Supporting Sexual Health and Intimacy in Care Facilities: Guidelines for Supporting Adults Living in Long-Term Care Facilities and Group Homes in British Columbia, Canada

Vancouver Coastal Health Authority,
July 15, 2009

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Table of Contents

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Executive Summary

Care facilities have an ethical and legal obligation to recognize, respect and support clients' sexual lives. "Supporting Sexual Health and Intimacy in Care Facilities," proposes guidelines aimed to help administrators and clinical leaders in care facilities and group homes develop their own guidelines to support healthy and safe sexual expression for adults living in these facilities. Funded by The Public Health Agency of Canada (Sexual Health and Sexually Transmitted Infections Section) and the British Columbia Ministry of Health (Healthy Children, Women and Seniors, Population Health and Wellness), a group of experts came together to develop these guidelines, which are grounded in clinical and ethical best practice, and the law.

The guidelines, which pertain to adults, age nineteen and above, living in care facilities in British Columbia (but can be readily modified for other jurisdictions) aim to:

- Describe the rights of clients.
- Explain the limits of what the law will allow.
- Clarify the facility's responsibility to care for clients and prevent foreseeable harm to themselves and others in the facility including care providers.
- Provide information regarding the issue of capability to consent to sexual activity.
- Define the roles and responsibilities of staff/caregivers.
- Describe staff education programs.
- Suggest means to provide privacy.

It is recommended that all adult care facilities, including nursing homes, group homes and assisted living settings in British Columbia use these guidelines to develop their own policies, procedures, and guidelines that reflect the particular culture of each organization/agency. As these guidelines deal with complex subjects and have been written for administrative staff or professional care providers, it is also recommended that facilities use the guidelines to develop policies and plain-language information guides for clients, families and front line staff.

How to Use The Guidelines

The *Guidelines for Supporting Sexual Health and Intimacy in Care Facilities* are intended for care facilities, including nursing homes, group homes, and assisted living settings in British Columbia, but may be useful in other care-giving settings and other locales. The Guidelines pertain to adults (age nineteen and above in BC) with mental or physical challenges and may be used as they are written or modified to meet the unique needs of individual facilities and their client populations. These client populations include, but are not limited to: seniors; seniors with physical disabilities; adults with cognitive challenges; adults with developmental disabilities, and adults with physical disabilities. While these guidelines were developed within a BC context and are based on BC law, they may be easily adapted for use in other jurisdictions within Canada.

Each guideline is supported by a legal and ethical rationale and a list of clinical (caregiver and/or facility) responsibilities.

These guidelines deal with complex subjects and have been written for administrative staff or professional care providers who may use them to develop policies and plain language information guides for clients, families, and staff. They may also be used to create comprehensive training materials and staff development curriculum to support policy implementation for frontline staff.

Each organization/agency needs to consider the perspective of their individual facility and staff complement when reading the information provided in this document. Recognizing that some sexual activities are not without legal or ethical risk, each agency will have to decide which of these risks are acceptable within their facility. These guidelines are meant to "guide" facilities not to dictate what they must or must not do.

Introduction

Intimacy and **sexual expression*** are integral parts of being human and are essential components of healthy living.[1] However, these important aspects of personal health and well being may often be overlooked or avoided when a person enters a **care facility** such as a nursing home, group home or assisted living residence.[2] This oversight may result despite the fact that age, disease, and developmental or physical disabilities do not necessarily diminish the desire for intimacy and sexual expression.[3] Moving into a care facility should not, in and of itself, equate to losing the opportunity to engage in intimate and sexual behaviors.

Comprehensive guidelines for **sexual health** and intimacy in care facilities are needed in order to ensure that the health and legal and ethical rights of **clients** and **staff** are properly addressed. The *Guidelines for Supporting Sexual Health and Intimacy in Care Facilities* provide guidelines for consistent standards of care within care facilities and clarify legal issues such as the ability to give consent for **sexual activity** (**sexual consent capability**) that concern **families** and **care providers**.

Although some health authorities[4] and care facilities[5] have developed principles and policies regarding sexual activity of individuals in care facilities, many facilities may not have had the resources and expertise to do so. As a result, client **sexuality** in care facilities may only be addressed when what is perceived as **problematic behaviour** arises.[6]

*** Bolded terms appear in glossary pp 51-53.**

[1] McCann, 2000: Weeks, 1986; Brown et al, 1994; Nye, 1999

[2] Berger, 2000: Earle, 2001; Lantz, 2001

[3] Dressel & Avant, 1983; Reinisch & Beasley, 1990; Starr & Weiner, 1981

[4] Relationships and Sexuality: A Guide to Policy for Individuals with Intellectual Disabilities and their Residential Service Providers, Regional Residential Services Society and The Nova Scotia Department of Health, Community Health Promotion Fund, 1998; Lottes and Kontula, 2000, New Views on Sexual Health: The Case of Finland, 2000; Northern Health Region Intimacy and Sexuality Practice Guidelines for Residential Care, draft 2006; Buttenschon, 1994: Hamilton, Ontario Working Group

[5] Hebrew Home for the Aged, Riverdale, New York; Providence Centre, Scarborough, Ontario; Shalom Village, Hamilton, Ontario, Reingold & Burros, 2004; Doyle, et. al., 1999

[6] Berger, 2000; Tabak & Shemesh-Kigli, 2006; Kuhn, 2002; personal communication, J. Bender, health psychologist, sexologist, and sex therapist, Sophia Rehabilitation Center, The Hague, The Netherlands, November 22, 2007

Sexuality is a value-laden, and generally private area of our lives. When sexuality is combined with institutional settings, what were once private matters must now be addressed in less-than-private environments.

As well, multiple values and beliefs about sexuality and disability,[7] sexuality and advanced age,[8] sexuality and reduced cognitive capability,[9] and sexuality and lack of privacy[10] add to the complexity of an already multifaceted subject. These guidelines aim to address those concerns. Facilitating healthy sexual behavior and allowing personal choice in care facilities demonstrates respect for individuals and can lead to better client outcomes.[11] As our population ages and more baby boomers enter facilities expecting to make choices and manage their lives, it will be essential to have clear policies and practices in place.

Addressing the issue of sexuality in care facilities may:

- Promote healthy sexual expression, thereby improving health and emotional status and the physical safety of all clients, including those with compromised cognitive function.
- Improve staff morale and safety by providing direction in the respectful support of sexual expression and management of potentially problematic sexual behaviours.
- Promote consistent standards of care within care facilities.

The *Guidelines for Supporting Sexual Health and Intimacy in Care Facilities* offer principles, clinical guidelines, and processes to promote best practice in supporting healthy expressions of sexuality by persons living in care facilities. The *Guidelines* encompass three perspectives: clinical, ethical, and legal. Each of these perspectives helps ground the discussion and supports the reasoning for all the suggested recommendations.

[7] Earle, 2001; Shrover & Jensen, 1998; Shakespeare et al., 1996

[8] Brown, 1994; Ehrenfeld et al. 1997; Evans 1999; Williams, 1999; Tabak & Shemesh-Kigli, 2006; Reingold & Burros, 2004

[9] Berger, 2000; Post, 2000, Tabak & Shemesh-Kigli, 2006; Kuhn, 2002

[10] Bermann, 2003; Glen & Jownally, 1995; Kaas, 1978; McCann, 2000

[11] Doyle, et al., 1999; Lewis & Bor, 1994; Mayers & McBride, 1988; Steinke, 1997; Turnstull, 1996

The *Guidelines* speak to such questions as:

What types of sexual expression can be supported in care facilities?

How should sexual relationships between persons with compromised cognitive function be addressed?

How can possible harm that may result from sexual activity be mitigated?

How can sexual expression be promoted with clients who have physical disabilities?

What happens when conflict arises between the personal values of clients and those of a staff member or the institution?

What if family members do not support the client's sexual activity?

What does the law have to say about clients engaging in paid-for sexual services in care facilities?

How can the privacy needs of clients be met?

What kind of staff training and support would be helpful?

The *Guidelines* make it clear that care facilities have an ethical and legal obligation to recognize, respect, and support clients' sexual lives. The *Guidelines* are intended to guide care facilities in knowing how best to support healthy sexuality with their clients, both those capable and those incapable of consenting to sexual activity, while supporting staff and care providers.

Guideline Development Process

Topics addressed by The *Guidelines for Supporting Sexual Health and Intimacy in Care Facilities* were identified by a focus group of health care providers from throughout British Columbia, persons with disabilities, older adults, representatives from advocacy groups, and experts in health care ethics and law who met in Vancouver in October 2006.

The *Guidelines* are based on the extensive clinical, ethical, and legal experience and expertise of the writers, an exhaustive international literature review, and personal communications about current practice with experts in the field in North America, Europe, and Israel. As well, The *Guidelines* have been reviewed by expert stakeholders and modified as per their recommendations.

Supporting Values

The following value statements underpin the clinical recommendations and responsibilities found within this document:

Sexuality is an integral part of the lives of all people and is a normal part of the lives of people living in care facilities.[12]

All persons are treated with respect, regardless of their age, sex, race or ethnic origin, disability, cognitive level, marital or family status, beliefs, sexual orientation, gender identity and expression, or socioeconomic status.

Feelings and capacity for sexual expression may continue with the most significantly impaired persons.[13]

People require a safe environment for sexual activity.

People have the right to make choices, as circumscribed by law and ethics, which caregivers may not agree with, or feel willing or able to support.

Dealing with clients' sexual expression should be respectful and caring and should not include revulsion, disdain, contempt, mockery or punishment towards the client.

Individual freedoms are preserved, as much as possible, in care settings.

