Intimate Relationships between Older People in Institutional Settings: Ageism, Protection or Fear?

Intime des relations entre les personnes âgées en milieu institutionnel : l'âgisme, de Protection ou de peur ?

*Short title*

**Intimate relationships in care homes**

John Williams

Professor of Law, Department of Law and Criminology, Aberystwyth University

Department of Law Criminology,

Hugh Owen Building,

Aberystwyth University,

Aberystwyth,

United Kingdom,

SY23 3DY.

Tel + (44)1970 622735

Email [jow@aber.ac.uk](mailto:jow@aber.ac.uk)

*Summary*

1. Objectives:

1. To clarify the implications of human rights on the right of older people within institutional settings to continue or develop intimate relationships with other residents.
2. To identify key issues facing practitioners when faced with intimate relationships within residential settings.
3. To emphasise the importance of avoiding assumptions based on stereotypical views of older people, their rights and their needs.

2. Equipment and methods: a review of the literature and case law on intimate relationships between older people in residential settings.

*Keywords*

sexuality, intimate relationships, older people, residential care, care home, human rights

la sexualité, les relations intimes, les personnes âgées, les soins en établissement, foyer de soins, les droits humains

# Introduction

Sexuality is thought to decline and eventually disappear as part of ageing. Alternatively, it is considered unnatural and distasteful conjuring up images of the ‘dirty old man.’ Older people are either ‘asexual or hypersexual’.(1) As with any assumptions about older people, the stereotype is not reality. Studies show that sexual activity continues into older age, although its nature and frequency may change. The extent of decline, in both qualitative and quantitative terms, is unclear. Lindau et al in their report on sexuality and health amongst older adults in the United States found that sexual activity declines with age.

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| *Age range* | *Prevalence of sexual activity* |
| 57 – 64 years | 73% |
| 65 – 74 years | 53% |
| 75 – 85 years | 26% |

Their study showed that women are less likely to be sexually active than men at all ages. Roughly half of the sample (both men and women) reported a sexual problem.(2) However, Beckman et al found that sexual activity amongst married and unmarried 70 year olds in Gothenburg, Sweden, increased between 1971 and 2001. It found that the level of sexual satisfaction increased, particularly in women. They reported that attitudes towards sexuality had changed. Older people, including those with dementia, may continue with flirtatious behaviour and with displays of affection. These may be open and welcome by the other person.(3)

Discussing sexuality is difficult for some people. There may be reluctance by doctors and other health or residential care practitioners to raise these matters with a patient or resident, particularly an older person where the practitioners is younger.(4) Subramani et al speculated about the cause of this professional reticence,

Sex is a difficult topic to discuss with older people. Society’s attitudes towards sexuality in later life and attitudes among older people themselves lead to unrecognised sexual problems in this age group. Professionals often fail to recognise these problems for various reasons, including lack of training, their own beliefs about sexuality in later life and sexual health priorities not perceived as being relevant to older people.(5) ( p.35).

Despite any change in their frequency and nature, intimate relationships remain part of the lives of many older people.(6) The emphasis in the reformed social care laws in England and in Wales is on the duty to promote the ‘well-being’ of people. Section 2 Social Services and Well-being (Wales) Act 2014 includes as one indicator of ‘well-being’ ‘domestic, family and personal relationships.’ There is an identical provision in the Care Act 2014 for England. The English eligibility regulations (the Care and Support Regulations, 2014) refer to the inability of a person to develop or maintain personal relationships. Local authorities in applying the criteria should consider whether their identified needs for care and support ‘prevent them from maintaining the personal relationships they have or because their needs prevent them from developing new relationships.’(7) (p 99).

Providers of residential care should not ignore the rights of older people to enjoy and benefit from intimate relationships. Such relationships can be complex embracing capacity, safeguarding and sometimes criminal law. They engage a debate that pervades social care law and older people, namely the balance between protection and autonomy.(8),(9),(10). It can also be challenging for practitioners in residential care and family members. The reluctance to countenance that older people have such needs and the belief that entering residential care ends expectations that intimate relationships can develop or be maintained, inhibits discussion. This article discusses the complex ethical, legal and practical issues engaged in the debate on older people and sexuality. It argues that the right to intimate relationships is a basic right found in the article 8(1) of the European Convention on Human Rights (ECHR) as part of private life, family life and home. This right can only be qualified under article 8(2) ECHR. Article 8(2) states,

There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The other right engaged in this discussion is the article 3 ECHR not to be subjected to inhuman or degrading treatment. Article 3 is an absolute right and cannot be qualified.

