"I need to come with heart":

A pilot project on access to intimacy for persons in residential care

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Executive Summary

This pilot project explores the feasibility of improving access to intimacy for residents of supported care facilities by providing education and training for sex workers in working with older and disabled persons and to staff on sex work and sex workers. The project ultimately aims to improve the quality of life of people in residential care by safely increasing the options for intimacy available to them.

The entire project was fully reviewed and received approval by the Massey University Human Ethics Committee Ohu Matatika 2 (application number OM2 23/01) before participant recruitment began.

This pilot project was structured as a longitudinal mixed-method project. Firstly, Touching Base of NSW engaged in a consultative process with members of the project steering group to develop and refine a training curriculum for the Aotearoa New Zealand context. NZPC recruited 15 sex workers, of whom 11 completed the entire initial intervention. Nine residential RACF staff were recruited, of whom five were eligible and completed the entire initial intervention. In the pre-workshop anonymous survey participant knowledge, attitudes, and beliefs (KAB) about sexuality and ageing were assessed by a short online survey. Participants were then invited to participate in synchronous online educational workshops of approximately 2.5 hours in length on ageing, sexuality, and intimacy. Sex workers attended one workshop, and staff attended a different one. A post-workshop survey assessed any immediate changes in KAB.

In Phase 2, interviews with sex workers and RACF staff who had participated in Phase 1 were conducted by the principal and co-investigator at approximately three months after the initial intervention (August-September). These interviews were designed to assess experiences related to sex work with older residents, and the enduring impact, if any, of the initial intervention.

It is clear that the workshop-based Touching Base training was had an impact on KAB, and the impact endured for at least the three months of the follow up period for both sex workers and RACF staff. All participants reported some benefits from the workshop. Some RACF staff said it was an 'eye-opener' and were eager to share their learnings with other staff in their facilities. At least one RACF staff participant reported arranging a visit with a sex worker for a resident and expected that such an arrangement would help address the resident's negative and disruptive behaviours.

Both sex workers and RACF staff participants took the issue of initial and ongoing consent very seriously. Several RACF participants said that they would now take intake assessments related to relationships, sexuality, and intimacy more seriously, so that resident needs and wishes about intimacy could be incorporated into long-term care plans. It is also important that sex workers feel safe and supported when working in RACF. Non-judgemental, non-stigmatising communications among the client, care staff, and the sex worker was suggested as a strategy to create supportive environments that honour all persons engaged in the transaction.

A key concern raised by both workers and staff was RACF staff attitudes about sexuality, intimacy, and sex work. Staff education is seen as a key towards shaping staff behaviours, and some staff managers said that they now planned to take mandatory education around sexuality and intimacy more seriously and with less of a 'tick-box' approach, since they were talking about real-life concerns with real individuals. Further research is recommended, and ways to link residents and sex workers could be explored.

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Introduction

This pilot project explores the feasibility of improving access to intimacy for residents of supported care facilities by providing education and training for sex workers in working with older and disabled persons and to staff on sex work and sex workers. The project ultimately aims to improve the quality of life of people in residential care by safely increasing the options for intimacy available to them. Upon the successful completion of this pilot initiative, it is our intention to apply for full research and programmatic funding to develop and expand the initiative.

The overarching research question of this project is 'Does providing education to sex workers and care facility staff improve access to intimacy for people in supported residential facilities?' Sub-questions ask how effective that education is: that is, whether the intervention results in changes in knowledge, attitudes, behaviours, and beliefs in participants; and whether any changes are enduring over time. Because of funding expectations, this project had to be entirely completed within one year, recruited a sample of convenience, and was designed as a pilot project.

