ARTICLE

Sexuality, sexual expression in long-term care and the law

Victor M. Aziz & Philip Slack

Victor M. Aziz, MB BCh, MD, FRCPsych, is a consultant old age psychiatrist in the Older People's Mental Health (OPMH) services, Devon Partnership NHS Trust, based at North Devon District Hospital, Barnstaple, UK. **Philip Slack**, MB ChB, MRCPsych, is a consultant old age psychiatrist in the Community Mental Health Team for Older People, Surrey and Borders Partnership NHS Foundation Trust, Leatherhead, UK. Both authors share an interest in medical education.
Correspondence Dr Victor M. Aziz. Email: victoraziz@doctors.org.uk

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SUMMARY

Balancing risk and safety in long-term care settings can be challenging while providing and respecting patients'/residents' needs and rights in terms of sexual expression. We look at factors affecting the expression of sexuality, including staff attitudes and reactions, and the lack of policies governing sexuality. We review the various statute and case law, other legislative and quasi-legal provisions governing sexuality and sexual expression. Finally, we consider the need for clear policies and training for both staff and family members.

LEARNING OBJECTIVES

After reading this article you will be able to:

- appreciate the person-centred care approach in relation to safeguarding issues
- demonstrate knowledge of the interplay between various aspects of statute and case law, other legislative provisions and quasi-legal provisions and sexuality
- understand the complexity of applying the law in relation to sexual expression in long-term care settings.

KEYWORDS

Sexuality; older people; long-term care; law; capacity.

In our first article, we discussed various aspects of sexuality and sexual dysfunctions in older people (Slack 2020). In this article we focus on the law relating to sexuality and sexual expression and its applications in long-term care settings and hospitals. The sexual expression of people with mental health conditions in hospitals or long-term care settings was not acknowledged in the past as it is nowadays. The issue of freedom of sexual expression scarcely arose because matters related to sexuality concerned people's private lives and were thought of as too sensitive to discuss in many contexts.

Sexuality in older adults is a topic often thought of as taboo and the more so if they have dementia. Observational studies have shown that residents in long-term care and dementia units continue to show a range of sexual expression, from flirtation to more physical signs of affection, although these are not always welcomed by other residents or staff (Hubbard 2003).

Long-term care settings

It is reported that an increasing number of older people in the UK are living with chronic conditions and cognitive impairment (Office for National Statistics 2018) and it is estimated that over 400 000 older people in the UK live in long-term care homes (Laing 2018). As people are living longer, more people will be living with dementia if the incidence remains the same. A report published by the London School of Economics and Political Sciences (Wittenberg 2019) estimated that there would be 907 900 older people with dementia in the UK in 2020 and projected that the number would increase to around 1.6 million in 2040, a rise of 80% compared with the 2019 estimate of 885 000. One can predict that the number of people living in long-term care will only increase as well.

The aim of long-term care is to facilitate independence as much as possible (CARF International 2010). However, the complexities of comorbid physical and cognitive impairments make this difficult to achieve.

In their study of respite care workers in London, England, Homer & Gilleard (1990) found that 45% admitted committing either verbal (41%) or physical (14%) abuse since they began working with the elderly. Magruder et al (2019) found that verbal/psychological abuse was the most reported type of abuse, neglect and exploitation in long-term care, whereas sexual abuse was the least reported, especially in nursing care.

Staff attitudes and reactions towards the expression of sexuality in long-term care may also complicate the matter. Villar et al (2016) reported variable staff attitudes and reactions towards masturbation, for example. The authors concluded that the discrepancy between professionals' own reported attitudes and those attributed to workmates suggests the existence of widespread negative reactions towards sexual activity in later life. Residents with dementia in nursing homes are often viewed as asexual or sexually inactive. Vandrevala et al (2017) explored nursing home staffs' narratives

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about their roles and duties within the context of sexuality in dementia. They found that staff tended to lean towards one view or the other, i.e. on one hand that sexual expression is a basic human right and part of human nature, and on the other that people with dementia might experience loss of sexual interest. This study raised an ethical dilemma about the dichotomy of labelling sexual behaviour as either appropriate or inappropriate.