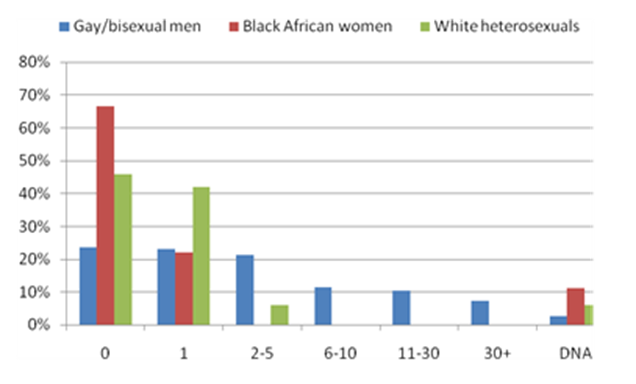
# Sexual health and older people

Ageist attitudes to sexuality and older people are illustrated by their marginalisation in sexual health programmes. Greater awareness of the sexual health needs of older people is required.(11) Assessing an older person’s sexual health can benefit them, in particular those with increased frailty.(12) Assumptions about the lack of sexual activity by older people lead to the conclusion they are not at risk of, for example, sexually transmitted diseases. As pregnancy is no longer possible, condom use is not promoted. Sexually transmitted diseases are increasing amongst people aged 50 years or more. For HIV, 20% of adults using HIV care are 50 years or older, partly because of longer survival rates. New diagnoses for that age group doubled between 2000-09. People diagnosed aged 50 years or above were more likely to be diagnosed late compared to those under 50 years (58% compared to 39%). This is a possible consequence of an unwillingness to screen older adults. The prognoses for a late diagnosis are less favourable.(13),(14)

The need for evaluation, counselling and education about sexual health is not confined to young people. Failure to appreciate the sexual health needs of older people places them at a significant disadvantage, is discriminatory and is ageist. Wilson, addressing the challenge for American practitioners, identifies their task:

Geriatric health care professionals must offer older adults adequate information and counselling relating to sexuality and aging. Evaluation of sexual health must be included as a standard domain in routine comprehensive geriatric evaluation of each patient. Additionally, national and community-based education programs will be helpful in encouraging cultural and societal acceptance of the sexuality of older adults.(15)

In the United Kingdom, the Joseph Rowntree report on people over 50 years living with HIV identified several concerns for this group. Poor experiences in primary care and fears that care homes and sheltered accommodation might be HIV prejudiced and/or homophobic were reported. The Report highlights a failure to acknowledge continued sexual activity in later life, so there is need for continued support for sexual health.(16) As figure 1 shows, many respondents continued to be sexually active.

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*FIGURE 1*

*Figure 1 – Number of sexual partners in the past twelve months – people aged 50 years or over who are HIV positive. (Power, Bell et al. 2010)*

The Report recommends that HIV testing and prevention initiatives must consider the needs of the 50 years and over age group, in particular gay and bisexual men. Generic services should also include the needs of older adults (see Recommendation 4). The Royal College of Nursing emphasise that care home staff must incorporate relationships and sex as part of their care of residents, including sexual health advice, sexual hygiene, and infection control.(17)

# Reproductive rights in the human right’s discourse

Discussion on human rights and sexuality often centre on reproductive rights at the expense of rights to enjoy and benefit from sexual activity and the right to access suitable sexual health and advice services. The dominance of reproductive rights risks excluding many, or most, forms of sexual activity. Same sex relationships, the use of contraceptives and masturbation are at risk of exclusion from a rights discourse if reproduction were its basis. Older people risk exclusion on this ground, for example postmenopausal women. In addition, for older men reproduction may not be possible. Male sexual dysfunction (erectile dysfunction and hypogonadism being the most prevalent) prevents intercourse and increases with age. These may not be because of ageing, but because of other conditions or treatments. Research shows that physiological potency declines with age. Unless treated, such conditions will prevent reproduction.(18) Developments in assisted conception have been successful in overcoming some causes of infertility. In 2006, Patricia Rashbrook gave birth to a son at the age of 63 years after IVF treatment; this generated great debate in the media on ‘older mothers’.(19) Treatments for sexual dysfunction are now available, although evidence suggests that older people may not be seeking help because of embarrassment.(18)