The project was funded by a small research grant from Massey University (MURF funding), which is intended for small research projects such as pilot studies. The fiduciary for the project was the NZPC*:* Te Waka Kaimahi Kairau O Aotearoa Aotearoa New Zealand Sex Workers' Collective [NZPC, used hereafter], formerly known as the New Zealand Prostitutes Collective. The research team included Prof Mark Henrickson of Massey University's School of Social Work, Dr Patricia Morgan, researcher at ANZSWC. These researchers collaborated with Saul Ibster, Operations Manager, and Emma Softly, Training Coordinator, of Touching Base, Inc. (https://www.touchingbase.org), a charitable organisation based in Sydney, NSW that has been assisting people with disabilities and sex workers to connect with each other, and to providing training for sex workers since October, 2000 (no similar organisation exists in Aotearoa New Zealand). Access to Survey Monkey for the pre- and post-workshop surveys for participants was provided by Diversity New Zealand www.diversitynz.com; the research team are grateful to Diversity New Zealand for this access. Drs Morgan and Henrickson undertook the Phase 2 interviews and analysis, and a small advisory group provided ongoing support to the project during implementation.

Background

The project has its roots in the previous Royal Society Marsden-funded research *What Counts as Consent: Sexuality and Ethical Deliberation in Residential Aged Care* (Henrickson et al., 2020) and its precursor feasibility and pilot studies. As such, then, the present study is knowledge transfer research. The foundational *Consent* study was a two-arm mixed method cross-sectional study using a concurrent triangulation design; 433 staff surveys were collected from 35 residential facilities across New Zealand, and 61 interviews were carried out with 77 staff, residents, and family members. Particularly relevant to the present study are staff responses to two survey questions: "My workplace should allow access to sex workers for residents who want this service, provided the resident is the one paying" were equally divided: 131 (30.2%) agreed with the statement, 157 (36.3%) disagreed, and 145 (33.5%) were neutral. The responses to the statement "I rely on my personal values more than anything else to guide me when I make decisions about sexual issues that arise in my workplace" were also very divided: 191 (44.3%) agreed with this statement, 96 (22.2%) disagreed, and the rest (n=146, 33.5%) were neutral or missing. These responses suggest that there is a wide diversity of opinion on access to sex work, but only 22.2% of staff rely on workplace or professional education when making essential decisions about resident expressions of sexuality,

preferring instead to rely on personal values. Concerningly, many staff participants were not aware of their facilities' policies on access to sex workers. What became clear from this study, however, is that access to sex workers is occurring in residential facilities of all types and settings across the country, although that access is heavily influenced by the personal attitudes of key staff (regardless of whether those staff have the right to make decisions about access). This project proposes to test whether providing accurate information and education to sex workers and to RACF staff about providing sexual and intimate services to elders makes the experience of older residents safe, supported, and life-enhancing, and to assess whether this education is effective.

The present project emerges from Intimacy Access, a community network of sex workers and community experts from which, for practical reasons, a smaller steering group for the project was drawn. Intimacy Access includes:

Ana (Anahit Massage)
Jessica Buddendijk (Aged Care Educator)
Mark Fisher (Body Positive)
Sharon Harris (NZPC)*
Prof Ngaire Kerse (Univ Auckland)
Sandra McDonald (Nurse, Ngāti Whātua, Ngāti Wai, Ngāpuhi)*
Dr Patricia Morgan (NZPC Researcher)
Orquidea Tamayo Mortera (Reg DRTh NZSDRT Inc. & Summerset New Zealand)*
Claire Ryan (Ministry of Disabilities/Whaikaha)
Pip Patson (DiversityNZ)*
Iris Reuvecamp (Vida Law, Wellington)*
Sally (NZPC-CHC)
Julie Watson (Rainbow Tick/Silver Rainbow)
Mark Henrickson (Researcher, Massey Univ)

**Project steering group; organisations are for identification purposes only and do not imply organisational endorsement.*