[12] Shalom Village Intimacy and Sexuality Practice Guidelines (1997/2005)
[13] Shalom Village Intimacy and Sexuality Practice Guidelines (1997/2005)

The Guidelines

GUIDELINE 1: FREEDOM/AUTONOMY OF SEXUAL EXPRESSION

The maximum amount of freedom is supported for clients' intimacy and sexual expression, compatible with the law, ethics, and the safety of others and self. Expression of sexuality is a component of a healthy quality of life and admission to a facility, in and of itself, should not result in the restriction or deprivation of sexual activity.

Legal and Ethical Rationale for Guideline 1: Freedom/Autonomy of Sexual Expression

Persons who reside in care facilities should have the same rights within those facilities that they would enjoy while living in their own homes. After all, our culture consistently maintains that these facilities are their homes.

The ethical principles of respect for autonomy, non-maleficence (do no harm), beneficence (do good), and justice (be fair) provide direction to care providers to always act in the best interests of residents.

All human beings have inherent rights to physical and emotional intimacy as well as sexual expression. The vast majority of people are born with emotional and sexual needs and no one thinks, in principle, to question the exercise of these rights *per se*, as long as lawful sexual activity (see legal rationales in Guidelines 2-8), is occurring, and public decency is safeguarded.

According to Maslow's hierarchy of needs, sexual intimacy is a basic human need along with the other physiological needs to eat, drink and breathe.[14] The only real difference is that the latter three are essential to human survival. This does not bring the need for sexual expression within the scope of the duty to provide "necessaries of life" found in section 215 of the *Criminal Code of Canada*. However, there can be little doubt that the comparison is apt to the extent that people in facilities who are unable to leave the facility and live on their own should not be prevented from lawfully satisfying their sexual needs. Instead, they should be supported to the extent possible, within the limits of the legal system and professional standards and ethical codes.

The *Canadian Charter of Rights and Freedoms (Charter)* protects "freedom of association"[15] and the "right to … liberty and security of the person…."[16]

[14] Maslow, 1943
[15] Section 2 (d)

No Canadian court has been called upon to recognize the right to satisfy lawful sexual activities. However, the law allows human beings to do whatever is not specifically prohibited. Any attempt to deny non-prohibited sexual expression to people who are unable to remove themselves from a facility is contrary to section 15 of the *Charter*, which prohibits unequal treatment and discrimination based on a disability.

The *BC Community Care and Assisted Living Act* also supports the proposition that persons in care have sexual privacy rights.[17] Welch and Clements (1996) argue that sexual activity rights for institutionalized persons, including those who are involuntarily placed and/or incapable of making many other personal decisions, emanate from both the *Charter* (1982), and the common law. Specifically, they state that long-term care residents have a right to a private and dignified setting for sexual activity and that a failure to provide it "…amounts to denial of access to the right to sexual intimacy."[18]

CARE FACILITY/CAREGIVER RESPONSIBILITIES FOR GUIDELINE 1: FREEDOM/AUTONOMY OF SEXUAL EXPRESSION

We live in a liberal democracy where individuals are free to make decisions for themselves based on their own values within the limits of the law. People with intellectual disabilities are entitled to make their own decisions to the fullest extent possible and are entitled to receive the support they need to protect them from unreasonable foreseeable harm.

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[16] Section 7

[17] The Adult Care Regulations under the *Community Care and Assisted Living Act* (CCALA) S.B.C. 2002, chapter 75, contain the following relevant provisions:

(1) Section 6.10: "A licensee must provide to all persons in care a level of care and supervision that, in the opinion of the medical health officer, is appropriate to meet the needs of the persons in care."
(2) Section 9: "A licensee must develop and implement written policies to guide staff actions in all matters relating to the care of persons in care."
(3) Section 9.3(3): "A care plan must take into consideration the abilities, the physical, social and emotional needs … of the person in care."
(4) Section 9.4: "A licensee must ensure that staff respect a person in care's privacy..."
(5) Section 10.3: "A licensee must to the greatest extent possible while maintaining the health, safety and well-being of all the persons in care, ensure that (a) the personal privacy of each person in care is respected, and (b) the privacy of each person's in care bedroom, locker and storage area is respected."
(6) Section 10.5: "A licensee must, to the greatest extent possible while maintaining the health, safety and well-being of all the persons in care ensure that residents are able to (a) receive visitors of their choice at any time, and (b) communicate with visitors in private."
(7) Section 10.8 deals with abuse and specifically states in the definition of "sexual abuse" that this "does not include consenting sexual behaviour between adult persons in care."

Note: these regulations only apply to those facilities licensed under the CCALA.

[18] Welch & Clements**,** 1996: 276

Therefore, care facilities and their staff have a responsibility to:

Permit clients the maximum amount of freedom to make their own sexual decisions if considered capable of giving sexual consent. (See Guideline 2)

Affirm that people who are aging or who have illness, disability or dementia, are sexual beings and should be afforded the opportunity for sexual expression in the same manner as their equivalents in the general population.

Ensure that intake assessments and care plans reflect the inclusion of sexual and relationship needs.

Recognize that care facilities are clients' homes and that it is appropriate for them to carry out their sexual lives in their homes.

Respect the rights of clients to self-determination concerning relationships, sexual expression, and family planning. Clients have the right to seek out and participate in lawful sexual activities.

Intervene with clients' sexual activity only when it is warranted. That is, when the activity harms the client and/or when it harms others (see Guidelines 2 & 3).

Recognize the ethical responsibility of care facilities to support the sexual health of their clients.

Articulate a facility or agency philosophy of supporting clients' sexual health and intimacy needs as a part of supporting their overall health and quality of life. This philosophy may be included within a mission statement and as part of the general orientation to the facility.

Provide clients with opportunities to improve their quality of life, which may include promoting and supporting a healthy sexual lifestyle.

Adopt holistic and client-centered approaches to care and incorporate human sexuality as a vital component of clients' humanity.[19]

[19] Earle, 2001; McCaan, 2000

Create a process to support sexuality and intimacy by asking questions of and obtaining input from clients, families, and staff.

Enrich clients' opportunities for intimacy and touch by providing group social events, semi-private spaces for friendships and intimate relationships to develop, private spaces for sexual activity, and opportunities for partners to share a room regardless of marital status or sexual orientation.

Recognize the potential consequences that may result if sexual activity is restricted and/or private space is unavailable: i.e., sexual behaviours may occur in public and cause distress to staff and other residents as well as embarrassment to clients themselves. Subsequently, a client's need for sexual touch may go unmet, which in turn may create decreased feelings of well-being and increased feelings of loneliness and depression.[20] In addition, decreased interaction with others may increase agitation and other potentially problematic behaviours.

Ensure that the agency philosophy about supporting the sexual health of clients is clearly articulated to both potential and existing care providers.

Ensure that care staff and family are aware that unless the law specifically prohibits a sexual act, then clients are allowed to engage in sexual activity.[21]

Provide a plain language guide to prepare clients and their families and assist with the decision-making process. This guide should be available in the languages most commonly used by clients at that facility. The guide could be made available during pre-admission so that clients and families can be reassured that harm will be prevented and rights supported.

[20] Roach, 2004
[21] Everett, 2008

GUIDELINE 2: CAPABILITY OF MAKING CHOICES – WHO MAKES THE DECISION?

Clients are presumed to be capable of making choices for themselves, including making decisions about sexual activity, unless determined otherwise. The role of substitute decision makers, including family, is unclear in the area of sexual activity and decision-making, and requires careful consideration. Where it is determined that a client has no sexual consent capability any legal risks should be considered as well as whether allowing the activity to occur can be ethically justified.

Legal Rationale for Guideline 2: Capability of Making Choices – Who Makes the Decision?

British Columbia legislation does not refer to consent for sexual activity, let alone specify a test to determine whether a person is able to consent to sexual activity. If a test were to exist it would likely be similar to the common law test of capability of consenting to any activity (most often to health care), which is whether or not the person has the capacity to understand the "nature and consequences" of their decision. This is similar to the criminal law test of capability to give consent to sexual activity which has been referred to "having full knowledge and appreciation of the consequences" (see further below).

If a person is involved in a sexual activity with another person, since this would ordinarily involve physical contact, the common law requires a consent to that touching. Most often this would not be an expressed consent but an implied one where it can be reasonably inferred from the circumstances that, if a specific consent had been sought, the person would have consented. British Columbia legislation, following the common law, presumes that a person is capable of giving consent. [22]

In other words, it must not be assumed that just because a client has been diagnosed with a condition, which may interfere with decision-making, the person is not capable of giving a valid consent to sexual activity. Although clearly the obligation to obtain consent is that of the people who contemplate having sexual contact with each other, if these people or one of them is a client in a facility and there is some concern about their capability to consent, the facility owes a legal obligation to be vigilant about the incapable client and take reasonable steps to protect him or her. [This will be further discussed with respect to provisions of the *Criminal Code of Canada* and the British Columbia *Adult Guardianship Act.*]

[22] Given that capability is assumed, how is incapability determined? This is a complex matter, although for most purposes the common law principles of understanding the nature and consequences of the decision to be made apply.

Since there is no legislated or common law test with regards to sexual consent capability, it follows that there is no legislation that expressly provides for substitute decision-making in this respect. Therefore 'temporary substitute decision-makers'[23] under the B.C. *Health Care (Consent) and Care Facility (Admission) Act* (HCCCFAA) are not legally authorized to make substitute decisions regarding sexual activity. This may confuse family members who almost always become such 'temporary substitute decision-makers' since they are asked to give substitute consent to health care. [24]

Obviously, if a person gives their representative specific authority to make substitute decisions with respect to sexual activity or if a court grants such authority to a personal guardian, those substitute decision-makers would be able to make such decisions. It seems unlikely that this will happen other than perhaps sporadically, but if this is the case, it should be clearly documented for staff.

