons who engage in a sexual relationship with each other must both be consenting.

Sexual consent capacity assessments for persons with cognitive impairments have been the focus of increasing attention in recent years [7]. Among the reasons for this are the recognition of the rights of people with disabilities, regulations requiring that residential provider agencies promote and protect the expression of those rights, and ethical standards that direct residential provider agencies to assist consumers to maximize their potential. The zeitgeist to promote and protect the sexual rights of persons with intellectual disabilities differs sharply from the early twentieth century belief systems that emphasized repression and overprotection [8].

Laws, regulations, and ethical codes

State, National, and international authorities are cited in the following list:

1. The New York State Office of Mental Retardation and Developmental Disabilities Commissioner's Memorandum [9] states that ''a parent, a legal guardian (appointed in conformance with Article 17-A of the Surrogate's Court Procedure Act or Article 81 of the Mental Hygiene Law [10]), or a committee (appointed by a court in conformance with Article 78 of the Mental Hygiene Law), cannot limit an adult person's sexual activity''. This has been promulgated as a regulation [11], which carries the force of law.
2. In *Griswold v. Connecticut* [12], the United States Supreme Court affirmed that every person has the right to privacy, to certain forms of sexual conduct, and to make reproductive decisions.
3. In its Standards of Practice (Standard 10, Section II A [13]), the National Guardianship Association has indicated that a ''guardian shall acknowledge the ward's right to interpersonal relationships and sexual expression''.
4. A policy statement of the American Association on Intellectual and Developmental Disabilities [14]—prior to 1/1/2007 that organization was named the American Association on Mental Retardation—asserts that ''people with mental retardation and related developmental disabilities, like all people, have inherent sexual rights and basic human needs. These rights and needs must be affirmed, defended, and respected''.
5. The preface to the European Manifesto on Basic Standards of Health Care for People with Intellectual Disabilities declares that ''people with intellectual disabilities have the same human rights as other citizens'' [15].
6. The United Nations Economic and Social Council [16] asserted that ''persons with disabilities must not be denied the opportunity to experience their sexuality, have sexual relationships and experience parenthood''.

Circumscribing the issues

Capacity is a state and not a trait [17]. It can vary over time. At one point in time, an individual with intellectual disabilities may be found incapable of having sexual relations due to knowledge deficits. Subsequently, if that individual receives sufficient training, education, counseling, and exposure to various social situations it may be possible to remedy the knowledge deficits. In a case like this, a repeat sexual consent capacity assessment may yield a finding that the individual has achieved capacity.

An adult person has sexual consent capacity if the requisite rationality, knowledge, and voluntariness are present. These three components are described in detail later in this article.

It is important to identify the boundaries of the sexual behaviors for which consent capacity is to be assessed. Based on the law, the behavior at issue involves ''any touching of the sexual or other intimate parts of a person not married to the actor for the purpose of gratifying sexual desire of either party'' [6].

Accord is lacking

Notwithstanding Kennedy and Niederbuhl's assertion [7 p. 509] that there is ''a consensus among psychologists regarding criteria for sexual consent capacity'', there is abundant evidence that there is no consensus concerning either the definition of capacity or the standards for its determination [2, 18, 19].

There are no universally accepted criteria regarding capacity to consent to sexual behavior. The criteria for sexual consent capacity vary across jurisdictions. In different states within the United States of America, the standards for sexual consent capacity have developed, refined, and codified through court decisions.

Sexual consent capacity in various jurisdictions

New York's morality standard

One of the standards that New York requires for a person to have sexual consent capacity is sometimes referred to as a ''morality standard''. According to this standard, a person must be mentally capable of understanding the social mores of sexual behavior. A person must be capable of understanding the non-criminal penalties (e.g., ostracism, stigmatization) that society may impose for conduct it labels as sexually immoral. An example of such conduct is sexually exploitive behavior.

The case *People v. Easley* [20] clarified that under New York law sexual consent capacity requires understanding and knowledge of the nature and possible consequences of the sexual act and of its moral quality. Frank J. Easley was convicted of rape. He had sexual intercourse with a woman past the age of statutory consent (i.e., past her seventeenth birthday) whose measured IQ was in the 45–54 range, which was considered the moderately intellectually disabled range, and who was deemed incapable of understanding the significance and moral quality of the act. In arriving at a standard of sexual consent capacity, the New York Court of Appeals in *Easley* determined that ''an understanding of coitus encompasses more than a knowledge of its physiological nature. An appreciation of how it will be regarded in the

framework of the societal environment and taboos to which a person will be exposed may be far more important. In that sense, the moral quality of the act is not to be ignored.''

