

Sexuality, Intimacy and Dementia

Supporting identity, dignity and relationships in aged care

A practical guide for residential aged care teams



FACILITATED BY

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DELIVERED BY

E4 People
Aged Care Staffing Specialists
Committed to upskilling the aged care
sector to deliver confident,
dignified dementia care.

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DEMENTIA TRAINING WORKSHOP SERIES

Welcome

FROM THE E4 PEOPLE TEAM

Across the Dementia Training Webinar series, we have brought together aged care professionals from across Australia to develop the skills, language, and confidence needed to provide dignified, person-centred dementia care.

This workshop, Sexuality, Intimacy and Dementia, was facilitated by Ashley Roberts, a Dementia Consultant with Dementia Support Australia (DSA), the behaviour management service operated by HammondCare. Ashley has approximately 20 years of experience in dementia care, completed his Master's degree on this subject in 2023, presented at the International Dementia Conference in 2024, and was published in the Journal of Dementia Care in 2025.

This is one of the most complex topics in residential aged care, and one of the least openly discussed. The new Aged Care Act, which commenced in late 2024, now explicitly requires providers to support residents to maintain relationships and to express their sexuality. This guide is designed to help your team think about that responsibility clearly, kindly, and well, with practical frameworks and the right language to use.

KEY TAKEAWAYS

- Sexuality is part of being human at every age, and continues to matter in residential aged care.
- A diagnosis of dementia does not automatically remove the capacity to consent to sexual activity.
- Language is the single most powerful lever for getting this right.
- The goal is to support residents' wellbeing, dignity, and dignity of risk, not to shut conversations down.

Acknowledgement of Country

E4 People and HammondCare acknowledge the Traditional Custodians of the lands on which we live, work, learn, and provide care. We pay our respects to Elders past and present, and extend that respect to all Aboriginal and Torres Strait Islander people.

We acknowledge that identity, connection and belonging are central to wellbeing. These same principles sit at the heart of every conversation about sexuality, intimacy and relationships in aged care.

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CHAPTER 01

Why this conversation matters, and why now

Sexuality, intimacy and relationships are part of being human at every age. They are linked to identity, self-worth, quality of life, and in most Western societies are considered a fundamental human right. None of that changes when someone moves into residential aged care, and none of it changes when someone receives a diagnosis of dementia.

Three things have shifted in recent years to put this conversation firmly on the agenda for every aged care provider in Australia.

The new Aged Care Act

Australia's new Aged Care Act commenced in late 2024. It explicitly expects providers to support residents to maintain relationships and to express their sexuality. Care home providers can no longer treat this as a private matter to be discouraged or worked around. The legal framework now matches what residents and families have always needed.

The baby boomer generation is moving in

Baby boomers were born between 1946 and 1964. They came of age during the sexual revolution, with widespread access to contraception, new pharmaceuticals such as sildenafil, and a more open public conversation about sex than any prior generation. The literature is clear: this cohort tends to place sexuality higher up the personal agenda than the generation before them.

It is now 2026. The earliest boomers are well into their seventies. People with younger-onset dementia from this cohort are already in residential care, and by 2041 we will be at peak boomer entry into aged care. The expectations boomers bring with them will test the sector.

The evidence is stronger than ever

Research on sexuality in older adults remained surprisingly sparse until Lindau and colleagues published the first major study in 2007, with a follow-up a decade later. The literature now consistently shows that most older adults remain sexually active and regard sex and intimacy as important to their life. There is no upper age limit to sexual responsiveness. The frequency and form may change, but the underlying need for closeness, affection and connection does not disappear.

"Sex does not disappear, it just changes form."

— *Ashley Roberts*

KEY TAKEAWAYS

- Sexuality and intimacy remain part of life for most older adults, including those living with dementia.
- The new Aged Care Act requires providers to support residents to maintain relationships and express their sexuality.
- The baby boomer cohort, now entering aged care, brings more liberal attitudes than the generation before.
- We are likely to see relationships of every kind in residential care, including same-sex relationships, far more often than we did ten years ago.

CHAPTER 02

Defining the terms

Most of the difficulty in this area comes from using a single word, sex, to describe a wide spectrum of human experience. Ashley uses a layered set of definitions that makes the work much clearer.