Disentangling reproductive rights from sexual rights is important when considering older people. Miller argues that conflation of these two rights results in sexual rights becoming a subset of reproductive rights. One consequence is that ‘… persons and practices not traditionally addressed within rights works must be explicitly named and brought within the circle of rights protection.’(20) The key questions are whether human rights law recognises a right to intimate relationships, and if it does, what are the circumstances justifying interference.

# Defining sexuality and intimate relationships

Definitions are important, although precision is elusive. Sexuality is a ‘complex and ill-defined concept.’(21) The history of sexuality, and pursuit of a definition, is well researched.(22)(23) For present purposes, a more pragmatic definition is used. Sexuality comprises several features. Sexuality embraces the ‘whole individual’ and is a reference frame in relation to others.(24)(24) Fried, in her literature review, identifies the following features of sexuality;

Sexuality is understood to be composed of sexual identity and orientation, gender identity, sexual desire, and sexual practices, which together constitute an individual's sexual "subjectivity" in society. Sexuality is, of course, affected by social location and, in particular, by experiences of race, class, cultures, and community… Sexuality is also variable and fluid and individuals' relationship to sexuality can evolve over time.(25)

It is fundamental to human beings going beyond procreation and biology and is about the pleasure and benefits of intimacy and the many ways of expressing or experiencing it. Sexuality does not presuppose a set standard or type; Fried refers to ‘sexual subjectivity’. Nor is there an upper age limit, although its dynamic nature may change how it is expressed or experienced. Typically, sexuality embraces intercourse, sexual contact falling short of intercourse, behaviour such as cuddling or handholding, and sadomasochistic behaviour. Intimacy, or intimate relationships, are a part of sexuality and are not restricted to sexual intercourse.

# Sexuality and the right to have private life protected under article 8(1) ECHR

The discussion below considers sexuality as a part of the human right to a private life, family life and home under article 8(1) ECHR. As noted above, this right may be qualified, but only under article 8(2) ECHR. Some sexualised behaviour is a criminal offence. Crimes include rape, incest, sexual assault, child sex abuse, grooming children, trafficking for sexual exploitation, sexual abuse of vulnerable people, voyeurism, and committing an offence (e.g. burglary) intending to have sexual intercourse. The European Court of Human Rights in *Laskey and others v United Kingdom* (26) said that the state must balance the autonomy of the individual with what is necessary in a democratic society to protect health under article 8(2) ECHR. (1997). The issue was whether consensual sadomasochistic behaviour by consenting adults could amount to a criminal offence. The United Kingdom courts said it could if the conduct was not ‘trifling or transient’; the European Court gave significant leeway to the state to decide the correct balance,

The determination of the level of harm that should be tolerated by the law in situations where the victim consents is in the first instance a matter for the State concerned since what is at stake is related, on the one hand, to public health considerations and to the general deterrent effect of the criminal law, and, on the other, to the personal autonomy of the individual. (para 44).

The European Court has recognised that sexual relations are part of private life under article 8 ECHRH. In Dudgeon v United Kingdom, it stated that the right to a private life included the right to sexual relations.(27) The case involved the ECHR compatibility of the Northern Ireland offence of gross indecency between males. It said of article 8,

… the maintenance in force of the impugned legislation constitutes a continuing interference with the applicant's right to respect for his private life (which includes his sexual life) within the meaning of Article 8.(para 41; see also Norris v Ireland(28)).

Under the law challenged, the activity was an offence even if it took place in private space and between consenting adults. In Lustig-Prean and another v UK (29) two Royal Navy officers were asked by service police detailed questions of an intimate nature about their sexual practices and preferences. The European Court held that this, along with the preparation of a report for the authorities, was a direct interference with their right to respect for their private lives.

# The American perspective

Davies et al describe the American experience as follows.