This morality standard was reaffirmed in *People v. Cratsley* [21]. Stanley G. Cratsley was convicted of raping Sherry K., a 33-year-old female employee of the Steuben Association of Retarded Citizens, whose measured IQ was 50. The court considered the woman incapable of understanding, at the time of the incident, the nature of her own or Mr. Cratsley's conduct by engaging in sexual intercourse. It was determined that she did not possess sufficient resources—intellectual, emotional, social, and psychological—to decide whether to engage in sexual intercourse with another person. In *Cratsley*, the People showed that Sherry K.'s functioning was so impaired as to be ''mentally defective'', i.e., she suffered from a mental defect which rendered her incapable of appraising the nature of her conduct.

It is important to note that the New York Court of Appeals in *People v Cratsley* asserted that the law does not presume that a person with intellectual disabilities is unable to consent to sexual intercourse (New York State Penal Law section 130.25 [1]), and proof of incapacity must come from facts other than intellectual disability alone. In New York, it is an element of every sex offense that the sexual act was committed without the consent of the victim (New York State Penal Law section 130.02 [2] [b]). The law does not recognize any claim that someone who lacked sexual consent capacity consented to sexual activity.

Contrast between New York and New Jersey

While New York has one of the most restrictive and conservative legal standards for sexual consent capacity, its neighboring state of New Jersey has one of the least restrictive legal standards. New Jersey only requires that a person must understand the sexual nature of an act and that the person's decision to engage in the sexual behavior is voluntary. There is no requirement that he/she understand the potential risks and consequences of the behavior. In 1997, the court in New Jersey upheld the conviction of four Glen Ridge high school male athletes for inducing a female classmate with intellectual disabilities to perform sexual acts. The main reason that the conviction was upheld was that the female did not understand that she could have refused and therefore she did not participate voluntarily [22]. Also, the Supreme Court of New Jersey [23] emphasized that an understanding of the risks and consequences of the sexual conduct is not required.

Variation among states

Apart from age of sexual consent and voluntariness requirements, Sundram and Stavis [24] noted that the sexual consent capacity standards in Alabama, Colorado, Hawaii, Idaho, New York, and New Mexico demand understanding of the nature of the sexual conduct at issue, of the potential consequences of the sexual conduct, and of its moral quality. In Arizona, Illinois, Indiana, Iowa, Kansas, and Louisiana the standards only require understanding of the nature of the sexual conduct at issue and of the potential consequences of the sexual conduct. As already mentioned, in New Jersey the sexual consent capacity standard requires that an individual understand

the nature of the sexual conduct at issue. Clearly, an individual can be deemed to have sexual consent capacity in one state and not in another.

Ireland

In Ireland, the statutory age for sexual consent is 17 years of age. There is recognition of the sexual rights of persons with disabilities in Ireland. Inclusion Ireland, which is the Irish National Association for People with an Intellectual Disability, supports the sexual rights of persons with disabilities as asserted by the United Nations International Covenant on Economic Social and Cultural rights [16].

If there is a need for a formal decision as to the sexual consent capacity of an individual in Ireland, the court makes it. There is presumption that an adult has legal capacity unless the issue of an individual's capacity is called into question. The assessment of a person's sexual consent capacity, which encompasses similar items to those used for assessing legal capacity in general, would focus on the following six areas: (a) ability to absorb relevant sexual information; (b) understanding of the information; (c) ability to critically evaluate different relevant considerations, including different advice; (d) understanding explanations of the nature of decisions to engage in various sexual behaviors; (e) understanding explanations of the consequences of decisions to engage in various sexual behaviors; and (f) ability to communicate a decision to engage or not engage in various sexual behaviors [25].

The United Kingdom

A legal and diagnostic criterion in the United Kingdom deems persons with severe intellectual disabilities as incapable of giving informed consent. Severe intellectual disabilities are referred to as severe learning disabilities in the United Kingdom; and it pertains to people with an IQ below 50. The incapacity applies broadly, and not only to sexual consent capacity. The age of sexual consent in the United Kingdom is 16 years of age. The British Medical Association and Law Society maintain that sexual consent capacity requires that an individual: (a) is able to understand what is proposed and its implications; and (b) is capable of voluntary choice [26]. Another way of stating the cognitive requirements for sexual consent capacity in the United Kingdom are that an individual must have: (a) basic sexual knowledge, and (b) understanding of the right to refuse to participate in a proposed sexual activity.