Roelofs et al (2019) studied factors that can influence staff's perception of sexuality in people with dementia. They found that therapists were more likely to have positive attitudes than staff giving direct care to the individual. They also found that higher educational level was related to more positive attitudes but did not find any significant association with staff having received specific sex education. There is contrasting evidence for how policies can influence staff attitudes, with reports of both reduced positive attitudes (Roelofs 2019) and improved attitudes towards sexuality of residents (Archibald 1998). The perception of the care being given does appear more strongly related to positive attitudes to sexuality, for example if the staff feel the care is person-centred (Roelofs 2019).

In person-centred dementia care, social interactions are integral to high-quality care; however, the lack of attention to sexuality as a resident's need/right is a potential limitation (Syme 2015). Balancing needs/rights and autonomy with the challenges of supporting sexual expression is an ongoing struggle for hospitals and care homes.

The lack of policies governing sexuality in these settings affect management of such situations when they occur (Cornelison 2013; Lester 2015). Few care facilities studied allowed sexual expression and had implemented related policies and training programmes (Tabak 2006; Shuttleworth 2010). Challenges facing staff and managers in providing such policies include patient factors, staff factors and environmental factors. For example, the resident might lack a partner since moving into care, some staff have the perception of sexual expression as a behavioural problem and the environment might lack the privacy required. Also, physical and mental health problems (including dementia), family concerns and legal liability are contributory factors (Hajjar 2003; Lantz 2004; Reingold 2004) and issues of consent and risk of exploitation/abuse complicate the matter (Tarzia 2012).

The idea that establishments think that they could prohibit or prevent sexual expression is in itself telling. In the case of MM, the judge makes clear that 'any public body which proposes to interfere with the sexual life of someone who, like MM, has capacity faces a heavy burden'. He notes that 'Particularly serious reasons' must exist and, in the case of someone in a long-standing relationship, 'especially pressing reasons must surely be shown to exist' (*Re MM (An Adult)* [2007]).

Human rights and sexual rights

The European Convention on Human Rights (ECHR) and the Human Rights Act 1998 have established that everyone has the right to live their lives free from coercion, intimidation, oppression and physical, sexual, emotional or mental harm. Article 8 of the ECHR covers the right to respect for private and family life, home and correspondence (European Court of Human Rights 2019), and the respect for the person's private life includes living in long-term care. The ability of individuals to achieve sexual health and well-being as well as being able to decide on their sexual needs should be respected, protected and fulfilled as part of the observance of basic human rights. Bringing sexuality within human rights requires commitment, advocacy, policies and legal frameworks that are constructive, just, equal and non-judgemental.

It is difficult to find a universally agreed definition of sexual rights. According to the International Women's Health Coalition (2020), sexual rights rest on the recognition that 'all individuals have the right – free of coercion, violence, and discrimination of any kind – to the highest attainable standard of sexual health; to pursue a satisfying, safe and pleasurable sexual life; to have control over and decide freely, and with due regard for the rights of others, on matters related to their sexuality, reproduction, sexual orientation, bodily integrity, choice of partner, and gender identity; and to the services, education, and information, including comprehensive sexuality education, necessary to do so'. The World Health Organization (WHO) (2015: p. 5) has defined sexual health as 'a state of physical, emotional, mental and social well-being in relation to sexuality'.

Unfortunately, despite better recognition of sexual rights in many countries, this is not the case worldwide. The WHO has called for countries to prepare 'equitable and gender-responsive health systems that consider the interaction of gender with wider dimensions of inequality, such as wealth, ethnicity, education, geographic location and sociocultural factors and implement them within a human rights framework' (World Health Organization 2019: p. 8).

The United Nations Convention on the Rights of Persons with Disabilities incorporates several sexuality-related rights. These include the right to health; the right to liberty and security of person; freedom from exploitation, violence and abuse; and respect for home and the family. There are

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BOX 1 The principles of the Mental Capacity Act 2005

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- An act done or a decision made under the Act for or on behalf of a person who lacks capacity must be done or made in their best interests.
- Before an act is done or a decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

also articles on the particular rights of women with disabilities and on awareness-raising to combat stigma. As the work continues, sexual rights championing and promotion will likely continue to grow, providing greater and better opportunities to include disabled and all other bodies (United Nations 2006).

The Equality Act 2010 provides further protections to the person. The Act makes it illegal to discriminate against people on the basis of certain 'protected characteristics', which include age, gender/sex, sexual orientation and disability (physical or mental impairment), and details the importance of reasonable adjustments to prevent people from becoming disadvantaged.