It should not be forgotten, of course, that even if it is determined that a particular substitute decision-maker has authority to give substitute consent to sexual activity and prohibits it for the person for whom they are the decision-maker, often it will be difficult from a practical point of view, to prevent all such activity. From a risk management perspective a care facility that finds itself in the position where they are told to prevent such activity needs to point this out to the decision-maker. More troublesome, as discussed below, even if a substitute decision-maker would have authority to give consent to an incapable person's sexual activity, this would not preclude the laying of charges for sexual assault against the other person involved in the activity although it likely would prevent an action for damages.

As pointed out above, it is the person who is proposing to have sexual contact with another person who has the obligation to obtain consent to such contact. Failure to do so is unlikely to result in legal action for damages against such a person but is not impossible. Legal action against the facility arising out of such a situation is even less likely but also not impossible. A plaintiff would have to prove that the facility knew or should have known that such contact was likely to happen and should have taken reasonable steps to protect the incapable person from that contact.

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[23] In British Columbia, if a substitute decision maker is appointed by a client this would be a "representative" and if appointed by a court this would currently be a "committee of person"

[24] As to whether the amendments to the *Representation Agreement Act* and the *Adult Guardianship Act* contained in the *Adult Guardianship and Personal Planning Amendment Act, 2007* (Bill 29) will be sufficient to allow a representative or personal guardian (a term which will supersede the archaic "committee of person") to make substitute decisions with respect to sexual activity of an incapable client, this will require further legal scrutiny.

As regards possible criminal repercussions, it is the perpetrator who would be prosecuted. This could happen if the person him or herself was capable of understanding that the person with whom they were about to have sexual activity was incapable of consenting. Technically, in fact, since the criminal law as has often been said, is a "blunt tool", anyone engaging in sexual activity in the broadest sense with another person can be accused of "sexual assault" within section 271 of the Criminal Code of Canada and convicted if it can be proven that the other person had not given consent. Section 273.1 of the *Code* makes clear that reliance on the fact that the other person is not objecting is insufficient to avoid being charged and convicted if it is determined that "the complainant [was] incapable of consenting to the activity". Moreover, according to section 273.2 he or she has to take "reasonable steps…to ascertain that the complainant was consenting." Although the courts have repeatedly stated that whether or not a complainant had sexual consent capability depends on the facts of each situation, in *R. v. R. (R.)*, 2001CANLII3091, the Ontario Court of Appeal, after referring to the test of capability mentioned above, also stated: "...where one of the participants has demonstrable mental limitations, the threshold of responsibility escalates exponentially." In one very recent case the Manitoba Court of Queen's Bench found a complainant to have been capable of giving consent to sexual activity in part because "she also seemed to understand what a condom is, what it means to ejaculate and the language she used and tone of her voice suggested she had a relatively good understanding of the nature and consequences of sexual activity". (*R. v. Prince,* 2008CANLII241)

As mentioned before, it is the perpetrator who runs the risk of criminal prosecution. However, when becoming aware of the possibility that sexual assault might be happening on its premises, a facility owes a duty to protect the incapable client to the extent it is within its power to do so. If it does not, anyone, including a staff member, can, in addition to calling the police, in British Columbia report the grounds for believing this is the case to a "designated agency" under the *Adult Guardianship Act* since "sexual assault" is specifically part of the definition of "abuse" that may be reported. Unlike the situation in several other Canadian provinces, the B.C. *Adult Guardianship Act* does not make reporting of abuse or neglect mandatory. However, there can be no doubt that, since reporting is encouraged and there is a clear avenue to do so, it would be considered to be a breach of the duty of a facility to protect its potentially vulnerable clients if it did not report the circumstances.

A brief mention of the type of situation, which may well be the most common one occurring in facilities, is in order. This involves sexual activity between two persons both of whom lack sexual consent capability. It is clear that if the first person to make physical sexual contact (who could normally

be charged with sexual assault) was at that time "suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act ...or of knowing that it was wrong" (section 16 (1) of the *Criminal Code*) no charges should be laid or conviction take place.

In the same situation if a civil action for damages were to ensue, as mentioned above, the facility where such activity occurs might be sued in negligence. For such an action to be successful, it would have to be shown that the standard of care was breached, that damages were suffered and that those damages were caused by the negligence of the facility. This includes that a court has to find that a 'reasonable' facility would have both foreseen and have been able to prevent the particular situation.

If the initiator of the activity, i.e. the first person to make physical contact with the other, is incapable of understanding the nature and consequences of their actions, it is highly unlikely that they will be found liable. This was for a while not as clear as under criminal law because of conflicting court decisions. Some courts may have given greater weight to the desirability of compensating innocent victims than to the defendant's lack of ability to understand the nature and consequences of their actions.[25] However, more recently, there appears to be more consistency in approach.[26]

Although no one would question the importance of these laws in order to prevent sexual exploitation they can become both legally and ethically problematic in specific situations.

Ethical Rationale for Guideline 2: Capability of Making Choices – Who Makes the Decision?

As noted in the foregoing legal rationale, the law speaks predominately to the issue of sexual assault and gives little positive direction or guidance in addressing the issue of sexual activity in care facilities. The law assumes capability unless proven otherwise, but gives little guidance in determining who is capable and who is not in respect to consenting to sexual activity. Regardless, there is an expectation that facilities are vigilant regarding incapable clients.

Despite the lack of legal direction, care facilities are faced on a regular basis with situations involving sexual activity and must, of necessity, make decisions about how to address them. Unless a given facility takes an

[25] The Alberta Court of Queen's Bench decision in *Wenden v. Trikha* (1991), 118 A.R. 319.

[26] The Alberta Court of Appeal decision in *Fiala v. MacDonald* (2001) 201 D.L.R. (4th) 680.

exclusively risk averse approach to this concern and prohibits all sexual activity, it will need some sort of framework with which to address the issue of sexual activity. These Guidelines propose an approach that is based on ethical considerations and process. The proposed approach strives to protect those in need of protection while allowing those who would, on balance, receive benefits from a sexual relationship, to engage in such a relationship.

Criteria for determining sexual consent capability

These Guidelines propose[27] that for individuals to have sexual consent capability and the right to engage in sexual activity *with another* with no third party intervention (e.g., the health care team), they must meet the following five criteria[28]:

1. Have basic sexual knowledge, such as the differences between male and female anatomy and function, and knowledge of the nature of sexual activity.
2. Understand the possible consequences, including risks, of the sexual activity to themselves[29] and their partners.
3. Have the ability to understand appropriate and inappropriate locations and times for sexual activity.
4. Possess the ability to express a personal choice and to resist coercion.[30]
5. Possess the ability to recognize distress or refusal in a partner and stop the activity.

These criteria, although relatively conservative, are not intended to prohibit sexual activity between individuals where one or more parties do not meet them. The criteria are intended solely as a benchmark to indicate when

[27] Although the law is not clear on this point, these proposals are made on the basis of the best ethical, legal, clinical advice and incorporate suggestions from an international literature search on the topic. The law is unclear because the issue has not yet been considered in the courts. Ethical and clinical standards support making decisions as a reasonable person would. This means that, faced with the same situation and clinical data, a similar caregiver would come to the same decision. If there is no relevant legislation and/or case law, the court will consider existing professional and ethical standards to determine what legal standard should apply.

[28] Kennedy 2003, Kennedy and Niederbuhl, 2001

[29] Is the client aware that unintended consequences could occur such as pregnancy or sexually transmitted infections? Can the client understand the information that is relevant to making the decision and appreciate the reasonable foreseeable consequences of a decision? Lichtenberg, 1997; Everett, 2008

[30] For example, the capacity to say no verbally or indicate nonverbally (or via augmentative communication strategies) to unwanted sexual contact, and/or the ability to differentiate between pleasurable/not pleasurable and abusive/not abusive sexual touch.

others (e.g., the health care team) may ethically intervene (perhaps temporarily to allow planning time, provide education and ensure that foreseeable risks of harm have been reduced to a reasonable level) in sexual activity between persons in a care facility.

Any intervention will require assessment of the unique circumstances of the client with a view to develop a client-centered plan (in conjunction with the client and/or family) that will support sexual activity while reducing foreseeable risk of harm to a reasonable level. For example, the health care team should determine if the client could be assisted through education in order to avoid exploitation and give consent before a final decision is made about sexual activity. (See Guideline 3 for determining the criteria and process for intervening.)

In part, sexual consent capability criteria 2, 3, and 4 also apply to individuals engaging in solitary sexual activity. Again, the criteria are not intended to restrict solitary sexual activity but to ethically "allow" others to reduce risk of harm should it be occurring and is not understood. Examples of activities that might be of concern include repetitive behavior causing genital abrasions or use of unsafe stimulation devices.

When considering whether an individual who does not meet the above criteria can resist coercion and express a personal choice, the notion of assent is important. **Assent** is the ability to express agreement and may be overt or implicit.[31] Even if individuals are not able to actively give consent to sexual activity, if they are able to object to other things they do not want by either words or behaviours, and if they do not object, they may be seen as assenting to sexual activity. Evaluating assent will be highly dependent on the individual circumstances of clients.