Health professionals frequently assume that once a patient is institutionalized, sexual problems or issues are resolved or disappear. Placement does not automatically end the sexual connection between a couple or the need for intimacy in a patient. Residents and their partners have the right to seek out and engage in sexual expression, and be given privacy to carry out intimate4 relationships.(30)

The American Supreme Court considered the right to sexual intimacy in several cases involving the question of whether it was protected under the American Constitution. The Constitution does not refer to intimate relations, but they are linked inexorably to rights referred to or developed by the Supreme Court in interpreting the Constitution. In Meyer *v. Nebraska*,(29) the Court, referring to the Fourteenth Amendment, said,

While this Court has not attempted to define with exactness the liberty thus guaranteed, the term has received much consideration and some of the included things have been definitely stated. Without doubt, it denotes not merely freedom from bodily restraint but also [for example,] the right . . . to marry, establish a home and bring up children . . .

Mr Justice Harlan in his dissent in *Poe v Ullman* recognised that safeguarding of the ‘home’ under the Constitution is not purely a property based right, but embraces the whole ‘private realm of family life’ and that it was difficult to imagine what is ‘more private or more intimate that a husband and wife’s marital relations.’(31)

*Griswold v. Connecticut*(32) was a significant case in identifying rights to privacy and to engage in forms of sexual conduct.(33) At issue was the constitutionality of 53-32 and 54-196 of the General Statutes of Connecticut. These criminalised providing contraception; the appellants, one of whom was a doctor and the other the head of the Planned Parenthood League, were convicted. In delivering the Supreme Court’s opinion, Mr Justice Douglas found that the Connecticut statute was unconstitutional. He said,

… I believe that the right to privacy in the marital relations is fundamental and basic – a personal right “retained by the people” within the meaning of the Ninth Amendment… (T)his fundamental right, …is protected by the Fourteenth Amendment from infringement by the States. (p 499).

This 1965 case was decided within the context of *marital* relationships. It did not ‘interfere with the State’s proper regulation of sexual promiscuity or misconduct.’ It recognised that at least marital relations, including sexual intimacies are protected by the Constitution.

## Sexual intimacy in institutional settings

Sexual intimacy in institutional care is not new. Townsend’s history of institutional care for older people in the United Kingdom from 1957-61, traces attitudes towards relationships. He reminds us that the old workhouse remained the mainstay of accommodation for the aged and handicapped into the 1960s. The study shows that within these institutions segregation was the guiding principle. It made it administratively easier to run the institution, particularly baths and toileting. Some staff felt it was improper to encourage mixing. The layout and design of the buildings, along with the division of functions among the staff depended on segregation. This also applied to married couples living in the same institution. Married accommodation was rare, indeed in one institution the married accommodation was less than it was in 1894. Where it was unavailable, a concession was that the wife was on one floor and the husband on the next level. Nevertheless, couples were often separated and even placed in separate blocks.(34) Were things any different in the new post-war care homes? There was great expectations of these new homes with Aneurin Bevan stating that ‘(T) he workhouse is to go.’(35) The Ministry of Health in 1949 talked about the opening by local authorities of ‘small, comfortable homes, where old people, many of them lonely, can live pleasantly and with dignity. The relationship within these homes was no longer that of master and inmate, but hotel manager and his guests.' (36) ( p 311). Was this aspiration realised when considering intimate relationships?

Townsend’s findings suggest that there was improvement, although segregation was still prevalent. Thirty five per cent of the new care homes in England and Wales were single sex. In mixed homes, segregation was often still the norm. There were reports that in mixed sex homes, those in charge were embarrassed by any romance that might develop between residents, and more embarrassed if that relationship was physical. There was evidence of feelings that in old age sexual needs or desires dissipate. Townsend comments,

It is true of course that the desire for sexual relationship may die completely in old age, especially among those who are infirm or disabled, but some people, and men more often than women, still feel the need to express affection and perhaps have physical contact with someone of the opposite sex. (p 141).

One quarter of the homes could accommodate married couples, but there are references to county councils refusing to give permission to married people living in a home. (p 140-42). Although an historical study, some attitudes and practices identified are prevalent today.