Criminal law

All legal systems use criminal law to deter, prosecute and punish harmful behaviour and to protect individuals from harm (World Health Organization 2015).

In England and Wales, the Sexual Offences Act 1967 decriminalised private homosexual acts between men aged over 21 (UK Parliament 2020), although the privacy restrictions of the Act meant that a third person could not be present and men could not have sex in a hotel. The Criminal Justice and Public Order Act 1994 subsequently lowered the age of consent for homosexual men from 21 to 18, and in 2001 it was further lowered to 16 (UK Parliament 2020). The law was not changed for Scotland until 1980, or for Northern Ireland until 1982.

The Sexual Offences Act 2003 created offences against persons 'with a mental disorder impeding choice'. These include offences against the person, inducements to the person and offences perpetrated by care workers. Offences most relevant to this article include sexual activity with a person with a mental disorder, inciting the person to engage in sexual activity, threatening the person to engage in sexual activity and specific offences when care workers are found to have caused sexual touching. The Serious Crime Act 2015 is also relevant to our article as it introduced offences related to family members (or those in an intimate relationship) engaging in controlling or coercive behaviour that has 'serious effect' on the person.

The Mental Capacity Act 2005

In England and Wales, the assessment of capacity is governed by the Mental Capacity Act 2005 (MCA), which requires capacity to be assessed in relation to particular decisions at particular times. The five fundamental principles of the MCA (Box 1) include a presumption of capacity, the right of individuals to be supported to make their own decisions, the right of individuals to be supported to make what might be seen as eccentric or unwise decisions, acting in the person's best interests if they lack capacity and taking the least restrictive alternative. These principles apply to the assessment of capacity throughout England and Wales. The two-stage test is whether the person has an impairment of, or a disturbance in the functioning of, the mind or brain and whether this prevents the person from understanding, retaining and weighing up relevant information or communicating their decision about the matter in question.

Capacity can be difficult to assess and is always assessed for a specific decision at a specific time, on the balance of probabilities. A good-quality capacity assessment is key but can be made more difficult with a potentially emotive topic and strong opinions that might be expressed by family and care professionals. This was an issue in *DP v London Borough of Hillingdon* [2020]. The judgment in this case used guidance on the quality of evidence required that traced to the European Court of Human Rights in *Sýkora v The Czech Republic* [2012]: 'any deprivation or limitation of legal capacity must be based on sufficiently reliable and conclusive evidence. An expert medical report should explain what kind of actions the applicant is unable to understand or control and what the consequences of his illness are for his social life, health, pecuniary interests, and so on. The degree of the applicant's incapacity should be addressed in sufficient detail by the medical reports' (para. 103).

It is important that clinicians are aware of their own views and prejudices, which might influence their decision-making. It has been argued that it

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can be difficult to separate normative judgements from the capacity assessment, particularly when deciding whether a person is appropriately 'using' or 'weighing up' information to make a decision (Banner 2012). Sometimes a dementia diagnosis can overshadow a capacity assessment and we would argue that it is vital that capacity is assessed fairly, without pre-judgements, to best respect the person's rights. It is important to remember that the MCA employs a functional test and not a status or diagnostic test.

It is important to understand that best interests decisions under the MCA cannot be made in relation to a person's ability to consent to sex. This is specifically excluded: 'Nothing in this Act permits a decision on […] consenting to have sexual relations' (section 27, (1)(b)). This prevents not just family and care professionals but also holders of a lasting power of attorney and the Court of Protection from consenting to such relations on behalf of a person without capacity. The MCA Code of Practice reinforces that there is a duty to act to protect vulnerable adults from harm in these situations (Department for Constitutional Affairs 2007).

A person needs to have capacity to consent to sexual intercourse, and engaging in sexual relations with a person without capacity is a criminal offence under UK legislation. Lichtenberg (2014) has proposed an assessment method to determine capacity for sexual relations. This is based on the fundamentals of the two-stage capacity test and it covers three areas:

(a) awareness of the relationship (Does the person know the partner (potentially not their spouse) who is initiating contact? What level of intimacy is the person happy with?)
(b) the ability to avoid exploitation (Does the person know what they want from the relationship, and how to say 'no'?)
(c) awareness of potential risks (Is the person aware of sexually transmitted infections (STIs), pregnancy, the time-limited nature of the relationship – e.g. due to health, placement changes – and how will they react when it ends?).