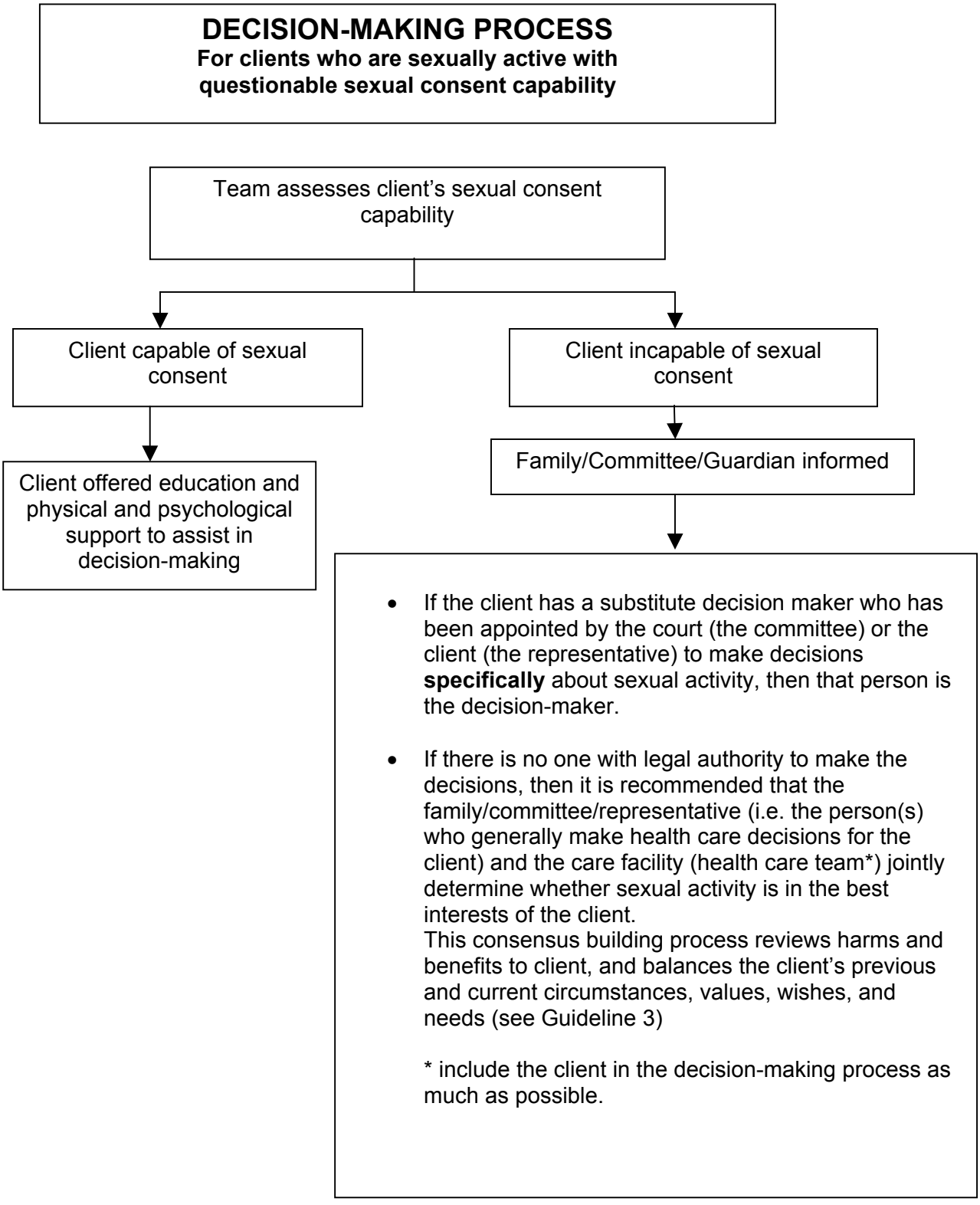
Determining the Decision Maker

As per the preceding legal rationale, if a client has a substitute decision-maker who has been appointed by the court or the client specifically to make decisions about sexual activity, then that identified person is the decision-maker about sexual activity. In the absence of such a person, the law gives no guidance about who can make such decisions. These Guidelines propose that the facility and the person or persons (substitute decision-maker(s)/significant others) who generally make health care decisions for the client should make the determination as to what ought to be done from an ethical/risk management perspective. The facility has a role in the decision as it has a duty of care to the client and an ethical duty to strive to

[31] Northern Health Authority (BC) Intimacy and Sexuality Guidelines, 2006

improve quality of life for residents. Although the substitute decision-makers have no legal right to make these decisions, the decision is unlikely to be acted upon successfully without the substitute decision- maker's support. It is recognized that this may be a complex process that may require consultations with experts such as sexual health clinicians, ethicists, and mediators. Involving the substitute decision-maker /significant others early in the process can help alleviate fears about their loved one in this value-laden area, and make a collaborative process between the care team, significant others, and the client more likely to be successful.

In deciding whether or not to permit sexual activity, the facility and substitute decision-makers will consider the physical, psychological, and emotional harms and benefits of sexual activity and, whether on balance of harms and benefits, sexual activity is in the best interest of the client. (See Guideline 3 for the considerations in making this determination.) Even if a consensus cannot be reached, a course of action must be chosen by the decision-makers in order to address the given situation. Each case needs to be considered individually and there may be times when the facility goes along with a family decision they do not agree with if it is the least stressful for the client. Options such as transfer to another facility may also be considered.


DECISION-MAKING PROCESS
For clients who are sexually active with questionable sexual consent capability
Team assesses client's sexual consent capability
Client capable of sexual consent
Client incapable of sexual consent
Client offered education and physical and psychological support to assist in decision-making
Family/Committee/Guardian informed
If the client has a substitute decision maker who has been appointed by the court (the committee) or the client (the representative) to make decisions specifically about sexual activity, then that person is the decision-maker.
If there is no one with legal authority to make the decisions, then it is recommended that the family/committee/representative (i.e. the person(s) who generally make health care decisions for the client) and the care facility (health care team*) jointly determine whether sexual activity is in the best interests of the client.
This consensus building process reviews harms and benefits to client, and balances the client's previous and current circumstances, values, wishes, and needs (see Guideline 3)
* include the client in the decision-making process as much as possible.

CARE FACILITY/CAREGIVER RESPONSIBILITIES FOR GUIDELINE 2: CAPABILITY OF MAKING CHOICES – WHO MAKES THE DECISION?

Respect the right of clients with sexual consent capability to engage in sexual activity that is not illegal after education and supplies are offered.

For clients who are capable of sexual consent, revealing private information to the family or others not directly involved in client's care violates client confidentiality.

Respect that clients who are not capable of sexual consent are sexual beings.

For clients who do not have sexual consent capability, communicate with the family/guardians early and often. Open communication helps to promote the family's trust with the facility as opposed to a situation where the family becomes aware of the sexual activity at a later time or from a different source.

Educate caregivers regarding the potential for cognitively impaired clients to demonstrate non-intentional sexual behaviour (e.g. such as a grasp reflex or reaching out to staff and inadvertently touching breasts or buttocks), as well as the potential reasons for disinhibited verbal or physical sexual behaviour, and how to manage these.

If situations cause the staff distress, provide support and opportunity for staff to debrief.

GUIDELINE 3: INTERVENING TO REDUCE RISK OF HARM

Reasonable care is taken to protect clients from foreseeable risk of harm arising from sexual expression. An approach to reduce the risk of harm is used with respect to risk to others and self. Interventions to reduce risk of harm range along a continuum, from provision of information to prohibition of activities. The type of intervention will depend on whether the client is capable or incapable of sexual consent, the reasonableness of the harm involved, and whether the risk is to self or others.

Legal and Ethical Rationale for Guideline 3: Intervening to Reduce Risk of Harm

Current law states that facilities and care providers owe a reasonable standard of care to the people who live in their facilities.[32] This includes a duty to prevent reasonably foreseeable risk of harm to anyone in the facility, in particular, to any person in care and to any person who is vulnerable because of a mental and/or physical disability.[33]

This must be "real" harm, which, in this context, means primarily physical harm, including justifiable fear of anticipated physical harm, but may also include emotional harm. Simply being offended because one disapproves of the behaviour involved does not constitute actionable or compensable harm. No one has the right to stop behaviour that is legally protected, such as same-sex sexual activities,[34] or that are not legally prohibited such as extra-marital relationships solely on the basis of disapproval or personal offense.

The appropriateness of intervening in clients' sexual activity depends on whether an individual is capable or incapable of sexual consent, whether or not the risk of harm is reasonable and whether the risk is to self or others.[35] All people, whether capable or incapable of sexual consent, are ethically allowed to engage in sexual activity that involves *reasonable risk of harm*, as they would in their own homes.

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[32] McSherry & Somerville, 1998; Everett, 2007

[33] The *Occupiers Liability Act*, which applies to anyone "who is in physical possession of premises, or who has responsibility for, and control over, the condition of premises, the activities conducted on those premises and the persons allowed to enter those premises" (section1), "owes a duty to take that care that in all the circumstances of the case is reasonable…that a person…on the premises…will be reasonably safe in using the premises." This duty of care refers to the "condition of the premises, activities on the premises, or conduct of third parties on the premises" (section 3).

[34] *Canadian Charter of Rights and Freedoms*

[35] Everett, 2008

Assessing whether risk of harm is reasonable

Reasonableness depends on:

The degree of probability that harm will result;

The seriousness of the harm;

The importance of the activity to the client;

The availability of less risky alternatives.[36]

Any assessment of reasonableness must include an assessment of possible steps that could be taken to reduce the level of potential foreseeable harm. Ideally, the reasonableness of the level of harm should be determined by an experienced group of interdisciplinary care providers, in consultation with the client and (if not capable of giving sexual consent) their families.

Ethically, assessment of the importance of sexual activity for clients incapable of giving sexual consent should be based on considerations of the individual's past and present circumstance.[37] Holding clients to the standards that they might have had when capable of sexual consent will not best serve some clients' well-being while others will be best served by supporting their past values.