In a study about the sexual consent capacity in the United Kingdom, Murphy and O'Callaghan [8] delineated six sexual consent capacity criteria: (1) knowledge of body parts, sexual relations, and sexual acts; (2) knowledge of the consequences of sexual relations, sexually transmitted diseases, and pregnancy; (3) understanding of appropriate sexual behavior and the context for it; (4) understanding that sexual contact must be voluntary; (5) ability to recognize potentially abusive situations; and (6) ability to show assertiveness in social and personal situations and to reject unwanted advances.

Differences in age of consent

The jurisdictional variation in ''age of consent'' is dramatic when compared between different nations, or between states in the United States of America. The Internet

address http://www.avert.org provides information about ages of consent in various jurisdictions. Avert.org is an organization in the United Kingdom, which is an HIV and AIDS Charity. The Avert.org list of ages of sexual consent range from as young as 12 in regions of some countries, to as high as 21 in other countries. Saudi Arabia and Malaysia require that people be married to engage in sex. Even in the United States the age of consent ranges from 14 to 18. Gay and lesbian sexual behavior is still outlawed in many countries. As indicated in the Internet website http://www.ageofconsent.com, many of the states in the United States had laws against homosexual behavior, but most of these laws have been repealed or otherwise invalidated.

Some countries have different laws for sex between two men and sex between two women. In some countries the age of consent is different for males and females, with the age for males typically being older. It should also be noted that age of consent and the age at which marriage is considered acceptable change not only by region and culture, but with the times. In some states in the United States, the statutory age of consent for gay or lesbian sexual relations differ from the statutory age of consent for heterosexual sexual relations.

Cases of severe or profound intellectual disabilities

Some professionals may deem persons who have severe or profound intellectual disabilities, along with inability to verbally participate in a capacity assessment, to be incapable of sexual consent. However, the President's commission for the Study of Ethical Problems in Medicine and Biomedical Research [27] advocated that professionals avoid deciding whether an individual has the capacity to make decisions simply on the basis of his/her status as having a mental disability. Ames and Samowitz [28] and Kaeser [29] take the position that some persons who function in the severe to profound ranges of intellectual disabilities, who are unable to verbally demonstrate the necessary rationality and knowledge, are capable of sexual consent. Those authors infer sexual consent capacity, for some persons who function in the severe to profound ranges of intellectual disabilities, based on ''demonstrated responsible behaviors''. Ames and Samowitz [28] have suggested the following criteria for inferring sexual consent capacity.

1. *Voluntariness*: A person must have the ability to voluntarily decide, without coercion, with whom he or she wants to have sexual relations.
2. *Safety*: Both participants in the sexual behavior must be reasonably protected from physical harm (e.g., sexually transmitted disease) or psychological harm (e.g., undesired separation from each other).
3. *No exploitation*: A person should not be taken advantage of or used by another (e.g., someone with power or higher status) in a way that is inconsistent with voluntariness.
4. *No abuse*: Psychological or physical abuse must not be present in the relationship.
5. *Ability to say ''no''*: A person must be able to communicate ''no'' verbally or non-verbally, and to remove himself or herself from the situation at hand, indicating a wish to discontinue the interaction.
6. *Socially appropriate time and place*: Either the person must be able to choose a socially acceptable time and place, or the person must be responsive to directives toward that end.

Kaeser [29] reported that this issue has sometimes emerged when staff learned that two individuals, who were both functioning in the lower range of intellectual disabilities (e.g., severe intellectual disabilities) and who lacked the expressive communication skills required to participate in a verbal assessment process, have been engaging in a sexual relationship. In such cases YAI/National Institute for People with Disabilities has utilized a committee of appropriately credentialed professionals to evaluate whether the relationship was one in which sexual consent criteria were satisfied. The committee collaborated with the parents, guardians, or correspondents of such individuals in reaching a decision to allow or disallow a sexual relationship in cases such as this.

Determinations have been made that two individuals with severe to profound intellectual disabilities have sexual consent capacity in the context of their specific relationship. The sexual consent capacity determination was not global, but was limited to their specific relationship. In a case like this, Ames and Samowitz [28] asserted that it is critical for the residential provider agency to provide adequate supervision and guidance to the individuals so as to ensure continued monitoring of an individual's responsible sexual behavior and consent.