Sexuality

A core part of being human, linked to identity. It includes biological sex, gender identity, social roles, sexual orientation, and preferences. It is more than physical acts; it is who a person is.

Sexual expression

The way a person communicates their sexuality outwardly. This includes how they dress, how they wear their hair, makeup, the way they speak, their attitudes, and the way they carry themselves. Ashley shared a personal example: keeping his hair long is, for him, a meaningful part of how he expresses his sexuality, going back to his early twenties. The lesson for aged care is simple and serious.

"One thing you don't do in aged care is cut my hair."

— Ashley Roberts

Self-expression is identity. When residents lose control of how they dress, how they style their hair, what they wear to bed, or how their body is presented, an important part of their sexuality is taken from them.

Sexual interactions

Behaviour that occurs in a sexual context. This can include physical contact with another person, the use of sexual aids, erotica, self-pleasure, and other activities of this kind. Ashley deliberately uses the word "interactions" rather than "behaviours," because the word "behaviour" already carries a clinical, often pejorative connotation in aged care.

Intimacy and affection

Two words that should appear far more often in residential aged care documentation than they currently do. Ashley reviews care home progress notes several times a week and almost never sees the word “affection” written down. Intimacy can include physical closeness, but it also includes emotional connection, the way couples communicate, “love languages,” mutual support, and shared experiences. Affection includes a kiss on the forehead, a hand held for comfort, an arm rubbed, a hug at the right moment. None of these are sexual by default, but they are part of the same human spectrum.

KEY TAKEAWAYS

- Sexuality is identity. Sexual expression is how that identity is shown. Sexual interaction is behaviour that occurs in a sexual context.
- Intimacy and affection are not the same as sex, and should be named distinctly in documentation.
- Using “interactions” rather than “behaviours” reduces unhelpful clinical loading.
- How a resident dresses, wears their hair, or presents their body is part of their sexuality. Protect that, every day.

CHAPTER 03

Whose values are these?

When a relationship surfaces in residential aged care, it almost always brings other people's values with it. Culture, religion, philosophy, family history, education, our own upbringing, and our individual experiences all play a part in the way we react. None of these are wrong. They become a problem when they override the resident's own values without anyone noticing.

FROM THE WORKSHOP

Four scenarios from the field

Ashley shared four real referrals Dementia Support Australia has received in recent months. As you read them, notice your own reaction.

1. A married couple are kissing for a prolonged period in their own bedroom. Staff find this confronting and report feeling disgusted.
2. A husband visiting his wife in residential care is asked to leave the shared bedroom while she is undressed and changed. Staff describe this as protecting her privacy.
3. Two unmarried residents are in a consenting, affectionate sexual relationship. A team member from the same cultural background as one of the residents raises an objection on cultural grounds.
4. A daughter visits her mother and sees her smiling, holding hands and laughing with another male resident. The daughter takes issue with this because her mother never behaved that way with her late father.

In each case, the resident's rights and choices have been overlaid with someone else's values. The first job of the team responding is to notice that, and to ask whose values are actually in play.

"Once you are in aged care, a relationship goes from being something quite private to being everybody's business. That shift is usually about safety, but it gets tangled up with culture, religion, philosophy and family history very quickly."

— Ashley Roberts

KEY TAKEAWAYS

- Real referrals almost always involve other people's values as much as the resident's situation.
- Name whose values are present. Staff, family, cultural background, the institution, the resident.
- The resident's own values, history and current preferences are the anchor.
- Safety is a legitimate concern. It is rarely the whole story.

CHAPTER 04

Eight myths worth retiring

Ashley walked the workshop through a set of commonly held assumptions, each of which the evidence has now retired. They are worth printing on a staff room wall.

1. Older people, especially those with dementia, lose interest in sex. False. Frequency and libido can decrease with age, but most older adults remain sexually active and regard intimacy as important. There is no upper age limit to sexual responsiveness.
2. Sexual activity is not appropriate in aged care homes. False. Aged care homes are people's homes.
3. People with dementia cannot consent to sexual activity. False. People with dementia can have what the literature calls sexual consent capacity. Diagnosis alone does not remove it.
4. Sexuality only involves sexual intercourse. False. Sexuality includes expression, intimacy, affection and a wide range of interactions. Reducing it to intercourse blinds us to most of what is actually happening.
5. Same-sex relationships do not exist in aged care. False. They do, and the sector will see many more as the boomer generation moves in.
6. Expressions of sexuality by people with dementia are always inappropriate or problematic. False. The word "inappropriate" often masks a sexual behaviour that is, in fact, appropriate but simply happening in the wrong place at the wrong time.
7. Families and staff should always intervene to stop sexual relationships. False. Families and staff do not, in law, hold the right to consent to or prohibit another adult's relationship.
8. Aged care team members should always discuss sexuality with residents at admission. Not necessarily. For many residents, the conversation is more appropriate once they have settled in and built trust. The conversation must happen, but the timing is person centred.