Method

This pilot project was structured as a longitudinal mixed-method project. Firstly, Touching Base engaged in a consultative process with members of the project steering group to develop and refine a training curriculum for the Aotearoa New Zealand context. NZPC recruited 15 sex workers, of whom 11 completed the entire initial intervention. With the assistance of a member of the steering group, nine RACF staff were recruited, of whom five were eligible and completed the entire initial intervention. All participants were voluntary and fully consented. Participants were offered a $125 Prezzie voucher for their time and participation in all three Phase 1 steps. In the pre-workshop anonymous survey (T1) participant knowledge, attitudes, and beliefs (KAB) about sexuality and ageing were assessed by a short online survey (22 question, which took 5-7 minutes) which was offered through Survey Monkey. Q1 of the survey asked participants to create a unique identifier so that post-workshop surveys could be matched (all identifier data including IP addresses were stripped from responses at the time of submission). QQ18-22 were optional demographic questions. The balance of the survey included five-point Likert-scale responses (Strongly Disagree to Strongly Agree) to statements developed in consultation with the research team and the steering group and were based in part on validated questions from the *What Counts as Consent?* study; some questions were reverse-scored. Participants were then invited to participate in a synchronous online educational workshop of approximately 2.5 hours in length on ageing, sexuality, and intimacy. Participants' KAB was reassessed at T2 within 24-48 hours after completing the workshop.

In Phase 2, interviews with sex workers and RACF staff who had participated in Phase 1 were conducted by the principal and co-investigator at approximately three months (T3) after the initial intervention (August-September). These interviews were designed to assess experiences related to

sex work with older residents, and the enduring impact, if any, of the initial intervention. Interviews were conducted using Zoom and were recorded by Zoom. Most lasted between 45-60 minutes. Recorded interviews were then auto-transcribed using Zoom and other AI technology, and corrected and clarified by the researcher who had conducted the interview. Where possible the transcription was reviewed by the participant; some participants had requested copies of their transcribed interviews, and these were provided to them. Once the transcription was verified, either by the participant or the interviewer who compared the transcript with the original recording, the audio and video recordings were permanently deleted, according to the approved ethics protocol. It is worth noting that auto-transcribers had difficulty with New Zealand accents and with terminology specific to the project, but these were clarified and verified. Participants who completed the interview were issued a $100 Prezzie voucher. One RACF staff participant did not respond to the invitation to interview; therefore there were four RACF staff interviews; there were nine sex worker follow up interviews.

The entire project was fully reviewed and received approval by the Massey University Human Ethics Committee Ohu Matatika 2 (application number OM2 23/01) before participant recruitment began. Pseudonyms are used in place of all participant names, and identifying information (such as locations) removed from quotations.

We are grateful to all our participants.

Findings Phase 1

A full iteration of all pre- and post-workshop survey findings is located in the Appendix to this narrative. This narrative highlights key findings relevant to Phase 1 of this project, and groups the findings into demographics; communication skills; attitudes to ageing and sex; knowledge; and free-responses.

Sex Workers

Of the 11 sex worker participants (SWP), five identified as being in the 20–30-year-old age group, and three in the 31-40 group. The number of years in sex work was very widely spread, with three SWP in each of the 2<5 years, 5<10 years, and 10 years and more groups. Six SWP identified as European, three as Māori, one as Asian (multiple responses were possible); three did not respond to the question. Six SWP described their gender as female, one as trans female, and one as gender-fluid presenting as female. One SWP identified as male, and two did not reply to the question. In a free-response question, SWP variously described their sexuality as pansexual (2), queer (2), hetero or straight (2), takatāpui (1), and bisexual (1); two participants left this question unanswered. Only two (18.2%) had previously attended a workshop on intimacy and sexuality for older persons.

All participants looked forward to the workshop on the pre-workshop survey (mean=5.00). After the workshop SWP said they enjoyed the workshop (mean=4.73, SD=0.567, range=4 to 5), and felt it was a good use of their time (mean=4.55, SD=0.688, range=4 to 5). Three SWP had previously heard of Touching Base (or thought they had).