Sexual intimacy caused concerns for practitioners in the late fifties and sixties. Today sexual intimacy in residential care continues to present challenges for practitioners.

For these purposes, it is important to identify the nature of care homes or residential care. The terms are patronising and make assumptions that all residents are in need of care. As noted above, Mr Justice Harlan in his dissent in the American case of *Meyer v Nabraska* (37) considered the concept of the ‘home’ under the Constitution as embracing the whole ‘private realm of family life’. This included marital relations. The concept of the ‘home’ is one that has received little attention. Within a legal context, this is definitely the case. Although ‘home’ features in many areas of law, it is usually as a financial or physical asset, or for some older people an institutional setting often entered after a life changing event such as fall or deteriorating health. Even the term ‘matrimonial home’, that all-important ‘family asset’, is described in terms of functionality. The cold definition in the New Zealand case of *Giles v Giles* (38)‘(T)he matrimonial home of the parties is the dwelling house that was used at the date the parties separated as the only or principal family residence.' is typical (at 765). For most residents of a care home, it is their home, maybe their final home. It falls within Article 8 European Convention on Human Rights.

The emotional significance of ‘home’ is an important feature of our lives; although, the legal concept of home has received little attention. As laypersons we know that there is ‘no place like home’, that ‘home is where the heart is’, and that ‘our home is our castle’. Yet the legal concept of home cannot be captured so neatly, because of the particular qualities of home. Home is a subjective experience that is not quantifiable. This is true with equal force of care homes. In her review of care homes in Wales, the Older People’s Commissioner for Wales noted that,

Many Rapporteurs commented that the homes they visited often had a functional,

institutional and clinical feel, rather than being homely, comfortable and welcoming,

which can have a detrimental impact upon residents’ quality of life.(39)

Social interactions, including intimacy need personal space and an accepting and not critical culture. They are not nurtured in a functional and clinical setting. Care home design, and the culture within the home, are important in ensuring that residents have privacy and private space.(3)(40) Woolhead et al found that for older people dignity was challenged by way of negative interactions between staff and patients. There is a lack of privacy, poor communication and insensitivity to their needs.(41)

The Royal College of Nursing in the United Kingdom identified several reasons sexual intimacies in care homes are complex. Sexual issues are not considered a priority for older people, which mean that the sexual needs of older people are not discussed and rarely addressed in nurse training. The physical environment in care homes is not conducive to sexual intimacies. There is a lot of shared living space with little private space; the need to help residents and prevent injury to staff (for example, single variable height beds) does not offer opportunities for sexual activity. Loss of physical or mental capacity, a feature of care homes, can also be ‘challenging in terms of intimate relationships and sex…’ In addition, the care home regime, with an emphasis of standardised practice, obscures awareness of sexual needs.(17) One respondent to their survey said,

Emphasis is placed on appearance and ensuring that residents have a good standard of personal hygiene, clothing and access to a hairdresser. They all appear clean and tidy (whether they want to appear clean and tidy or not!) and there is emphasis (driven by the regulatory authority) on providing activities for the residents, but are we providing what the residents REALLY want?

The extent to which care home workers recognise the possible sexual needs or sexual preferences of older residents is questionable. In part, this may be because of the transient nature of the care home workforce, linked to the stress of doing the job. (42) There is a risk that care homes may run according to the priorities of the staff rather than those of residents and families.(43) This may extend to staff assessments of sexual needs or residents.(44)

A further problem is whether staff in residential settings are trained to identify sexual or intimate relationship needs, or to recognise that when they take place they are not always wrong or undesirable. Most residential care in England and Wales is provided within a regulatory framework by the independent sector rather than the public sector. In England over 85% of residential care is provided by independent providers.(45) Regulation 23(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 states,