Capacity assessment is essential

Some residential provider agencies lack the professional resources to properly address the sexual consent capacity issues of the persons with intellectual disabilities who they serve. Direct care staff and administrators of residential provider agencies may lack education and training in this area. Consequently improper decisions may be made to ignore or restrict all intimate relationships between persons with intellectual disabilities. Such decisions may violate the individuals' rights and impose unfair, if not illegal, restrictions on persons who have sexual consent capacity [30]. It is challenging to strike an appropriate balance between providing protective oversight while allowing persons with intellectual disabilities to enjoy the rights and freedoms that are valued by society. Those who have sexual consent capacity have a right to pursue pleasurable and fulfilling sexual relationships [31].

It is reasonable to presume the persons whose sexual consent capacity is in question have an implied right to access services to assess their capacity and support them in achieving capacity if identified deficiencies can be ameliorated.

Some benefits available through sexual consent capacity evaluations are:

1. allowing persons with sexual consent capacity to exercise their sexual rights;
2. protecting persons who lack sexual consent capacity from the untoward results of illegal sexual relations, such as harm or exploitation; and
3. elevating people from non-consenting to consenting status as a result of identification and remediation of sexual knowledge deficits.

A sexual consent capacity assessment distinguishes those unmarried persons who are legally permitted to have sexual relations from those who are not legally permitted. If one, or both, partners in a marriage are under the statutory age of sexual consent, sexual relations between them is legal. A person with sexual consent capacity has the right to have sexual relations with another consenting adult who has

sexual consent capacity. In New York, an unmarried person must be at least 17-years-old to have sexual consent capacity (New York State Penal Law Section 130.05). It is considered statutory rape if a person of age 17 or older has sexual intercourse with a person under the age of 17, who is not his/her spouse.

Questionable capacity of those with cognitive impairments

Many persons with cognitive impairments have sexual consent capacity. Even a person with a legal guardian can have sexual consent capacity. An individual who has a plenary legal guardian could be assessed by a licensed health care professional and found to have sexual consent capacity. The National Guardianship Association's Standards of Practice (Standard 10, section II, A, 2000) state that the ''guardian shall acknowledge the ward's right to interpersonal relationships and sexual expression. The guardian must take steps to ensure that a ward's sexual expression is consensual, that the ward is not victimized, and that an environment conducive to this expression in privacy is provided''.

Consider the situation in which a ward wants to have a sexual relationship while the guardian opposes it. According to the National Guardianship Association's Standards of Practice (Standard 10, section II, B, 2000), ''The guardian shall ensure that the ward has information about and access to accommodations necessary to permit sexual expression to the extent the ward desires and to the extent the ward possesses the capacity to consent to the specific activity''. If the ward and the guardian continue in disagreement, this conflict may need to be resolved via a judicial proceeding [32]. A legal advocate for the ward could even seek to have the guardianship overturned, based on the guardian's unreasonable disregard of the ward's established sexual consent capacity. The New York Legislature has clearly indicated that decision-making authority by the guardian of a person with intellectual disabilities should not infringe on the ward's right to make decisions where he or she is capable (Chapter 516 of [33]). There has been increasing recognition that persons with cognitive impairments have the same constitutional rights as those without disabilities. For example, the American Association on Intellectual and Developmental Disabilities has advocated against unnecessary guardianships [34].

A method for determining sexual consent capacity

The commonly used method for determining sexual consent capacity involves an assessment by a qualified health care professional (psychiatrists, psychologists, social workers, and physicians are generally recognized). At the Center for Disability Services, the assessment process involves three general methods of obtaining information, which are fairly standard in the field of intellectual and developmental disabilities.

1. a review of relevant records (including information about reproductive ability, psychiatric, and developmental disabilities);
2. discussions with selected people who know or work with the individual being assessed (e.g., parents, staff members at a residential provider agency); and
3. a face-to-face interview with the person which includes a mental status evaluation and a set of questions that elicit information about the person's relevant knowledge and voluntariness.

Individualizing the assessment

It is important that the assessor adapts and individualizes the capacity assessment process with specific individuals. Examples of such assessment modifications follow.