CHAPTER 05

Why supporting relationships matters

Loneliness, isolation, under-stimulation and boredom are four of the most common drivers of changed behaviours in residential aged care. They are also four of the conditions a meaningful relationship most directly relieves.

There is a small but growing body of literature suggesting that being in a loving relationship can support cognition, lift mood, lower blood pressure, and provide the kind of sense of purpose that gets a person up in the morning. Ashley notes that none of this would surprise anyone working in the field.

"Given the proximity in which people with dementia are expected to live in residential aged care, it should not be a surprise that relationships happen. But it is."

— Ashley Roberts

Residents in a care home live in close, daily proximity to other people who share their stage of life. Many have been in long-term relationships before. The arrival of a new connection should be treated as predictable and as a positive contributor to wellbeing, not as a crisis to be managed.

KEY TAKEAWAYS

- Relationships are an antidote to loneliness, isolation and boredom in care.
- Emerging research suggests cognitive, emotional and physical benefits from intimate relationships in later life.
- Relationships in aged care are predictable, not surprising. Plan for them.
- Wellbeing, dignity, and the resident's own preferences are the things being protected.

CHAPTER 06

The barriers we put in the way

Ashley identified a set of barriers that explain why so few care homes actively support resident relationships, even when their residents clearly want them.

- Staff attitudes. Often well intentioned, often grounded in a wish to protect, sometimes simply uncomfortable.
- Consent concerns. Real and serious, but frequently used as a blanket reason to shut things down without proper assessment.
- Ageism. The unspoken assumption that older people should not be doing that.
- Personal, religious or cultural values, held by staff, leaders or families.
- Family views. The most common single barrier. Families do not legally have the right to consent to or prohibit relationships, but their wishes carry strong informal weight.
- Missing or outdated policies. Many providers either do not have a current policy on sexuality and relationships, or have one written long ago and never revisited.
- Lack of privacy. Doors required to stay open, communal living, fire policies, constant supervision. The physical environment can make appropriate expression of sexuality almost impossible.

"Care home providers are stuck. The legislation now expects them to support relationships, but the policies, the privacy, and sometimes the staff attitudes are not yet there. The way through is to think about it more, not to shut it down faster."

— Ashley Roberts

CHAPTER 07

Language is the lever

If you only change one thing after reading this guide, change the language your team uses. Ashley made the case in the workshop that more progress can be made by sharpening vocabulary than by almost any other single intervention.

From “behaviours” to “interactions”

The word “behaviour” carries a strong clinical and often negative connotation in aged care. Where the activity is not actually problematic, calling it an “interaction” keeps the description neutral until further assessment shows otherwise.

From “inappropriate” to specific descriptions

“Inappropriate sexual behaviour” (ISB) is gradually being replaced in the literature by “unwanted sexual behaviour” (USB). Many behaviours described as “inappropriate” are not inappropriate in themselves; they are simply happening in the wrong place or at the wrong time. Naming what is actually wrong (the location, the timing, the lack of consent of another person) is more useful than the broad word.

Use the word affection

Ashley reviews progress notes constantly and almost never sees the word “affection.” Holding hands, a peck on the cheek, a hug, an arm around the shoulder, a kiss on the forehead, a sit-together on the couch: all of these can be described as affection rather than as sexual behaviour, and most of the time, that is exactly what they are.

FROM THE WORKSHOP

Forty SIRS reports in a month

Ashley described a care home Dementia Support Australia was asked to visit. The home had submitted approximately forty SIRS (Serious Incident Response Scheme) reports in a single month for unwanted sexual behaviour. On the surface, this looked alarming.