An example of this approach to assess capacity for sexual relations appears in the case of JB, outlined in Box 2. It was further clarified that consent is not to sexual intercourse in general but is person and situation specific, as in the case of *R v C* [2009].

BOX 2 Assessing capacity for sexual relations

In the case of JB, the judge held that, when considering whether, as a result of an impairment of, or disturbance in the functioning of, the mind or brain, a person is unable to understand, retain, or use or weigh information relevant to a decision whether to engage in sexual relations, the information relevant to the decision may include the following (at para. 100):

- The sexual nature and character of the act of sexual intercourse, including the mechanics of the act;
- The fact that the other person must have the capacity to consent to the sexual activity and must in fact consent before and throughout the sexual activity;
- The fact that [the individual] can say yes or no to having sexual relations and is able to decide whether to give or withhold consent;
- That a reasonably foreseeable consequence of sexual intercourse between a man and woman is that the woman will become pregnant;
- That there are health risks involved, particularly the acquisition of sexually transmitted and transmissible infections, and that the risk of sexually transmitted infection can be reduced by the taking of precautions such as the use of a condom.'

(*A Local Authority v JB (by his litigation friend, the Official Solicitor)* [2020])

Safeguarding

The Care Quality Commission (CQC) regulates and monitors care provision in long-term care settings in England. One of the CQC's fundamental standards is that care providers must safeguard the person from abuse. It is also acknowledged that the presence of risk alone should not automatically lead to restrictions on a person but that the risk must be properly assessed and found to be 'unacceptably great' (Care Quality Commission 2017).

The CQC requires care providers to meet concerns about safety by providing safe care and treatment and safeguarding care home residents from abuse, improper treatment or neglect (Social Care Institute for Excellence 2017). The responsibility of safeguarding vulnerable adults applies to all health and social care staff and this includes long-term carers. In 2020, the CQC released a report into sexual safety. It identified that 3% of notifications of abuse or alleged abuse related to sexual abuse, 48% of which was classed as sexual assault, and that men were four times more likely to carry out the act, whereas women were three times more likely to be the victims (Care Quality Commission 2020). Common themes in this report were the importance placed on communication, empowering both staff and residents to talk about sexuality and what they are and are not comfortable with, and the need for policies to be updated. The report says that adult social care should support care recipients to develop and maintain relationships and express their sexuality. However, according to the CQC, safeguarding adults at risk should be integrated into existing systems and processes for delivering care. The CQC advises that staff should take a proactive approach to safeguarding and focus on prevention and early identification, especially where there are known risks, and work effectively with relevant organisations to engage appropriately and implement protection plans (Social Care Institute for Excellence 2017).

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BOX 3 Clinical vignette

Mr Y, an 80-year-old man with recently diagnosed vascular dementia, has moved into a care home as his wife was struggling to meet his care needs at home. His children and wife are happy with the care home environment and Mr Y appears to have settled well in the new surroundings and enjoys visits from family. Care home staff have ensured that he is able to spend private time in his room with his wife.

Unfortunately, in recent months the care home has stopped the family visiting because of the COVID-19 pandemic and it is not clear when these restrictions will be lifted. Mr Y has begun spending more time with another male resident in the home and enjoys his company. On a recent video call to the home, Mr Y's wife saw him sitting in the lounge holding hands with a male resident and Mr Y did not appear to recognise his wife during the call. This caused understandable distress to his wife and family, who have now complained to the care home. The family state that this is not keeping in Mr Y's normal behaviour and think that the other male resident must be taking advantage of his vulnerability.

How might you advise care home staff to act initially while developing a longer-term plan?

What further information would you want to gather about the people involved?

How would your approach differ based on the possible outcomes of a capacity assessment on Mr Y?

Safeguarding complements both the Human Rights Act 1998 and the Equality Act 2010. Care professionals have a responsibility to protect vulnerable individuals who do not consent to or were pressured into consenting to any inappropriate touching, indecent exposure, sexual abuse or rape (Box 3). The Department of Health (and later the Care Act 2014) defines an adult at risk as a person aged 18 or over 'who is or may be in need of community services by reason of mental or other disability, age or illness; and who is or may be unable to protect him or herself against significant harm or exploitation' (Department of Health 2000: para. 2.1). There is a difficult balance that needs to be struck when considering the rights and safety of both the individual and other residents in long-term care. Key principles of safeguarding are protection, prevention, empowerment and proportionality: protection of the individual and prevention of harm, balanced with the need to empower them to make their own choices and, if intervention is needed, to ensure a proportional response using the least restrictive option (Department of Health 2014).