Conditions for intervening in clients' sexual activity

Any intervention that is applied in respect to clients' sexual activity must meet the following five conditions**:**[38]

1. The intervention must be effective (i.e. must decrease the risk of harm, be based on sound judgment, and standards of care and/or evidence-based medical practice). For example, condoms can be provided to reduce the risk of contracting or transmitting a STI, and safe and effective contraceptive options can be provided to prevent unwanted pregnancy.

2. The intervention must not create harms greater than those it intends to prevent. For example, creating private space for one client must not interfere with another client's access to their

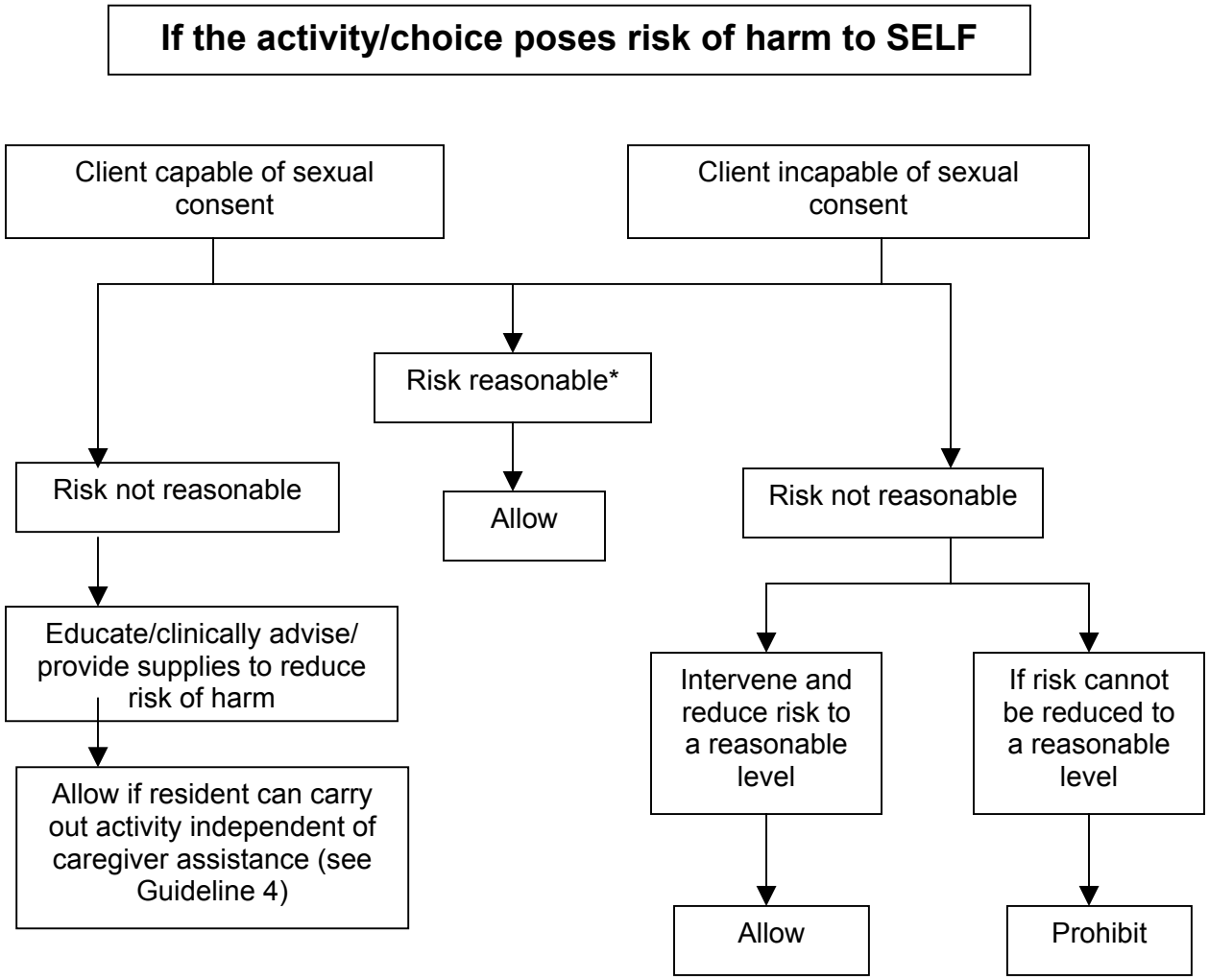
[36] Feinberg, 1986:2
[37] Berger, 2000; Post, 2000
[38] Browne, Blake, Donnelly & Hebert, 2002

room or private space, and sedation or mobility restrictions should not be used to prevent a client from giving unwanted sexual touch to another unless other less harmful options have been explored first.

3. The intervention must be the least intrusive that is effective. For example, when assisting a client to find private space for sexual activity involve as few people as possible in the arrangements in order to maintain privacy.

4. The intervention must not be discriminatory. For example, it would be discriminatory to intervene in client's sexual activity solely based on the fact that they live in residential settings.

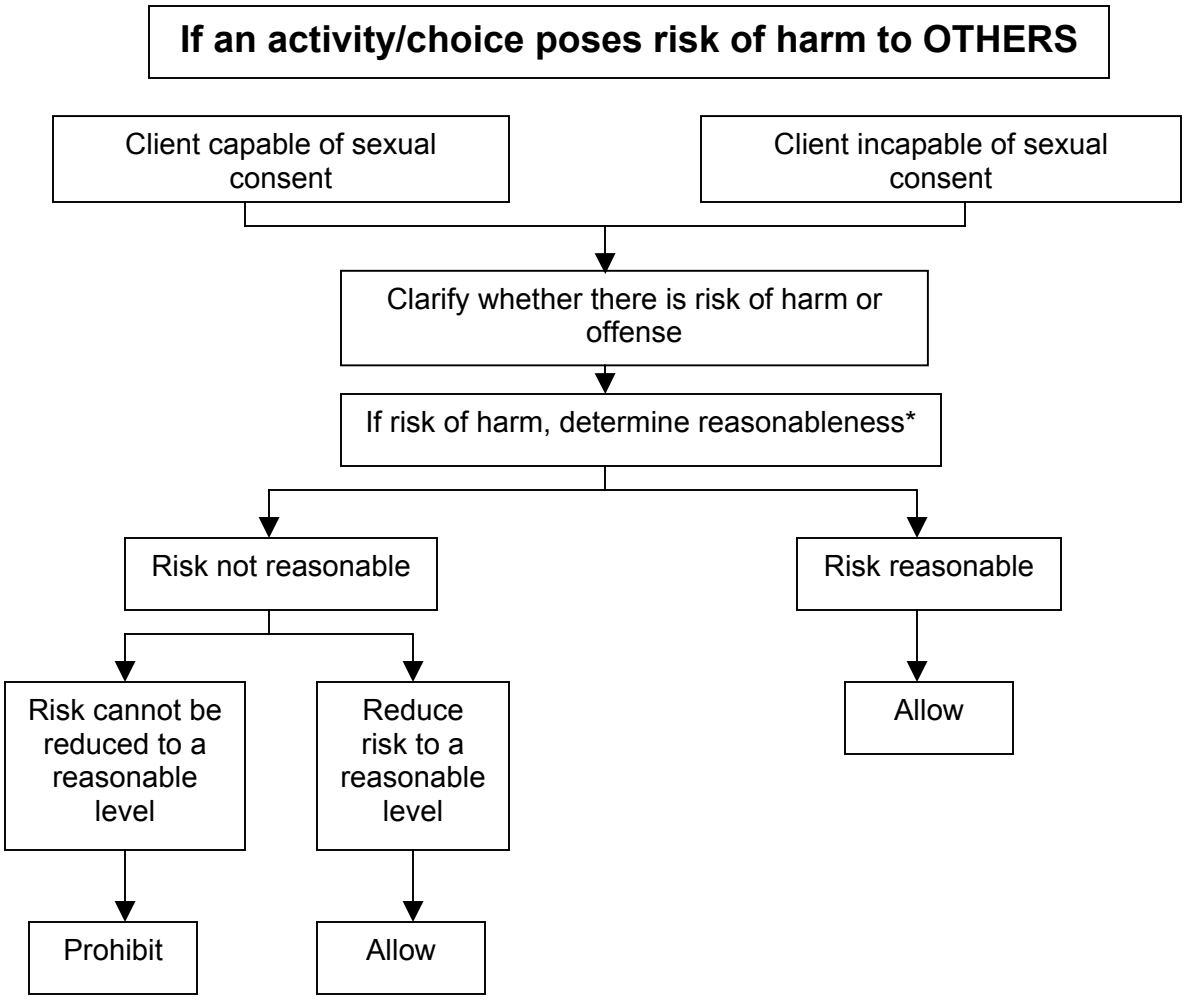
5. The intervention must be thought justifiable, if at all possible, to those on whom it is imposed. For example, whenever possible, explain to clients (either verbally or using appropriate communication devices) why interventions are necessary.



* Reasonableness depends on:

The degree of probability that harm will result;
The seriousness of the harm;
The importance of the activity to the client;
The availability of less risky alternatives.[39]

[39] Feinberg, 1986:2



*Reasonableness depends on:

The degree of probability that harm will result.
The seriousness of the harm.
The importance of the activity to the client.
The availability of less risky alternatives.[40]

[40] Feinberg, 1986:2

CARE FACILITY/CAREGIVER RESPONSIBILITIES FOR GUIDELINE 3: INTERVENING TO REDUCE RISK OF HARM

Clients capable of sexual consent

Provide access to accurate information to help clients capable of sexual consent make informed decisions about sexual activity.

Ensure medical supplies and/or equipment are available to protect against sexually transmitted infections and pregnancy; minimize physical risk of harm, and maximize independence with sexual expression.