1. Prior to the assessment, a staff member, with whom the person has a comfortable relationship, should explain the purpose and process of the assessment.
2. The assessor should be someone the individual is likely to feel comfortable with (e.g., someone with the same gender, someone the person is familiar with).
3. Memory tasks presented during the mental status exam to persons with traumatic brain injury should involve recognition rather than recall.
4. Communication with a person who has impaired speech may require the use of augmentative communication devices or alternative means of communication. Additionally, it may be useful to include the presence of a staff member who is skilled in communicating with, and providing emotional reassurance to, the person. It may be useful to enlist assistance from a family member or staff member who is familiar with effective ways to present questions and information that are understandable to the individual [2, 35, 36].
5. Communication with persons who have limited expressive language skills may require the use of alternative means of communication.
6. During the assessment of a person with impaired hearing, whose primary mode of communication is signing, the utilization of a person fluent in sign language is essential.
7. A person whose primary language is not English should be assessed through the medium of his/her primary language. A translator may need to participate in the assessment process.
8. The assessment of a person who has severely impaired speech and impaired motor control (e.g., due to cerebral palsy) may need to rely on eye movement responses or crude pointing responses from that person.
9. Manikins, rubber models of genitals, pictures, etc. may be helpful in assessing the sexual knowledge of a person who has impaired communication.
10. Some persons who have intellectual disabilities strongly want to gain approval, and avoid disapproval, from others. Consequently their responses to a portion of the capacity assessment items may reflect a disingenuous ''pleaser'' quality. It may be useful for an assessor to reword and re-administer an item, for which the initial response seemed characterized by a desire to give the approved response. The rewording could involve the use of the third person (e.g., ''another consumer at the day program'') rather than the second person (e.g., ''you'').
11. Having a preferred staff member present, along with the assessor, during the assessment may promote more frank responses to assessment items. The individual to be assessed should be informed that he/she may elect to have another person present during the assessment if that would enable him/her to be more comfortable.
12. During the assessment, relevant information should be provided in a manner consistent with the individual's oral comprehension level and level of intellectual functioning. The individual may need to be allowed to review information for longer time periods.

Assurances that all responses will be kept completely confidential should not be given since it is conceivable that disclosures about past or ongoing abuse may require follow up, and even a formal investigation.

Sample script

The script that follows presents a sample introduction to the sexual consent capacity interview.

> We are meeting today because you were referred by staff at your residence. You were referred because staff believe that you are interested in having a sexual relationship. The reason for our meeting is to find out whether or not you have the capacity to have sexual relations with another person. Having capacity means that you have knowledge about sex and the ability to understand proper sexual behavior. It is important for both people in a relationship to have the capacity if they think they might want to have a sexual relationship. We'll talk more about that later. For now, I want you to know that you can have another person sit in with you, or you can meet alone with me. It's up to you. Do you want to have another person sit in with you during this meeting? I'll be asking you some questions today about relationships, sex, and some other things. Just do your best. We don't expect everyone to know everything and you don't have to know everything to have capacity. It is important that you give honest answers. Don't worry about whether your answers are right. If you tell me about anything that involves danger to you or others I may need to do something in order to create safety. You are free to ask questions or bring up concerns at any time. I'll also see you again one or two more times. In addition to the questions, I'll be showing you a video with some couples, and I'll ask you questions about what you see. Once we're all done, I will present a report to a small committee called the Sexual Rights Committee. The Committee listens to the report and will make a decision about whether you understand enough to have a sexual relationship. The committee treats the information as confidential; that is, they don't share it with others except for the information that your staff needs to know. Then, you will be told the decision.

Three primary areas to be assessed

The three main areas of sexual consent capacity are rationality, knowledge, and voluntariness. These are the most widely accepted legal criteria for valid consent capacity [3, 37, 38]. Details regarding each of these areas follow.

Assessing rationality

Rationality is the ability to critically evaluate, to weigh the pros and cons, and to make a knowledgeable decision. In order to assess the level of an individual's rationality there are several factors that should be examined.

Any and all diagnosed neurological, psychiatric, or medical conditions that may impair the individual's judgment, perception, or thinking (e.g., dementia, schizophrenia, medication side effects, traumatic brain injury, drug intoxication) should be considered.

These do impact on rationality, although the presence of a particular condition or diagnosis may not render a person incapable of sexual consent.

The individual's level of intelligence is very relevant. Impaired intellectual functioning is a common reason for calling a person's sexual consent capacity into question. If the IQ is above 69 (i.e., intelligence that is above the level of intellectual disabilities) the individual probably has capacity; and a mental status exam may suffice. When there are no significant mental status impairments, a person whose IQ is above 69, who has had exposure to relevant sexual information, could be considered to have sexual consent capacity. In contrast, if the IQ is below 40 (i.e., intelligence that is at or below the level of severe intellectual disabilities) the individual very likely lacks the communication skills needed to participate in a capacity determination based largely on direct interviews. However, an individual with an IQ below 40 who has adequate communication skills should receive a mental status exam; and, depending on the results of the mental status exam, a full assessment of knowledge and voluntariness may be in order. An individual whose IQ is between 39 and 70 should receive a thorough capacity assessment, including a mental status exam and an evaluation of the individual's relevant knowledge and voluntariness [39].