The Court of Protection

As we have previously mentioned, the Court of Protection has a vital role in deciding potentially complex cases involving capacity and sexuality. There is an ever-expanding list of case law that can provide guidance and reflection on this topic. We will touch on recent cases that are relevant to our article.

Capacity to consent to accessing a sex worker was examined in the case of AB, outlined in Box 4.

The importance of initial and repeated memory assessment was highlighted in a case concerning capacity to consent to a sexual relationship with a long-term partner (*re SF* [2020]). SF was a 45-year-old woman with mild learning disabilities, depression and frontal lobe dementia that caused her to have difficulties in expressing herself and in understanding others. She lived with her husband of 25 years, who was 'significantly older than her'. The local authority had made an application seeking declarations about SF's lack of capacity in several domains, and for decisions to be made in her best interests. Expert evidence from the

BOX 4 Capacity to consent to accessing a sex worker

The case of AB (referred to as P in the judgment) concerned a 51-year-old man with a diagnosis of moderate learning disabilities, autism spectrum disorder, harmful use of alcohol and psychosis due to solvent misuse. He lived in supported housing and met prostitutes for sexual relations, at times travelling to The Netherlands to meet sex workers there. This was an application by the local authority for the court to determine P's capacity and best interests, specifically with regard to contact with sex workers.

A psychiatrist gave the following evidence:

'P has limited insight into the risks that others might pose to him, including sex workers, and overestimated his ability to keep himself safe. He could not think through the potential consequences of visiting sex workers, including the possibility of financial exploitation or involvement with the criminal justice system. I believe that P failed to both understand the information necessary to make decisions about contact and was unable to weigh up the benefits and risks. It is therefore my opinion, that P lacks capacity in this area and this is as a result of his learning disability and autism.'

The court held that it was wholly contrary to P's best interests for him to have sexual relations with prostitutes and that it was inappropriate for the court to sanction the same. The judge found that P lacked capacity to make the decision, specifically with regard to his health and welfare and the potential for sexual exploitation. He noted that 'a care worker who causes or incites sexual activity by an individual for payment, with another person, commits a criminal offence, pursuant to ss. 39, 42 and 53A of the Sexual Offences Act 2003'.

(*Lincolnshire County Council v AB* [2019])

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psychiatrist who evaluated SF drew a distinction between what she referred to as SF's 'episodic' memory (i.e. her recollection of past personal experiences that occurred at particular times and places) and her 'semantic' memory, which relies on the 'feeling' associated with her bank of memories rather than the 'facts' surrounding them. As a result, the psychiatrist considered that SF's difficulty managing contact with others applied to new relationships rather than existing ones, such as her relationship with her husband.

It was the judgment of the court that SF had capacity to decide on maintaining contact and a relationship with her husband and to consent to sex with him. However, in view of the rapid deterioration in her dementia, he directed that SF's capacity should be reviewed again in 3 months' time. It was decided that she had capacity to consent to an ongoing sexual relationship with her husband but not with a stranger and that she remained vulnerable outside her marriage. The learning point was that, while there is good reason for doubting the reliability of a person's short-term recall, they may still have sufficient ability to retain information to exercise capacity.

Policies and training

Policies

Mental disorder may impair the capacity of an individual to make one decision but not another. Mental disorders can cause sexual disinhibition in some people and they may become embarrassed or frightened of both the behaviour and its consequences. Very often, the staff in hospitals and long-term care settings are not sure what actions they can take to protect the patient from harm while respecting their autonomy, and how to facilitate sexual rights while respecting the rights of others. There is wide variability in local policies and available training on sexuality in long-term care settings.

The Care Act 2014 requires care providers to have clear policies and procedures that reflect the statutory guidance (Department of Health 2014). This would include policies on the information collected when someone moves into long-term care, such as their sexual orientation, relationships and preferences. It also includes policies on how staff should deal with possibly inappropriate sexual behaviour. However, the literature has reported the lack of such policies, training and procedures in many long-term care settings (Lester 2015; Syme 2016). Doll (2013) surveyed nursing homes and demonstrated the need for specific policies and staff training regarding sexuality to be developed with the input of residents, their families and the staff.