Communication skills

Perhaps unsurprisingly, prior to the workshop most SWP felt they had the *communication skills* to negotiate sexual services with older clients (mean=4.00, SD=1.095), and there was little change in the post-workshop survey (mean=4.73, SD=4.73), although the wider variance in the responses (indicated by the larger SD) is of interest. Equally, SWP felt *confident in their ability* to negotiate

services with an older client on the pre-workshop, (mean=4.09, SD=0.701), and there was again little change in the post-workshop survey (mean=4.45, SD=1.214), although the overall means in each case increased slightly. (The sample is too small and does not meet assumptions for parametric statistical analysis, so *p* values were not calculated for any change; we cannot say any change was 'significant'.) However, the mean for feeling *confident in their ability to talk with a family member* about providing sexual services to an older relative was showed greater change between the pre-workshop survey (mean=2.73, SD=1.421, range 1 to 5) and the post-workshop survey (mean =4.36, SD=0.809, range=3 to 5). Similarly, the question about feeling *confident in their ability to negotiate services with residential care staff* also increased from the pre-workshop (mean=2.55, SD=1.44, range=1 to 5) to the post-workshop survey (mean=4.18, SD=0.603, range 3 to 5). The workshop appears to have helped SWP feel more confidence in talking with family members RACF staff about providing sexual services to a family member or resident.

Attitudes to ageing and sex

SWP felt that intimate relationships that involve pleasurable touch are a lifelong human right, although there was an increase from the pre-workshop (mean=4.30, SD=0.67, range 3 to 5) to the post-workshop (mean=5.00, SD=0). There was a small increase in responses to the statement 'Sexual activity may improve the well-being and quality of life of older and disabled people' from the pre-workshop (mean=4.82, SD=0.405) to the post-workshop (mean=4.91, SD=0.302). There was an unexpected finding on the first reverse-scored item 'People over 65 have little interest in sexual activity' from the pre-workshop (mean=1.55, SD=0.522, range 1 to 2) to the post-workshop survey (mean=1.82, SD=1.401, range 1 to 5), although the reverse scoring may have contributed to this finding. There was a minor change in responses to the statement 'Sometimes all clients want is someone to talk to' from the pre-workshop (mean=4.45, SD=0.688) to the post-workshop survey (mean=4.73, SD=0.467). 'Thinking about providing sexual services to an older person makes me feel uncomfortable', decreased from the pre-workshop (mean=2.45, SD=1.563, range 1 to 4) to the post-workshop (mean=1.55, SD=0.934, range 1 to 4). Mindful of the possible confusion from the first reverse-scored item, the workshop appears to have had a positive effect on SWP attitudes towards sex and ageing.

Knowledge

In the pre-workshop survey SWP felt they knew enough about *the laws related to consent* to provide sexual services safely to older persons (mean=3.91, SD=0.944, range 2 to 5), but after the workshop they appeared much more confident (mean=4.64, SD-0.505, range 4 to 5). Similarly, on the reverse-scored item 'People living with dementias can never reliably consent to sexual intimacy', there was a change from the pre-workshop (mean=3.00, SD=1.095, range 2 to 5) to the post-workshop (mean=1.70, SD=.0949, range 1 to 3), meaning that on average SWP disagreed more strongly with the statement. Finally, participants also *felt more confident in their ability to provide services to someone who requires help to move or to engage in sexual activity* from the pre-workshop (mean=3.30, SD=1.567, range 1 to 5; one SWP did not respond to this question) to the post-workshop (mean=4.30, SD=1.52, range 1 to 5). We may conclude from this that the workshop appears to have had a positive impact on SWP knowledge about legal issues related to consent, and the practical issues related to providing services to persons who required assistance to move.

Free responses

A willingness to learn were clearly reflected in the pre-workshop comments about why SWP chose to participate in the project. It is worth noting that some participants were already providing services to older and/or disabled clients, and this may have skewed the apparent changes after the workshop, since these SWP would already have had a relatively high level of experience and knowledge:

- I'm a sex worker that would like to improve my work with older clients
- I want to learn more about how to offer services to those who are elderly or disabled, and how to make myself more appealing to those who are elderly or disabled.
- It's always good to learn new things as you never know when you may need that skill set
- Have a lot of elderly clients
- To be more knowledgeable in how to provide great service to older clients
- Continued education & training as a sex worker
- To learn and be more informed and know safe practices of how to work with older persons and disabled, especially when there are physical challenges and mental challenges, such as dementia. I wish to learn how to communicate with family and care facility staff that is inclusive and safe for everyone.
- I am a full-service worker who identifies as disabled, therefore I am an advocate for destigmatising sex while living with disabilites. I am a strong believer in the positive impact of sex and want to learn more so I can provide my services for those who need it but may feel their needs are not valid due to age/disabilities
- To educate myself on how to provide services for older adults/ individuals that live with a disability