On closer review, the team discovered that residents holding hands were being documented as sexual acts. Once staff were supported to describe what they were actually seeing, including residents holding a hand for comfort or for balance, the number of SIRS reports dropped sharply.

Nothing about the residents had changed. The language used to describe them had.

"Half of those residents were holding on to someone's hand just to maintain balance. It is not anyone's fault. People just did not have the language to describe what they were seeing. So they jumped to sexual."

— Ashley Roberts

Test for intent

When in doubt, ask: what is the intent? A hand held for balance is not the same as a hand held to lead a person to a bedroom. A hug at a sad moment is not the same as a prolonged embrace. Naming the intent (where it can reasonably be inferred) often resolves an apparent sexual concern into something simpler and more accurate.

KEY TAKEAWAYS

- Use "interaction" rather than "behaviour" where the activity is not clearly problematic.
- Use the word affection liberally in progress notes when that is what you are seeing.
- Replace "inappropriate" with a specific description: the location, the timing, the consent issue.
- Where intent is reasonably clear, document the intent, not the assumption.

CHAPTER 08

Sexual consent capacity

Sexual consent capacity is the capacity of a person to consent to a specific sexual activity. It is the central legal and ethical question whenever sexuality and dementia intersect. There is no formal, standardised assessment tool yet in widespread use in Australia, and developing one is non-trivial. The principles below, however, are well established.

Diagnosis alone does not remove capacity

When in doubt, ask: what is the intent? A hand held for balance is not the same as a hand held to lead a person to a bedroom. A hug at a sad moment is not the same as a prolonged embrace. Naming the intent (where it can reasonably be inferred) often resolves an apparent sexual concern into something simpler and more accurate.

What to assess

Indicative considerations when forming a view on capacity include:

- Awareness of the other person. Does the resident recognise who their partner actually is? If the resident believes the other person to be their long-deceased spouse, capacity in that moment may be compromised.
- Voluntariness. Is the resident participating freely, without pressure or exploitation?
- Knowledge of the relationship. Does the resident understand what is happening between them and their partner?
- Ability to recognise risk. Can the resident identify and respond to obvious risks?

Capacity is not all or nothing

A resident may not have capacity for one form of sexual activity, but may still have capacity to express their sexuality in other ways. Where partnered intimacy is not appropriate, support for sexual expression may still be both possible and important. This requires careful, person-specific thinking rather than a blanket policy.

"Dementia is progressive, so most people will, at some point, lose sexual consent capacity. But our job is not to assume that on day one. Our job is to think about it carefully and to err on the side of supporting the person's dignity for as long as we can."

— Ashley Roberts

KEY TAKEAWAYS

- Sexual consent capacity is decision specific and can change over time.
- Diagnosis of dementia alone does not equal incapacity.
- Awareness of partner, voluntariness, understanding of the relationship, and ability to recognise risk are the four common indicators.
- Even where capacity for partnered activity is unclear, support for sexual expression may still be possible.

CHAPTER 09

Unwanted sexual behaviour

The BPSD textbook defines unwanted sexual behaviour as: sexual behaviour by a person living with dementia that may exceed objective assessments of what is appropriate, where the behaviour is disruptive or aggressive, and where it potentially impinges on the rights of other people.

This is a clinically useful definition because it anchors the issue in disruption, aggression, or violation of another person's rights, rather than simply in staff discomfort.

Categorise what you are seeing

Once the team is satisfied that what they are observing is genuinely unwanted, it helps to categorise the relationship involved:

- Resident to resident.
- Resident to staff. The classic example is a resident with moderate to severe dementia misreading social cues during personal care, particularly during showering.
- Resident to visitor or family.
- Resident to themselves, including self-pleasure in inappropriate contexts.
- Staff to resident. This is a separate, serious matter, addressed through safeguarding processes, not through behaviour management frameworks.

Some dementias increase libido

Frontotemporal dementia commonly does. Lewy body dementia can. Alzheimer's disease can in some cases. Hormonal pathways in the brain explain much of this. This is not a moral failing of the person; it is a clinical feature of their condition.

Contributing factors to consider

- Sleep deprivation.
- Urinary tract infections and other infections.
- Delirium.
- Medication effects, including Parkinson's medications that can dramatically increase libido.
- Staff approach, including tone, body language and proximity during care tasks.
- Misinterpretation of the situation by the resident, particularly in personal care contexts.
- Loneliness, boredom, and lack of meaningful engagement.