Rationality criteria advanced by Stavis and Walker-Hirsch [40] include the following: awareness of person, time, place, and event; ability to accurately report events and to differentiate truth from fantasy or lies; ability to describe the process for deciding to engage in sexual activity; ability to discriminate when self and another are mutually agreeing to a sexual activity; and ability to perceive the verbal and nonverbal signals of another's feelings.

The Center for Disability Services has followed the lead of Stavis and Walker-Hirsch [40] in advocating that a person's history be examined for evidence of the person having been sexually exploited as well as evidence of the person having sexually exploited others. It is important to note that a history of exploiting others would not preclude a person from having sexual consent capacity. Sexual consent capacity is cognitive rather than behavioral. An individual may have sexual consent capacity even if he/she engages in unwise, illegal, or socially proscribed sexual behaviors. An exploitive individual deemed to have sexual consent capacity would need a level of supervision consistent with the residential service provider's responsibilities to provide protective oversight of all individuals receiving residential services.

Assessing knowledge

The Center for Disability Services' capacity assessment process focuses on several areas of sexual knowledge. These include:

1. the specific sexual behaviors in question;
2. the choice to accept or reject the sexual behaviors in question;
3. the illegality and unpleasant consequences of various specific sexual behaviors;
4. pregnancy and sexually transmitted disease prevention;
5. social and legal constraints on time, place and context; and
6. the physical, legal, and ethical responsibilities associated with pregnancy and parenting.

The first five areas of knowledge, which are listed above, have been at the core of the knowledge portion of the verbal sexual consent capacity assessment used by the

New York City-based agency YAI/National Institute for People with Disabilities [28]. The sixth knowledge area above was suggested by Stavis and Walker-Hirsch [40].

Stavis and Walker-Hirsch [40] recommend that the following elements of knowledge be considered in an assessment of sexual consent capacity: basic understanding of sexual activities, know-how regarding safe sex and sexually transmitted diseases, the physical and legal responsibilities of pregnancy, consequences of illegal sexual behavior, awareness of others' rights and that another's objection must be honored, and appropriate times and places for sexual activities.

An individual may have shown by words or deeds that he or she has an exclusively gay or lesbian orientation. In such a case, the individual's sexual knowledge could be considered sufficient for sexual consent capacity even if the individual lacked knowledge about the responsibilities of pregnancy or about pregnancy prevention.

For a person to be found capable of giving informed consent for an elective medical treatment, it is necessary that the person demonstrate awareness of the risks of the proposed treatment [39]. In a similar vein, an individual who has sexual consent capacity must be able to show awareness of the risks, or potential consequences, of sexual relations.

In order to be deemed capable of sexual consent, a person must show awareness that it is illegal to subject another person to sexual contact in any of the following circumstances:

1. through forced coercion;
2. if the other person lacks sexual consent capacity; and
3. when the other person is under the age of 17 (New York Penal Law Section 130, Sex Offenses).

There are various published sources of items for a sexual knowledge survey. Sources of relevant sexuality information include: Stavis and Walker-Hirsch's list of 23 considerations [40]; the American Association of Sex Educators, Counselors and Therapists (P.O. Box 238, Mount Vernon, IA 52314-0238); the Life Horizons series (1999)—visit http://www.siecus.org/pubs/biblio/bibs0009.html; the internet website of YAI/National Institute for People with Disabilities—visit http://www.yai.org, then use the tab ''Training Materials'' and select the topic ''Social/Sexual''; Griffiths & Lunsky's *Socio-Sexual Knowledge and Attitudes Tool—Revised* (2003)—visit http://stoeltingco.com/; *Sexual Consent and Education Assessment* [30]; and McCabe's *Sexuality knowledge, experience and needs scale for people with intellectual disability, 4th edition* (1994) (Available from the School of Psychology, Deakin University, Burwood, Victoria, Australia).

Assessing voluntariness

Excessive susceptibility to coercion, duress, or undue influence in this matter could impair a person's sexual consent capacity. Voluntariness requires that a person must be be able to take self-protective measures against unwanted intrusions, abuse, and exploitation.

Unwillingness, inability, or ambivalence with regard to expressing a choice would also compromise voluntariness [41]. A person must be aware that he/she has a choice to perform, or avoid, prospective sexual conduct.

In assessing voluntariness, it can be helpful to review information from records of recent years compiled by providers of residential and day program services. Conversations with staff who currently provide services to the person as well as direct discussions with the individual are also essential. It is important to find out if the person whose capacity is being assessed has been sexually exploited or coerced into a sexual relationship.