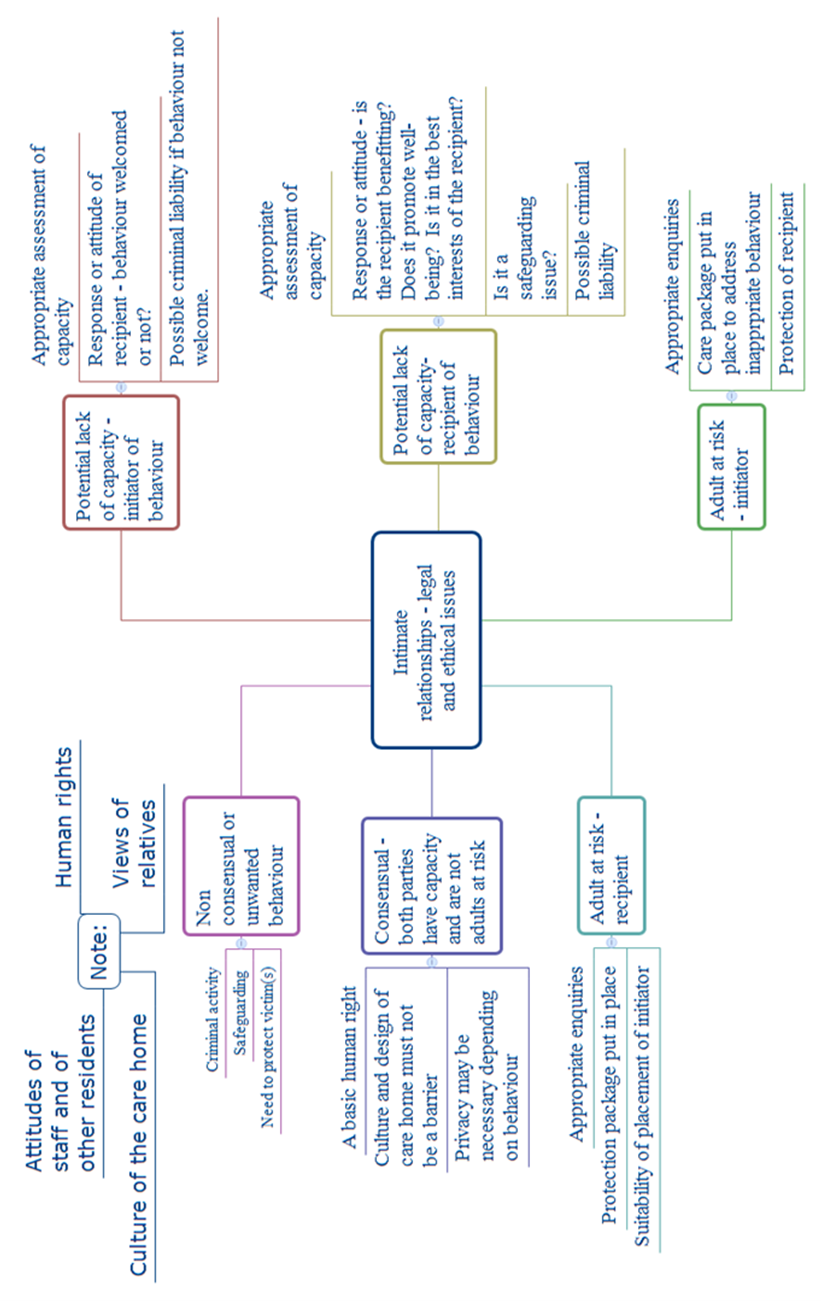
The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate training, professional development, supervision and appraisal.

The Care Quality Commission (CQC), the body with legal responsibility for inspecting and promoting higher standards in care homes, requires all providers of residential care to take account of and maintain residents’ personal relationships. This is one of two references to ‘personal relationships’ in this lengthy document.(46) (p.64). The CQC requires care homes to provide induction for staff, which includes addressing the rights of people who use the service. (p. 135) Another area of concern is the high turnover of staff; there is a sector staff turnover of 19%. This is accompanied by low pay and lack of emotional support for staff. (47) Demotivated and transient staff are unlikely to be aware of, be trained in, or sufficiently skilled to respond to the sensitivities of intimate relationships between residents.