The workshop clearly met most SWP expectations ('Did the workshop meet your expectations?'):

- Yes the workshop was great in helping me realize I was doing things correct when it come to my older clients.
- Yes, and exceeded it. All facets of aged care environments were covered, different insights from people who have received and provided sexual services to disabled and elderly clients were shared, and information about how to market myself to service users was included - approaching the care agencies involved.
- It's was amazing an a eye opener.
- Totally amazing, great info and ran well considering it's online
- Yes it did, I found it really helpful to go over all consent side of things, and to know that it is the persons right to be able choose if they would like sexual services. Family or social care shouldn't be able to with[h]old that from them.
- More than my expectations. great combo of peer education, and knowledge of navigating family/carers/ housing.
- Yes the workshop met my expectations. Knowing that both facilitators as well as all participants are sex workers made me feel comfortable. The workshop covered working with older people and touched on working with people with disabilities, which is what I expected.
- Met them and went beyond! I felt very safe, it was formal and informal :)

The SWP also found many aspects of the workshop helpful:

O18. What did you find most helpful during the workshop?

- Consent around dementias.
- The videos sharing views from service users and providers, and the experiences shared by the male coordinator (unsure how to spell his name sorry).
- All of it is helpful. An[d] something that is well worth doing
- Information and new tools
- I really enjoyed the videos that got actual people who had disabilities to talk about their experiences with sex workers and how this has had a positive influence on their life.
- the peer education, listening to stories of other sex workers. I enjoyed the video content to see real world of what happens. having the conversation for disability and sex.
- 1. Having two facilitators who have worked with older and disabled clients is a valuable resource that offers great insight. 2. The chance to hear other sex worker's questions around the workshop topics. 3. Talking openly about what could happen.
- This isn't about the content we learnt but I wanted to note as someone with ADHD who often struggles to follow what others would perceive to be basic instructions, I found accessing the venmo [Vimeo] and links really easy as they talked us through where to locate them! The consent section was very beneficial to me :)
- Hearing real life stories about sex work, negotiations and reminders about consent
- Learning how to better communicate and get proper consent
- Talking about the more technical aspects of navigating the interaction with an older adult

Participants also offered some ideas about what further could be included in the workshop. Several of these were about including views and perspectives of family and support staff, and stories about other sex worker experiences in providing services to older clients and clients with disabilities. Two others asked for business tips. Importantly, one client asked about options for funding for sexual services; this in fact exists in Aotearoa New Zealand through a dedicated fund at Whaikaha.

RACF Staff

RACF staff participants were considerably less diverse than SWP; two CSP described themselves as being in the 31–40-year age group, and one each in the 41-50, 51-60 and 60+ age groups. Two CSP said they had 10 or more years of experience, two had five but less than 10 years' experiences, and one has between one- and two-years' experience in residential aged care. Three described themselves as European/Pakehā, one as Asian and one did not respond to the question. All five identified as female, of whom three identified as heterosexual/straight, one as bisexual, and one did not respond to the question. Two (40.0%) had attended a workshop on intimacy and sexuality for older persons previously.

Questions for the CSP were slightly different from those asked of the SWP because CSP do not offer sexual services to their residents or clients. However, many questions were identical.

CSP said they enjoyed the workshop (mean=4.00, SD=1.225, range=2 to 5). However, it should be noted that the scoring on this item for two participants (low) was at variance with their narrative comments (very enthusiastic); this item should therefore be treated with great caution.