There are questions to be asked about what the policies and training should look like, whether policies should be national or local (or perhaps both) and who should regulate them. For example, when directors of nursing in long-term care facilities in the USA were surveyed they cited a preference for a top-down approach and a national lead on these policies (Syme 2016).

There have been various attempts to suggest aspects that should be included in these policies. The key points proposed by Christie et al (2002) included beginning by identifying key stakeholders, arranging focus groups to clarify values and reviewing what other local organisations are doing. They also highlighted the importance of defining what key terms (such as sexuality, intimacy, sexual behaviours of concern) mean and what the suggested interventions are (from redirection and other behavioural approaches to medication in high-risk situations) (Christie 2002).

As highlighted by Le Gallez et al (2018) in this journal, the court has a difficult balance to reach between making paternalistic incursions into personal autonomy and freedom on the one hand and protecting the individual on the other, and it runs the risk of discrimination against people with mental disorders who lack capacity. Policy makers face similar problems.

The Last Taboo is an important booklet, published through the International Longevity Centre UK, that covers many aspects of sexuality in long-term care. It sets out further factors to consider when developing policies, including what values are being promoted, making sexuality a standard part of social history taking on admission to the home, what staff support is available and ensuring that the policies are closely aligned with the MCA (Bamford 2011). It also highlights the importance of documenting not just the outcome of the capacity assessment but also the process that was taken to reach that decision.

Returning to Syme et al (2016) and their survey, directors of nursing suggested incorporating changes to the environment to make the expression of sexuality more feasible, including wider beds and 'knock first' or 'do not disturb' signs. Many proposed that sexuality should be considered not just on admission to long-term care, but that it should be revisited during the resident's stay. It was also suggested that policies should involve guidance on how to work effectively with family and include educational resources.

Person-centred care

It is important in developing these policies that the perspectives of the residents be central in discussions. Policy makers should ask themselves whether they are doing enough to understand the point of

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view of the residents living in long-term care or whether they still too often take a paternalistic approach. Roelofs et al (2015) completed a systematic review of the literature on sexuality and intimacy in care homes and found that the perspective of residents was often lacking. This is further explored by Mahieu & Gastmans (2015) in their systematic literature review, which suggested that if we are striving towards person-centred care then we need more research into this area.

In addition to this evidence suggesting failure to include residents in these discussions, the involvement of residents can be further reduced by the presence of dementia. Mahieu et al (2014) argue that the presence of cognitive impairment can lead to the individual being reduced to 'patient status' and the resulting focus on capacity/competence ignores broader aspects of their sexuality. They argue that sexuality is an essential part of existence that does not cease because a person develops dementia and therefore we should not overestimate vulnerability in this group.

There is also a lack of research into the experiences of lesbian, gay, bisexual and transgender (LGBT) older residents in long-term care, potentially further marginalising this group of people. This group also appears more at risk of not being considered when policies are developed. Mahieu et al (2019) described that there is still a perception among the LGBT community that older LGBT residents in long-term care are discriminated against on the basis of their sexual orientation or gender identity.

Clearly, more work needs to be done to ensure inclusion of people's views when developing policies and guidance for long-term care.

Training

Education is a recurring theme in discussions on developing these policies but it can be difficult to establish what evidence-based and effective training looks like.

It appears that the lack of specific training on sexuality for many long-term care nursing staff has been linked with more negative opinions towards sexual behaviours in long-term care (Gastmans 2014). Gastmans (2014) suggested that limited knowledge about older adults' sexuality could be linked with nurses describing feelings of confusion, embarrassment, anger, denial and helplessness when confronted by acts of intimacy.

The CQC has advised that induction and ongoing training on sexuality and relationships, together with training and awareness of equality, diversity and human rights issues, should help staff to reflect on their own duty to maintain compassionate yet professional boundaries (Care Quality Commission 2019). However, it is important to keep training about personal relationships separate from training on safeguarding, deprivation of liberty and the MCA (Skills for Care 2020).