"If the person themselves is upset by what they have done, that is a strong sign that what you are looking at is genuinely an unwanted sexual behaviour for them, not just for you."

— Ashley Roberts

CHAPTER 10

Golden rules for responding well

When a sexual interaction or unwanted sexual behaviour occurs, the way staff respond in the first sixty seconds usually determines the trajectory. Ashley shared the following golden rules with the workshop.

1. Do not make it worse. The single most important rule. Reactive responses such as shouting, public shaming, telling the resident they are being “inappropriate,” or attempting to argue them out of the moment, almost always escalate.
2. Do not argue. You will not win an argument with someone living with dementia. Do not try.
3. Stay calm and de-escalate. Use the standard framework: de-escalate, validate, redirect.
4. Redirect to something familiar and non-sexual. A photograph in the room, a family memory, a meaningful task, a change of room or activity.
5. Promote privacy. Close doors. Move the person to a private space. Where home policy prevents this, work with leadership to change the policy, not the resident.
6. Use a friendly, light-hearted tone where possible. Drawing attention to the moment can entrench it.
7. Document precisely. Describe what was actually observed, the context, and the response. Avoid loaded language.
8. Look for contributing factors. UTIs, sleep, delirium, medication changes, loneliness. The behaviour is rarely the whole story.

FROM THE WORKSHOP

The barn doors

Ashley described a recent referral for a gentleman engaged in self-pleasure in his own bedroom. There would normally be nothing to refer. The gentleman had every right to do what he was doing, in his own private space.

The problem was the home's policy of using stable-style "barn doors," where the lower half could be closed but the upper half had to remain open at all times for supervision. The resident, living with dementia, did not think to close anything before beginning. The home's policy made the act visible, and visibility made it a "behaviour."

The work to resolve this was not with the resident. It was with the policy.

CHAPTER 11

When language gets it wrong

Ashley closed the workshop with the example that perhaps best illustrates everything in this guide.

FROM THE WORKSHOP

The compression stockings

Dementia Support Australia received a referral for a gentleman in a regional care home. The reported behaviour was that he was going into other female residents' rooms and stealing their stockings.

The single word stockings did the damage. Staff imagined lingerie. They wondered why he was collecting it. The discussion escalated. His wife, called in to speak with the team, was distraught. Staff became uncomfortable around him. There was a serious consideration of moving him to a different care home, which in a small regional area would have meant his wife could no longer visit.

When the team reviewed the case notes carefully, they found a missing word. Not stockings. Compression stockings. The gentleman had been pulling compression stockings up on other residents as a kindness, helping them with a task he had done a thousand times.

One word was all it took to redirect a man's life, his marriage, and his care.

"The rumour mill can kick off very quickly. This is why it matters so much to be precise about what we are actually seeing and what we are actually writing down."

— Ashley Roberts

KEY TAKEAWAYS

- Describe behaviour precisely. The wrong adjective can change a life.
- Avoid leaping to sexual framing as the default explanation.
- Review existing case notes for language that may have anchored a misinterpretation.
- When in doubt, slow down, gather more information, and ask: what else could this be?

About the facilitator and the series

THE FACILITATOR

Ashley Roberts

Ashley is a Dementia Consultant with Dementia Support Australia (DSA), a national behaviour management service operated by HammondCare. He has approximately 20 years of experience in dementia and aged care. Ashley completed his Master's degree on the subject of sexuality, intimacy and dementia in 2023, presented at the International Dementia Conference in 2024, and was published in the Journal of Dementia Care in 2025. He delivers training on this subject for aged care providers across Australia.

THE TRAINING PARTNER

HammondCare and Dementia Support Australia

Dementia Support Australia is a national service that supports residential aged care providers, home care services and individual practitioners to respond to behaviours of concern in dementia. DSA is operated by HammondCare, one of Australia's most respected providers of dementia care, education and consultancy. HammondCare also operates The Dementia Centre, the educational and research arm of the organisation.

THE DELIVERY PARTNER

E4 People

E4 People is an Australian healthcare staffing brand committed to upskilling the aged care sector. Our Dementia Training Workshop Series brings sector-leading expertise to residential aged care facilities across the country, equipping teams to deliver confident, dignified dementia care every day.