Provide assistance as appropriate for clients with physical disabilities (see Guideline 4).

Recognize that clients have the right to make choices about how they express themselves sexually, even if the chosen activity poses some risk of harm.

Recognize that some chosen forms of sexual expression may offend others but this does not necessarily qualify as real "harm". Nevertheless, actions can be taken to minimize potential offence to others. For example, should clients choose to access erotic magazines, posters or videos, encourage clients to keep them in private storage (such as a closet or drawer).

Clients incapable of sexual consent

Support clients (who are incapable of sexual consent) to reduce the foreseeable risk of harm to a reasonable level and provide information and medical supplies as necessary.

Take care to avoid using safety and protection from risk of harm as a blanket reason to restrict sexual activity unless there has been an appropriate assessment of the reasonableness of the risk of harm in each individual situation.

Consider if an inappropriate behaviour (e.g. public sexual activity) is occurring because of lack of support for less risky sexual activity (e.g. provision of private space) and take steps to remedy the lack of support.

Perform a thorough assessment to ensure that the client's behaviour is not considered inappropriate solely because of the values and beliefs of others, including care providers.

Ensure that assumptions about sexuality (e.g. men as sexual aggressors and females as vulnerable and in need of protection) are not affecting the decision-making process when evaluating the potential for harm. For example, be aware that some adult children might feel differently when considering sexual expression for their mother versus their father.

Intervene in the sexual activity of clients who are incapable of sexual consent in order to reduce the risk of harm to a reasonable level while honouring the five conditions of interference (see pp. 27-28). Prohibit sexual activity when the risk of harm cannot be reduced to a reasonable level.

Act in the least intrusive and most respectful way to prevent potential harm. For example, if a staff person discovers sexual contact between clients with cognitive impairment, staff must intervene to assess harm. Using a calm, respectful approach, staff can sensitively intervene while maintaining the privacy and dignity of the clients involved.

FACILITY RESPONSIBILITIES TO STAFF FOR GUIDELINE 3: INTERVENING TO REDUCE RISK OF HARM

Create a process for caregivers to be able to address difficult or perceived inappropriate sexual behaviour.

Educate caregivers that if they take reasonable steps to identify and reduce potential harm (without needlessly interfering), they are likely to be acting ethically.[41]

Encourage caregivers to participate, where appropriate, in providing input in the process of identifying and reducing potential risk of harm.

[41] Everett, 2008

GUIDELINE 4: PROVIDING SEXUAL HEALTH INFORMATION AND ASSISTANCE WITH SEXUAL EXPRESSION

Clients receive appropriate sexual health information and care including, as determined to be appropriate, assistance with sexual activity.

Legal and Ethical Rationale for Guideline 4: Providing Sexual Health Information and Assistance with Sexual Expresssion

Given that sexual behaviour within a facility should be supported whenever possible, within ethical and legal limits, persons in care should be provided with information about how to safely engage in sexual activity and cope with their sexuality and needs within their specific context. Several of the provisions in the *Adult Care Regulations* (see Guideline 1) are broad enough to include not only the giving of information but also the care involved for sexual activity.

Ethically, a just society demands that everyone has the opportunity to participate in activities that may improve their quality of life. Care facilities have the opportunity to provide clients with the assistance they need to overcome those aspects of their disabilities that curtail opportunities for sexual activity.[42]

Staff already regularly support clients in their expression of healthy sexuality. Assistance with sexual activity may refer to anything from helping a client to wash and dress for a date, to pushing them in their wheelchair to a group facility activity, to helping them dial the number of their partner or spouse, to helping them position themselves on their bed for private self-stimulation. In fact, assistance with sexual activity, such as listed, may be viewed on a "scale of facilitation" for sexual activity, with the actions on the lower end of the scale, (such as providing privacy by means of curtains or closed doors) being generally less problematic for staff/facilities than those on the higher end, (such as assisting with positioning a couple with mobility challenges for the purpose of private sexual activity).[43] Assistance criteria should be clearly articulated within the policies/guidelines of the facility and be congruent with professional ethics and standards to avoid dilemmas for the staff.

For activities that are legal in our society, staff may provide support if the client is capable of sexual consent but unable to do this activity for

[42] Everett, 2005
[43] Earle, 2001

him/herself provided the activity is deemed to be a reasonable risk. For instance, in some institutions, obtaining sexually explicit materials or aids for a person in care may be considered appropriate. Although these guidelines encourage facilities to provide this support if requested by a client, it remains questionable if a staff member is obligated to do this. There is, however, nothing illegal about the obtaining of such materials or aids. Staff may require education and support to be comfortable assisting the client in this process while respecting the necessary professional boundaries and institutional policies.

For clients who are incapable of sexual consent, facilitating sexual activity can be even more complex. In these situations, caregivers, facility and family may be guided by what actions the person has performed historically, i.e. if there are no specific health instructions then it is the behavioural pattern of the client, (as well as current wishes), that can help guide decision-making regarding sexual activity preferences.

Staff members may have strong personal feelings or values about providing some forms of assistance. However, when it is appropriate for assistance to be provided, the facility has an ethical obligation to do what is possible to ensure that the assistance is provided.

Some caregivers may not be able to provide assistance if it is outside their scope of practice, or staff may feel that assisting clients with sexual expression is not part of their role. Incorporating comprehensive sexual activity guidelines into the philosophy of a care facility can decrease the time and energy that staff spend grappling with the decision-making process in the absence of policies.

Finally, the issue of clients accessing paid sex workers is a well-known clinical issue in facilities that has historically been difficult to address. It is beyond the scope of these guidelines to consider the debate of sex work in general. However, as accessing sex workers is a reality in facilities, it is prudent to include law relevant to this issue.

There are two common issues facilities grapple with. The first of these involves clients needing assistance to contact a paid sex worker. Since the Criminal Code provisions are broadly worded and there are no specific court cases addressing this type of situation, it is not possible to say with certainty that there could be no legal problems if a health care provider contacts a paid sex worker on behalf of a client who is capable of sexual consent. It is however unlikely that charges would be laid and highly unlikely that there would be a conviction, though not impossible, as this is the nature of criminal law.

The second issue is that of a health care provider finding a client in the company of a sex worker on the premises of the facility. There is no duty under criminal law or a civil duty of care that demands an intervention in this situation.[44] Furthermore, it is not illegal for this to be occurring on the premises. This does not negate the facilities responsibility to the client to ensure that the sexual activity that is occurring is within reasonable risk.

It is recommended that decisions about these concerns be addressed by the management of a facility, possibly after speaking with regulatory bodies or by obtaining specific legal advice about a particular situation.

CARE FACILITY/CAREGIVER RESPONSIBILITIES FOR GUIDELINE 4: PROVIDING SEXUAL HEALTH INFORMATION AND ASSISTANCE WITH SEXUAL EXPRESSION

Develop clear policies related to providing assistance with sexual activity/expression. A lack of clear policies could lead to safety concerns for both clients and caregivers. Encourage clear guidelines, consistent standards and open dialogue amongst caregivers as they deal with these issues. The failure to write a sexuality policy for the care facility places decision-making in the hands of individual caregivers who must make decisions on an incident-by-incident basis. This can be problematic because caregiver attitudes about sexual activity may vary widely and a lack of guidance may cause confusion and fear in both caregivers and clients. Where there are no guidelines, one caregiver acting alone runs a greater risk of professional censure and potentially legal implications if acting to support or limit sex and intimacy needs.

Provide clients with access to assessment, sexuality education and treatment of sexual concerns (including routine STI screening and testing) regardless of age/disability/cognition.

[44] Concerns are often expressed with respect to section 212 of the *Criminal Code* that prohibits several activities in connection with "a common bawdy-house." Clearly, a care facility is not a common bawdyhouse. The subsections dealing with prostitution concern themselves with inducing a person into prostitution or controlling them for the purpose of prostitution. On the face of it, subsection 1 (a) could cause some concern. It makes anyone guilty of an offence who "procures, attempts to procure or solicits a person to have illicit sexual intercourse with another person…." This concern disappears, however, once it is realized that there is no definition of "illicit sexual intercourse." This prohibition, therefore, pertains to activities that are already otherwise prohibited such as sexual intercourse with someone under the age of consent.

Conduct a complete sexual health assessment. This should include an assessment of physical and psychosocial sexual health concerns upon admission or shortly after admission. Many clients will deny sexual questions or concerns when first asked but are pleased to be acknowledged as a sexual person. Asking questions about sexual concerns also communicates a positive acceptance of sexuality and allows the client to feel free to raise concerns when and if they occur. As the clients are likely to reside in the facility long term it is important to reassess their needs and provide opportunities for open dialogue.

Respect the client's sexuality, including sexual orientation, gender identity and expression, marital status, illness, age and disability, in a non-judgmental and humane way.[45]

Assist clients to overcome aspects of their disabilities that curtail opportunities to have sexual lives by providing professional information, providing access to assistance with pre-and post- sexual care and supporting clients to have the materials and technology available so that they can carry out sexual activity that is not illegal on their own. (In some cases the facility may have access to sexual health professionals and/or occupational therapists and physiotherapists who can suggest specific strategies that may permit the client to carry out activities on his/her own.)

Boundaries for Caregivers When Providing Assistance with Sexual Activity

Be aware that there are limits to the type of sexual assistance staff can provide. It is the responsibility of staff to maintain their professional codes of ethics and act within professional boundaries and standards of practice.

This means that staff can assist with the set up and/or clean up for sexual activity BUT NOT participate in or be present during the activity itself. Assisting clients with care before and after sexual activity does not need to compromise staff/client relationships. It is important that both the staff member and the client understand that the assistance is being given in a care-giving capacity and not as a "friend" or "participant."