A blended approach to learning about personal relationships that gives staff enough space and time to explore and discuss each other's thinking about the subject is much needed. The training programme might include learning about the importance of stable relationships and about the physical aspects of relationships, including boundaries, consent, respect, love and sex. The recognition that people who need care and support might want to become intimate or sexually active is important. Training might also include the regulatory and legal frameworks relating to personal relationships and their effect on how staff provide care and support (Skills for Care 2020).

The desire or need to express one's sexuality does not necessarily expire with age. Bauer et al (2014) describes the development of an assessment tool to support the normalisation of sexuality in care homes for older people. The tool enables the staff of residential care facilities to identify how supportive their organisation is of all residents' expression of their sexuality, and thereby improve where required. The tool also enables facilities to monitor initiatives in these areas over time.

Another important area to consider in training is 'safe sex', particularly concerning STIs and sexual dysfunctions.

We have mentioned that understanding of potential risks related to sexual intercourse needs to be included when assessing the person's capacity to consent. This understanding of risk extends from residents to staff. Residents' access to general practice and genitourinary medicine services should be considered, as should the availability of items such as condoms and other protective items.

Older people are still at risk of STIs such as HIV, chlamydia and gonorrhoea. Studies show that in the USA, Australia, China and Korea there is evidence of increasing rates of many STIs in the over-50s (Minichiello 2012). There may also be a need for resident and staff education. Smith et al (2020) studied older adults' knowledge of STIs and found consistently low scores on their questionnaire.

In addition to potential pathological changes we should also consider how physiological changes in the older person can affect their sexuality and potential for satisfactory experiences. It is beyond the scope of this article to discuss in detail changes in sexual functioning in older adults but it is worth mentioning that studies have found them to be common. For example, a US study reported that 39% of women had problems with vaginal lubrication and 37% of men had difficulty achieving an erection (Lindau 2007).

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We should remember the involvement of family members in training and education. Lichtenberg (2014) suggested not only that family need to be involved in discussions about sexuality and intimacy, ideally from an early stage to introduce the topic, but also that they should not be forgotten when education programmes are being offered.

Conclusions

Balancing risk and safety in long-term care settings and hospitals can be challenging while providing for and respecting the patient's needs and rights in terms of sexuality. Protecting residents from sexual abuse or mistreatment and the collective rights of other residents requires further support and clear policies to be put in place. Respecting the views of all stakeholders – the individual concerned, family, other residents and staff – in determining the best way to manage sexuality in long-term care requires a fine balance.

The clinician would of course assess cognition as part of a capacity assessment but they should be mindful of the possible need to arrange appropriate reassessment over time, as highlighted by recent case law (*re SF* [2020]).

There is a lack of research into many areas discussed in this article, but particularly noticeable is the need for further research into the experiences of LGBT older residents in long-term care. The paucity of studies leads to potential to further marginalise this group of people.

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MCQ answers
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MCQs

Select the single best option for each question stem

1 According to Laing (2018), the estimated number of older people in the UK currently living in long-term care settings is:
a 400 000
b 100 000
c 500 000
d 1 000 000
e 50 000.

2 According to (Roelofs et al (2019), factors that can positively influence staff members' perception of sexuality in people with dementia include:
a giving direct care
b lower educational level
c receiving specific sex education
d having a general policy
e person-centred care.

3 Sexual rights have been defined as a state of physical, emotional, mental and social well-being in relation to sexuality by the:
a the Mental Capacity Act
b the Mental Health Act
c civil law
d the World Health Organization
e all of the above.

4 Lichtenberg (2014) proposed that assessment of capacity to consent to sexual relations should include the person's:
a awareness of the benefits of the relationship
b awareness of comorbid physical illness
c awareness of the relationship
d awareness of the law
e awareness of the financial gains.

5 Which of the following best reflects the Care Act 2014 definition of an adult at risk?
a a person aged 16 or over who is or may be unable to protect him- or herself against significant harm or exploitation
b a person in need of community services by reason of mental or other disability who is or may be unable to protect him- or herself against significant harm or exploitation
c a person who needs in-patient care by reason of mental or other disability and is or may be unable to protect him- or herself against significant harm or exploitation
d a person who is subject to acceptable level of risks and is or may be unable to protect him- or herself against significant harm or exploitation
e a person who is unable to consent to treatment and is or may be unable to protect him- or herself against significant harm or exploitation.

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