Communication skills

Prior to the workshop, CSP were neutral on the question about whether they had the *communication skills to negotiate sexual services with older clients* (mean=3.00, SD=1.581, range 1 to 5). There was a large change on this item in the post-workshop survey (mean=4.20, SD=0.447,

range 4 to 5), and the smaller standard deviation suggests that the responses were more tightly clustered. (Again, the sample is too small and does not meet assumptions for standard statistical analysis, so *p* values were not calculated for any change.) They also initially scored their *confidence in their ability to talk with a family member* about providing sexual services to an older relative as a neutral (mean=3.00, SD=1.483, range 1 to 5), but this score increased markedly in the post-workshop survey (mean =4.00, SD=0.548, range=4 to 5) and were more tightly clustered. Similarly, the question about *feeling confident in their ability to negotiate services with sex workers* also increased from the pre-workshop (mean=3.20, SD=0.837, range=2 to 4) to the post-workshop survey (mean=4.40, SD=0.548, range 4 to 5). Participation in the workshop appears to have helped CSP to feel more confident in talking with residents, family members, and sex workers about providing sexual services to residents.

Attitudes to ageing and sex

CSP were entirely agreed that *intimate relationships that involve pleasurable touch are a lifelong human right*, (mean=5.0, SD=0), and this score did not change in the post-workshop survey. There was a small increase in responses to the statement ‘Sexual activity may improve the well-being and quality of life of older and disabled people’ from the pre-workshop (mean=4.60, SD=0.548) to the post-workshop (mean=5.0, SD=0) surveys. There was no change on the reverse-scored item ‘People over 65 have little interest in sexual activity’ (both means=1.20, SD=0.447, range 1 to 2). The reverse-scored item ‘Thinking about arranging sexual services for an older person makes me feel uncomfortable’, decreased from the pre-workshop (mean=1.80, SD=0.867, range 1 to 3) to the post-workshop (mean=1.40, SD=0.548, range 1 to 2), and it is of interest that the post-workshop item was more closely clustered. There was no change on the item ‘Rather than sex, sometimes all a resident wants is someone to talk to’, (both means=4.80, ESD=0.447, range 4 to 5; OSD=1.00, range 4-5). Responses reflected a change in attitude towards the reverse-scored item ‘Sex work may be legal in Aotearoa New Zealand, but I think it is immoral’ from the preworkshop (mean=2.20, SD=1.304, range=1 to 4) to the post-workshop survey (mean=1.40, SD=0.800, range 1 to 3). It should be noted, however that most participants in this group were European; research from the *Consent* study found that non-European workers’ and kaimahi attitudes towards sex work are different, so this item may be interpreted with caution: if the sample had included more non-Europeans it is possible that the change might have been larger, or if cultural and religious attitudes are more entrenched, the same. The workshop appears to have had a positive effect on CSP attitudes towards sex and ageing, and sex workers, although CSP demonstrated a high level of familiarity with the issue on several items (interest in sex, wanting to talk rather than engage in sexual activity).

Knowledge

CSP scores for ‘I know enough about the laws related to consent to arrange sexual services safely for older persons’ increased markedly from the pre-workshop survey (mean=2.20, SD=1.304, range=1 to 4) to the post-workshop survey (mean=4.40, SD=0.548, range=4 to 5). On the reverse-scored item ‘People living with dementias can never reliably consent to sexual intimacy’, there was a slight decrease from the pre-workshop (mean=2.80, SD=1.789, range 1 to 5) to the post-workshop (mean=2.00, SD=1.707, range 1 to 3), meaning that on average CSP disagreed more strongly with the statement, and there was less variance in their responses. CSP showed a large change in their responses to the statement ‘I am aware of ways that my workplace can enhance expressions of sexuality in older residents from the pre-workshop (mean=2.80, SD=1.905, range 1 to 4) to the post-workshop surveys (mean-4.00, SD=0.707, range 3 to 5). We may conclude from this that the

workshop appears to have had a positive impact on CSP knowledge about legal issues related to consent, and the practical issues related to providing services to persons who required assistance to move, or the way residential care facilities can be more accommodating of sexuality for their residents.