Prior to providing any form of assistance with sexual activity the caregiver needs to clarify the nature and extent of the involvement.

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[45] Welch and Clements, 1996

Institutions have an obligation to staff to provide access to education and support in order to adequately and safely do this.

Circumstances where assistance may be refused:

(i) The resident is incapable of giving sexual consent and the risks of harm to self and/or to others are unreasonable.[46]

(ii) The resident is capable of giving sexual consent and the risks of harm to self and/or to others of an activity are unreasonable. In this situation, because the resident cannot act independently and needs assistance from caregivers, those caregivers must have the ability to decline assistance, given that the assistance would support unreasonable risk.[47]

[46] Reasonableness depends on the degree of probability that harm will result, the seriousness of the harm, the importance of the activity to the client, and the availability of less risky alternatives. (Feinberg, 1986:2)

[47] ibid

Guideline 5: Informing clients and their families of sexual activity policies

Prior to admission, clients and significant others, as appropriate, are informed of the facility's policy regarding sexuality and sexual health.

Legal and Ethical Rationale for Guideline 5: Informing Clients and their Families of Sexual Activity Policies

Rarely is there clear legislation of the right to be given information about policies, including sexuality policies in a facility. The legal basis for the need to inform clients and families is extrapolated from the *Adult Care Regulations*, section 6.3: "The licensee must have…mechanisms in place to facilitate effective communication between persons in care and staff," as well as section 9: "A licensee must develop and implement written policies to guide staff actions in all matters relating to the care of persons in care."

Such communication should start when the care plan is first formulated.[48] The new provisions with respect to care facility admissions support this.[49] Once these legislative provisions take effect, section 21 will make clear that as part of the process to obtain valid consent to admission, a person or their substitute decision maker will have to be given "information about the care the adult will receive in the care facility [and] the services that will be available to the adult…." Also, providing information about such policies is included in the duty to provide safe care and a safe environment.

Regardless of the legislation, it is considered ethical practice to inform all prospective clients of facility policy so that they are aware and, if they have a choice, may decide whether they want to be admitted to that facility.

CARE FACILITY/CAREGIVER RESPONSIBILITIES FOR GUIDELINE 5: INFORMING CLIENTS AND THEIR FAMILIES OF SEXUAL ACTIVITY POLICIES

Provide the facility's policy on sexuality/sexual health prior to admission if at all possible. Preparation of a plain language document and access to a supportive staff member to answer questions will assist clients and families with communicating policies about capability, consent and limitations of rights as a substitute decision-maker. The presumption of capability to give consent unless proven otherwise should be clearly articulated in a sensitive manner.

[48] *Adult Care Regulations*, Section 9.3
[49] *Welch & Clements, 1996*

Provide staff members with information about the role of the family. Health care providers have many concerns about the role of families regarding client capability to give sexual consent and confidentiality. Clear guidelines and policies for staff may reduce the potential for conflicts with family members when trying to discuss sexual health issues/concerns.

Inform family members of clients with cognitive impairments about the facility's policy and educate them about possible disinhibition and common concerns as soon as is reasonable following admission. The family should be made aware of the confidentiality requirements and protection for the rights of the client and the fact that the facility is trying to balance the client's needs for sexual expression along with prevention of harm.

Provide clients and families with opportunities to raise concerns about sexuality and sexual activity in a private manner.

GUIDELINE 6: PROVIDING CLIENTS' RIGHTS FOR PRIVACY AND PROTECTION OF CONFIDENTIALITY

Clients have a right to privacy. A facility should be viewed primarily as a resident's home and secondarily as a workplace for staff. The right for privacy entails three components: privacy of information, privacy of one's body (as it pertains to personal care) and privacy of personal space.[50]

Legal and Ethical Rationale for Guideline 6: Providing Clients' Rights for Privacy and Protection of Confidentiality

Welch & Clements (1996) argue that sexual activity rights for institutionalized persons, including those who are involuntarily placed and/or incapable, come from both the *Charter* (1982), and common law. Specifically, they state that long-term care residents have a right to a private and dignified setting for sexual activity and that a failure to provide it "…amounts to denial of access to the right to sexual intimacy".

At the time Welch and Clements (1996) had to state that the *Charter* applies only to government institutions. That is no longer the case. In the following year the Supreme Court of Canada held[51] that the *Charter* applies to private entities if they are implementing a specific government policy or program. Therefore the conclusion seems inescapable that care facilities that are licensed, regulated and inspected under provincial legislation, in particular those that are also funded by the provincial government, directly or indirectly, must comply with the *Charter*.

The sections of the *Charter* that apply are section 7 ("Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice") and section 15 ("Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination based on race, nationality or ethnic origin, colour, religion, sex, age or mental or physical disability").

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[50] Relationships and Sexuality: A Guide to Policy for Individuals with Intellectual Disabilities and their Residential Service Providers, Regional Residential Services Society and The Nova Scotia Department of Health, Community Health Promotion Fund, 1998.

[51] In *Eldridge v. British Columbia (Attorney General)* [1997] 3 S.C.R. 624. It should be noted that facilities such as private, for profit, proprietors or corporations that likely would not be covered under the *Charter* would still have to comply with the *BC Human Rights Code.*

Although the courts have not yet expressed a clear constitutional "privacy" right, there is little doubt that section 7 supports such a right. This would also support the right for individuals who reside in care facilities to conduct their sexual activities in private. Moreover, section 15 would support the argument that since non-institutionalized persons have the ability to have private sexual lives, it is discriminatory not to provide persons in care facilities with a private and dignified setting for sexual activity since these facilities are intended to be as home-like as possible.

A care facility's responsibility to ensure that consensual sexual activity occurs in private comes from various sections of the *Criminal Code*. Sections of Part V define what is meant by a public place, disorderly conduct, nudity, causing a disturbance, indecent exhibition, and loitering.[52]

In a public place, the *Criminal Code* prohibits disorderly conduct,[53] nudity,[54] and causing a disturbance, indecent exhibition, or loitering.[55] McSherry and Somerville[56] argue that these prohibitions give hospitals and care facilities "the authority to restrict sexual activity, or at the very least, ensure that consensual sexual activity occurs in private."

From an ethical viewpoint, the facility has an obligation to provide residents with accessible and adequately equipped private spaces for sexual activity. In addition, caregivers have an obligation to reduce risk of harm or the possibility of illegal activity by redirecting clients to private spaces if they are carrying out sexual activity in public.

[52] Under the *Criminal Code* [Sections of Part V (i.e. "Sexual offences, public morals and disorderly conduct")] public place is defined as follows: Any place to which the public have access by right or by invitation, express or implied...
[53] Section 173(1)
[54] Section 174(1)
[55] Section 175(1)
[56] 1998:100-101

Privacy rights encompass three areas: Privacy of information, Privacy of one's body, and Privacy of personal space

1. Privacy of information

The right to privacy of information is outlined in the *Freedom of Information and Protection of Privacy Act*[57] and the *Personal Information Protection Act*.[58] Respecting the privacy of clients' information is essential. The need for privacy extends to privacy of sexual information.
Only those with a need to know in order to provide care should have access to this information.

2. Privacy of one's body

A basic premise of common law is the right to privacy of one's body. Clients must give verbal or implied consent to any care-giving activity that potentially invades this privacy.

3. Privacy of personal space

Lack of privacy within residential care facilities is an overriding concern for both clients and health care staff. Demographic pressure on the number of beds available acts to reduce space for private sexual expression and intensifies the issues that clients and staff face. In addition to the importance of providing physical private space, the concept of privacy and how it is viewed within care facilities needs to be considered.

CARE FACILITY/CAREGIVER RESPONSIBILITIES FOR PRIVACY OF INFORMATION

Uphold clients' right to privacy of their personal information.

Consult clients whenever possible in the process of determining who needs to know particular information.

Chart and discuss sexual concerns and activities with discretion and respect, i.e., on a need to know basis. While the need for appropriate documentation is understood, documentation should be objective and only be done when issues of harm or safety arise or for the purpose of

[57] *Freedom of Information and Protection of Privacy Act*, R.S.B.C., chapter 165. Please note that this act refers to all "public bodies" and the *Personal Information Protection Act,* S.B.C. 2003 is the equivalent legislation covering private bodies.
[58] *Personal Information Protection Act*, S.B.C. 2003, chapter 63

continuity of care. Clients fear being the subject of gossip within the care facility; it is important to model a respectful approach with them.[59]

With a client incapable of giving sexual consent, family members should be given an opportunity to communicate their concerns and be part of the decision-making process. Communicate early and often with the family regarding any concerns with sexual expression. However, in the instance of an adult client capable of giving sexual consent, revealing private information to the family violates client confidentiality. (Unless explicit and documented approval is given by the client to allow information to be provided to another individual.)

CARE FACILITY/CAREGIVER RESPONSIBILITIES FOR PRIVACY OF ONE'S BODY

Always ask permission to touch a client for any care-giving activity, or medical and nursing intervention.

Use appropriate and respectful draping for any personal care activity in which parts of the client's body may be exposed.

CARE FACILITY/CAREGIVER RESPONSIBILITIES FOR PRIVACY OF PERSONAL SPACE

Uphold clients' rights to access properly equipped private rooms for sexual activity.

Honour clients' rights not to be intruded upon in their own rooms or any space designated for sexual activity. If safety is a concern, ensure the client has access to a call bell or other alert system and always knock when entering the room.

Provide opportunities for partners to share a room where possible. The overall goal is to try to maintain the client's relationships and honour the couple's wishes, (regardless if one individual needs more care than the other).