# Legal and ethical issues

The practitioner’s response to the actuality or the possibility of an intimate relationship between residents in a care home requires a sensitive assessment of the legal and ethical issues involved. It requires the response (whether in the context of an individual case or the formulation of policy and guidance) to be driven by the following:

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| 1. Capacity | Those involved in such relationships must have capacity to consent. Assumptions as to capacity must be avoided; it must be assessed within the context of the relationship or its stage of development. Capacity to consent to sexual intercourse will differ from that required for lesser acts of intimacy such as hand holding or cuddling. |
| 1. Criminality | Practitioners must be aware that some forms of intimate behaviour may be criminal offences and residents must be protected. These include rape, offences under the Sexual Offences Act 2003 and the Sexual Offences Act 1956. The offence of harassment must be included – see Harassment Act 1977. |
| 1. Safeguarding and abuse | All care homes must have a safeguarding and protection policy. It is essential to be certain that any intimate relationship is not abuse. |
| 1. Equality 2. The views of relatives, carers, friends and practitioners | The Equality Act 2010 makes it illegal for the provider of a service to discriminate against a person on the grounds of sexual orientation. Providers, such as care homes, have a duty to promote equal opportunities for lesbian and gay residents.  Intimate relationships between older residents may cause distress to family members. They may expect their relative to be ‘protected’ from what they might see as unsuitable behaviour. Practitioners may also have reservations about any king of intimate behaviour arguing breach of their duty of care. |

No one case will be the same. The variables are many and include incapacity, nature of the behaviour, safeguarding, the views of others, duty of care and vulnerability. Figure 2 identifies some of key issues. In considering these in a particular case, regard must be had to human rights. Any response must be proportionate and legal. For a consensual couple, the emphasis must be on minimal intrusion (if any) and ensuring a supportive and non-judgmental environment. Where incapacity is involved, or one or both are adults at risk, greater involvement is required. However, it must not be predicated on the basis that intimacy is *per se* wrong and to be disapproved of or prevented, although it may require monitoring so that behaviour does become unwanted or abusive. Hand holding or cuddling, and more, may be beneficial for a couple who lack capacity, although it may (not must) be wrong for the relationship to develop any further.

*Fig 2 Issues to be considered in responding to intimate behaviour between older residents*

# Challenges for practitioners

Practitioners cannot afford to ignore the possibility of intimate relations within residential care settings. To do so poses two risks. The first is that the culture and physical environment within a care home setting is not conducive to, or hostile to the development of such relationships. Second, such relationships may develop in circumstances where they are abusive or even criminal. The Royal College of Nursing in its guidance asks how confident nursing staff are in dealing with sexuality and intimate relationships of older residents in care homes. It also recommends practitioners identify their strengths and weaknesses through discussion with their peers. It uses the P-LI-SS-IT model as a basis for its defined level of competence in this area. (17),(48),(49) There are four levels to this model.

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| *Level 1* | Permission – it is implicit that issues relating to intimate relationships are acknowledged within a home – the environment, culture, practices and attitudes communicate that they are integral to living; |
| *Level 2* | Limited information – general information is available to residents, family and staff. Access to specialist information is available when appropriate. |
| *Level 3* | Specific suggestions – opportunities to explore issues within a therapeutic relationship. Specialist advice and information available; and |
| *Level 4* | Intensive therapy - Professionals with specialist qualifications (for example, psychosexual counsellors or specialists in erectile dysfunction) offer intensive therapy. Practitioners support residents and monitor health and wellbeing. (17 p 12) |

This approach will provide a supportive and facilitating environment and meets human rights expectations.

# Conclusion

Intimate relations are a human right embracing private life, family life and home. Qualifying a person’s enjoyment of that right must satisfy article 8(2) ECHR and be proportionate. Increasingly social care legislation requires public authorities to *promote* well-being. Intimate relationships are a part of well-being. Regarding all intimate relationships within a care home setting as abuse, unethical and potentially criminal is ageist. A case-by-case approach is required. The approach must be sensitive to a wide range of factors; some are outlined in Figure 2. Intervention to prevent an intimate relationship developing or progressing must be carefully thought out, otherwise it is unlawful and violates the right to family life and home life. Sensitivity is required in explaining relationships to relatives and friends who may be appalled by the thought of their older relative having any form of intimate relationship. Practitioners need to address any personal issues they may have about relationships. They also need training and support so they are confident in the assessments they may make, including identifying risks. Good record keeping is essential.

The fact we live longer is something to be celebrated.(50) Part of that celebration is the recognition of the right of older people to enjoy and benefit from intimate relationships without fear of condemnation, qualified only by compelling reasons for interfering.

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