Final determination of capacity

At the Center for Disability Services a Sexual Rights Committee makes the final determination concerning an individual's sexual consent capacity. The membership of the Center for Disability Services Sexual Rights Committee includes qualified professionals with many years of experience in the field of Intellectual and Developmental Disabilities. There have been two licensed psychologists, two licensed social workers, the agency attorney, and the chief residential administrator. The Sexual Rights Committee carefully applies accepted professional standards and considerations in its review and discussion of the information yielded from the assessment process. The Sexual Rights Committee process diffuses the responsibility for determining sexual consent capacity; and it promotes a balanced exchange of ideas in a competent and thorough manner. Sexual consent capacity determinations thus have the support of clinical, legal, and administrative approval. The correct legal standard, based on tort or common law, is that professional judgments concerning a person's consent capacity should be made by properly qualified professionals in a manner consistent with accepted professional standards.

The committee process serves the added purpose of lessening the influence of personal bias by the assessor in the final capacity determination. If an individual assessor had the sole responsibility for determining a person's sexual consent capacity, there may be a bias toward a finding of capacity or incapacity. If the assessor is overly sympathetic and lacking in objectivity towards the person, the assessment outcome may err in the direction of capacity. In contrast, a bias towards a finding of incapacity might occur because such a finding carries less liability exposure for the assessor than a finding of capacity. The final determination of sexual consent capacity via a committee process can diffuse liability exposure and provide enhanced objectivity through the consensus of the professionals on the committee.

Consider a hypothetical case in which an individual assessor determined that a person with intellectual disabilities had sexual consent capacity. If that person then became pregnant or contracted a sexually transmitted infection through a consensual sexual relationship, the parents might blame the assessor for the unwelcome outcome; and they might institute punitive actions against the assessor.

Insufficiency in rationality, knowledge, or voluntariness may result in a determination of incapacity. Some deficits (e.g., advanced dementia) may not be easily remediated, but other deficits may be subject to remediation. A thought disturbance, such as paranoia or delusions, may impair rationality until antipsychotic medication improves the person's mental status. If a person with mild intellectual disabilities was found insufficient in the domain of knowledge, appropriate education and training may enable that person to learn what is necessary to be deemed capable. In the case of a person whose voluntariness has been compromised by undue influence from another person, it may be possible to decrease or limit the undue influence

sufficiently to elevate the person's decision making from the level of incapacity to the level of capacity.

Protection from harm

In *Youngberg v Romeo* [42], the United States Supreme Court affirmed that there is a constitutional right to ''protection from harm'' afforded to individuals residing in institutions, and likely also for individuals treated in the community by professionals in a state licensed program. *Youngberg* holds that it is a constitutional rights violation if a person in a state institution is harmed because there is a ''substantial departure from professional standards''.

Duane Youngberg was the Superintendent of the Pennhurst State School and Hospital, a Pennsylvania State Facility, when Nicholas Romeo was placed at there in 1974. Mr. Romeo, who had profound intellectual disabilities, was 26 years of age at that time. While at Pennhurst he did not receive adequate care and treatment; and his safety was not maintained. The Court asserted that a person with intellectual disabilities has constitutionally protected liberty interests under the due process clause of the Fourteenth Amendment. The person is entitled to minimally adequate training or habilitation as reasonably might be required to ensure his safety and to facilitate his ability to function free from bodily restraints.

Under state law and under federal constitutional law, there is an obligation for the state and its professional licensees to protect persons under their care, who have been adjudged to lack capacity, from unreasonable harm, including that caused by sexual activity. Consider the hypothetical case of a state-licensed program that serves persons with intellectual disabilities, and which negligently determines that an individual has sexual consent capacity. Suppose that individual subsequently contracts AIDS. There could be both tort and constitutional civil rights liabilities. There could be a violation of the individual's right to be protected from unreasonable harm.

Discussion

There are many persons with intellectual disabilities or developmental disabilities who have the capacity to participate in intimate relationships. Residential provider agencies that serve such persons should assist them to develop and realize their fullest potentials. This encompasses enabling them to exercise their constitutionally guaranteed sexual rights as well as safeguarding them from harm. Unfortunately, there have been many instances in which the sexual rights of people with disabilities have been ignored and even suppressed [24]. The sexual consent capacity standards for those with intellectual disabilities or developmental disabilities also apply to those with dementia. In both populations there are brain dysfunction and cognitive impairments. The capacity assessment methods may be different in the two populations due to differences in literacy and oral language comprehension [43]. There are many individuals with cognitive impairments who have sexual consent capacity.