Identify accessible private space even if it is space that can be booked for private visits and/or promote home visits or conjugal visits.

Provide recommendations to health care planners about space requirements and configurations of care to promote private spaces and

[59] McSherry and Somerville, 1998

opportunities for couples' accommodation when new residential care facilities are being developed or renovated.

Consider how clients can be provided with a way to communicate their need for privacy in a respectful and confidential way. For example, give clients an option to have discreet "do not disturb" signs to place outside their room.

Consider safety issues such as access to lifts, a bathroom, call bells, condoms, and lubricants to enhance pleasure and minimize risk**.**

GUIDELINE 7: PROVIDING PROCEDURES AND ADDRESSING CONCERNS REGARDING SEXUAL EXPRESSION

Legal and Ethical Rationale for Guideline 7: Providing procedures and addressing concerns regarding sexual expression

In the event of differing values and/or disputes about what is right, there should be a focus on fair process. The concept of procedural justice focuses on fair process. It is important that any process for addressing concerns about sexual expression does two things. First, it should make room for all relevant parties to have a fair say. Second, the process used to make decisions should be open and accountable.[60]

CARE FACILITY/CAREGIVER RESPONSIBILITIES FOR GUIDELINE 7: PROVIDING PROCEDURES AND ADDRESSING CONCERNS REGARDING SEXUAL EXPRESSION

Ensure that all of the following questions can be answered in the affirmative:

a) Does the process allow for all relevant parties to have a fair say?
b) Are the appropriate decision-makers identified?
c) Do the decision-makers have the necessary information to make a sound decision? Do they have the appropriate clinical, administrative, and legal background to understand the information or have ready access to those who can provide a contextual understanding?
d) Will those most affected by the decisions have reasonable opportunity to participate in the process?
e) Will decisions be communicated to all involved and impacted?

In the case of concerns about sexual activity there should be a concerted effort to minimize the number of staff involved in order to protect the privacy of the client.

Ensure the clients' right to privacy and confidentiality. Staff should understand that, while the concept of teamwork is supported, occasionally the clients' right to privacy and confidentiality takes precedence.

[60] The dispute resolution process outlined in the *Adult Care Regulations* section 10.14 can be consulted to assist in decision-making.

GUIDELINE 8: TRAINING STAFF/ CAREGIVERS FOR SEXUAL HEALTH CARE

Staff/Caregivers are trained to work with clients regarding issues of sexuality, including training for sexual health care that is provided.

Legal and Ethical Rationale for Guideline 8: Training staff for sexual health care

The overall aim of education curricula should be to promote a positive attitude towards healthy sexuality, sexual activity, and providing supportive sexual health care. Staff should be provided with ongoing education and support to understand and implement the sexuality/sexual health policies of the facility. This training would include skills and knowledge to provide sexual health care that is safe for the client and the staff member(s).

CARE FACILITY/ STAFF/CAREGIVER RESPONSIBILITIES FOR GUIDELINE 8: TRAINING STAFF FOR SEXUAL HEALTH CARE

Conduct regular education, including case reviews and discussions on sexuality and care-giving, preferably facilitated by an ethicist or clinician who has experience with values related to sexual activity.

Provide sexuality-related training for new and existing staff including a discussion of staff's responsibility to be respectful about clients' sexual lives (even if their own values differ) and obligation to support the facility's sexuality policies.

Educate and support staff in order to ensure successful implementation of sexuality guidelines and policies in the care facility.[61, 62]

[61] Fairchild, 1996

[62] There are a number of issues that need to be considered in terms of staff education and supports. Labour shortages, increased acuity of clients and limited access to educational programs result in an increasingly stressful work environment. People who enter health care professions care a great deal about their clients and do not intend to restrict sexual rights or freedoms but may not understand the implications of restricting sexual expression. Many staff were educated at a time when sexual activities were not discussed within their professional training program and/or were educated in other countries.

Develop an ongoing staff education program which could include:

a) Exploration of staff personal values, with reassurance that while they do not have to change their personal values, they should provide care as per the client's expressed wishes. The education program must be respectful of the staff's past history as well as their personal and cultural value system. [63]
b) Exploration of various forms of sexual expression, gender identity and expression, and sexual orientation.
c) An understanding that sexuality is an integral component of health and quality of life for most people. Age, disease, and developmental or physical disabilities do not necessarily diminish the desire for intimacy and sexual expression.[64]
d) Information about changes to sexuality following illness or disability.
e) The benefits of sexual expression to feelings of well-being, health and positive self-concept.
f) The benefits of supporting appropriate sexual expression to diminish inappropriate sexual behaviours.
g) Principles of how to discuss the subject of sexual health with clients and practice with conducting a sexual health assessment.
h) Rights of the clients to privacy including how to deal with the use of erotic materials in a client's private space.
i) Prevention of abuse and protecting clients from harm (including information on sexually transmitted infections and pregnancy).
j) Clarification of the roles and responsibilities of staff including discussion of provision of sexual assistance.
k) Professional boundaries regarding requests to assist in sexual activities or relationships.
l) An understanding of consent and capacity within the context of sexual health care.
m) How to communicate with families and relatives about the issue of sexuality and capability.[65]
n) Presentation of the facility sexuality policy and how administration will support decision-making regarding sexuality and sexual activity.
o) Direction and policy on when and how staff should access support and consultation regarding clients' sexual health issues.

[63] Reingold, 2004
[64] Mayers 1998
[65] Archibald, 2003

Conclusion

This document proposes guidelines underpinned by clinical, ethical and legal foundations, to be used by care facilities to develop their own policies, procedures, and guidelines to support sexual health and intimacy for their residents. Developing a framework that supports sexual health and intimacy in facilities will not only assist caregivers help residents engage in sexual expression that is healthy and safe, but will also improve the quality of residents' lives. Each of the eight guidelines contributes to improved health, emotional status and safety of residents, as well as improved caregiver confidence, skill and knowledge in providing sexual health care. By incorporating the principles, clinical guidelines and processes outlined in this document, facilities will promote best practice in supporting healthy expressions of sexuality of persons living in care facilities.

Guideline Reviewers

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Glossary

Assent

Capability in the area of sexual expression includes the concept of assent as well as consent. When considering whether an individual can resist coercion and express a personal choice, the notion of assent is important. Assent is the ability to express agreement and may be overt or implicit.[66] [67]

Even if individuals are not able to actively give consent to sexual activity, if they are able to object to other things they do not want by either words or behaviours, and if they do not object, they may be seen as assenting to sexual activity. Evaluating assent will be highly dependent on the individual circumstances of clients. There is no legal definition of the term "assent."

Care Facilities

There are many different terms used to describe care facilities. These guidelines are meant to provide recommendations for group homes, assisted living facilities, complex care, extended care, nursing homes, or any residential care facility.

Caregiver/Care Provider/Staff

The person providing care to the client within a facility whether it is direct care, provision of education or supervision of staff providing care. These guidelines are not meant to make recommendations for family caregivers, though they may be helpful in engaging and supporting family and clients in discussion and decision-making of complex situations. These terms will be used interchangeably throughout the document as necessary.

Client or Person in Care

The adult resident, patient or person receiving care in a facility. These guidelines do not specifically address the person in care who is receiving care in their own home although sections of the guidelines may be helpful for caregivers providing in-home care. These guidelines were written for adults receiving care and are not meant to address issues relating to the care of children and youth in residential settings.

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[66] Northern Health Authority, (BC) Intimacy and Sexuality Practice Guidelines, 2006
[67] There is no legal definition of the term "assent."

Family

An individual or group of individuals with whom the client shares a personal connection/bond. May or may not be blood related or related by marriage. Anyone who the client feels is significant to them.

Problematic Sexual Behaviour

Sexual behaviour that causes concern to families, care providers or other residents. It is important to consider whether the behaviour is harmful to the person participating or their partner, or is considered problematic because of another person's beliefs or values.

Sexual Activity and Expression

Sexual activity refers to ANY observable behaviour such as reading or viewing erotic materials, self-stimulation, touching others in a sexual way or by having oral or manual sexual stimulation or intercourse.

Sexual expression may include, but is not limited to, sexual activity. It may include behaviours such as, how people may express themselves through how they dress, how they communicate verbally and non-verbally, family and relationship roles, or simply holding hands.

Sexual Consent Capability

Sexual consent capability is the ability to consent to sexual activity and is assessed by considering whether the individual has:

Basic sexual knowledge, such as differences between male and female anatomy and function, and knowledge of the nature of sexual activity.[68]

An understanding of the possible consequences, including risks, of sexual activity to themselves[69] and their partners.

Have the ability to understand appropriate and inappropriate locations and times for sexual activity.

The ability to express a personal choice and to resist coercion.[70]

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[68] Kennedy 2003, Kennedy and Niederbuhl, 2001

[69] Is the client aware that unintended consequences could occur such as pregnancy or sexually transmitted infections? Can the client understand the information that is relevant to making the decision and appreciate the reasonable foreseeable consequences of a decision? Lichtenberg, 1997; Everett, 2008

The ability to recognize distress or refusal in a partner and stop the activity.

Sexuality

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.

Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.[71]

Sexual Health

Sexual health is a state of physical, emotional, mental and social well-being related to sexuality. It is not merely the absence of disease, dysfunction or infirmity.

Sexual health requires a positive and respectful approach to sexuality and sexual and social relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be protected and fulfilled.[72]

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[70] For example, the capacity to say no verbally or indicate nonverbally (or via augmentative communication strategies) to unwanted sexual contact, and/or the ability to differentiate between pleasurable and abusive sexual touch.

[71] World Health Organization, Gender and Reproductive Rights, 2002.

[72] World Health Organization, Gender and Reproductive Rights, 2002.

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