Although there are some legal guidelines for determining sexual consent capacity, there has been a paucity of clinical standards. This article presents a standard for assessing sexual consent capacity along with suggested assessment practices. The suggested assessment practices need to be validated in the future.

Protection versus empowerment

Agencies that are subject to the rules of the New York State Office of Mental Retardation and Developmental Disabilities have protective oversight responsibilities. The legal and ethical responsibility agencies have for ''protective oversight'' can pose dilemmas. This occurs when a positive determination of capacity conflicts with the responsibility of the agency to provide a safe environment for people receiving its services. For example, an individual who can articulate the risks and meet all the criteria for capacity may choose to engage in risky sexual behaviors. Ames and Samowitz [28] have noted that the rights of people with intellectual disabilities have often been abridged under the guise of protecting the individuals by inferring lack of capacity, based solely on the fact that the individual is disabled. During the early 20th century, people with intellectual disabilities were considered asexual or promiscuous. In the past the occurrence of promiscuous behavior was sometimes used as a justification for institutionalizing a person. Persons with intellectual disabilities were considered a threat to society because they would reproduce and have offspring with intellectual disabilities. Nevertheless, the dual responsibilities to empower and protect persons with intellectual disabilities are real and cannot be overlooked [44]. It is incumbent on agencies, then, to distinguish restrictions imposed due to a lack of capacity from those based on a legal and ethical requirement for protective oversight. The former is largely a clinical decision, the latter is administrative.

Limited capacity

Usually a capacity evaluation is a ''yes or no'' determination with regard to the decision at hand. That is, a person is either found to be capable or not capable [39]. However, in the case of sexual consent capacity some authors [28, 29] argue in favor of limited capacity. The threshold for a determination of sexual consent capacity can depend on the risks of the proposed sexual relationship. Examples follow. A person may be found capable of consenting to sexual intimacy with one specific person and not others. Another person may be found capable of consenting to some sexually intimate behaviors but not capable of giving consent for others which would be likely to cause undue harm. There are situations in which knowledge of pregnancy issues is irrelevant to sexual consent capacity (e.g., a homosexual relationship, a heterosexual relationship in which pregnancy is not possible).

An agency that finds an individual to have limited sexual consent capability has the significant challenge of needing to provide adequate supervision and monitoring to ensure that the individual's sexual behavior remains within the recognized level of capability.

The use of a clinical standard for assessing sexual consent capacity helps afford respect for individual dignity and autonomy in compliance with legal regulations as well ethical codes [5]. Legal, ethical and moral codes dictate that reasonable efforts should be made to include individuals, and/or their advocates, in decisions affecting their lives in order to avoid possible victimization.

A further nuance in some cases involves taking the level of risk of the proposed behavior into account in the capacity determination. Sexual acts vary in their level of risk. An example of where this comes into play would be a case of two individuals

with intellectual disabilities who request time alone together. They might want to engage in kissing and touching, but not want further physical intimacy. If these individuals have indicated that they are not interested in having sexual intercourse, they should not necessarily be held to the knowledge standards that would be necessary for people planning to have sexual intercourse.

One way in which a residential provider agency might address the issue of limited sexual consent capacity would be to allow partial privacy in designated areas in the residence. Staff would provide periodic visual monitoring to ensure that the individuals maintain a level of physical intimacy within the limits of the individuals' consent capacity. The threshold for a determination of capacity for sexual touching is lower than the threshold for sexual intercourse.

A complication arises when individuals with severe physical disabilities—such as two people with spastic quadriplegia—who would require assistance from another person to have sexual intercourse, make such a request. There are persons who have sexual consent capacity but who would need physical assistance from another person in order to have sexual relations. Such persons may not have the ability to independently undress or the ability to independently position their bodies so as to make sexual intercourse possible. Cases such as this highlight the delicate balance between the protection of people with disabilities from harm or exploitation while also ensuring the protection of their rights. There is precedent for such a couple to pay another person to physically assist them to have sexual intercourse in a motel room. It is desirable for one or both members of such a couple to have adequate communication skills to report any exploitive or unacceptable behavior by a person providing physical assistance. Ideally, actions to facilitate the sexual activity of a couple in which both partners had severe physical disabilities would include safeguards that protect the members of the couple from the harm of abuse and exploitation. It is also important that people who are enlisted to provide the necessary and appropriate physical assistance in such a situation should be protected against false allegations of sexual abuse or exploitation. These challenges are worthy of additional research and study.

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