Free responses

CSP had a number of practical reasons, often based on workplace experiences, why they chose to participate in the study:

- To learn about how can we enhance the sexuality aspect of care for elderly residents, what is right and what is not appropriate. Where to find info if we need to provide this service, how to gauge/assess the sexuality aspect of care.
- I am working with elderly residents and experienced few incidents related to the sexuality. At the same time, I am promoting diversity and inclusion in the workplace so understanding the Sexuality and intimacy is very important part in my job role.
- Wanting to understand how we can best support residents (including those living with dementia) to express & maintain their sexual lives if that's what they want, how to educate & communicate with families about these issues & help them navigate, and how we can support the frontline staff who manage the risk and scenarios in real life, ensure they're educated & comfortable & know what's expected from them and what's not.
- I have had an interest in sexuality for residents for a long time and have conducted my own research and education on the topic. I find that it is a topic that a lot of people feel uncomfortable talking about, including residents, staff and families and is often seen as taboo or unrecognized. I am concerned that if there is some discomfort talking about sexuality between a married couple then there is little space to even have conversations for many others.
- Had a previous situation that was ethically tricky for residents in dementia care

Finally, by way of soliciting other feedback we asked CSP to note anything they would have changed about the workshop:

- would be good to look at how to start a conversation and places that are doing this already and how they got to that point, otherwise it was great
- Jamboard was an excellent platform for sharing ideas, perhaps the discussion of the answers on the jam board can be initiated once everyone has written their answers and done some individual thinking. Some people cannot listen and think at the same time. Overall, a very informative education helped me to develop that confidence I didn't have enough before the session.
- It was great!!!!

Participant responses were quite positive, but would have appreciated some guidance from others on how to initiate conversations.

Discussion and conclusion, Phase 1

Education certainly appears effective in improving both SWP and CSP confidence in their abilities to communicate with residents, family members and CSP (for SWP), and residents, family members and sex workers (for CSP). It had an impact on attitudes towards sex, intimacy, and ageing (for SWP) and sex, intimacy and sex workers (for CSP), and the knowledge of both participant groups about key aspects of sexuality and ageing (including knowledge of laws, ability of people living with dementia

to consent). CSP showed increased awareness of how their workplaces could be made more intimacy-friendly. SWP saw opportunities to expand their businesses.

There was strong initial agreement in both groups on sexuality and intimacy as a lifelong human right; that sexual activity may improve the wellbeing and quality of life of older persons; and the interest of people over 65 in sexual activity; these items showed little change in the post-workshop survey. It is highly likely that people who already held these beliefs were attracted into the study, leaving little room for change. A larger, more diverse, and possibly probabilistic sample would show differences before and after the workshops.

Participants also offered practical suggestions on enhancing the training, although all were highly satisfied with the training.

Findings Phase 2

Sex Workers

The nine sex workers we interviewed were located all over the motu, including large urban centres, smaller urban centres, and some smaller towns. The interviewees included a variety of ethnicities including tangata whenua; several identified with more than one ethnicity. All were clear that they had freely chosen to do sex work and had chosen their work setting. Jade said,

> *But I also actually like the work. And I feel like I'm not allowed to like the work because I'm meant to be this broken, damaged* [person]. *Or I've got no other resort. And it's nothing against the Bible workers or people that I know that there are sex workers out there that hate it. But I think that there's room for nuance*.

Some participants worked independently, some worked in a brothel or for a manager/madam; some toured, and one worked out of a mobile van. Some interviewees hosted clients in their own space, preferring to have complete control of the environment and the client experience; some went to clients wherever they lived; some did both. All interviewees had experience with a range of clients including older clients, and others also with disabled clients; the interviews focussed their experiences with these clients and of the workshop. There was a wide range of interviewee ages, from participants in their twenties to in their fifties. Some identified as women, other as men; some identified as heterosexual and others as sexually diverse including gay or lesbian or bisexual. As a matter of research ethics all personal or potentially identifying details have been removed from the interview transcripts; although some participants were willing to be identified, we have not identified them.

Impact of the workshop

Researchers were most interested in whether the workshop participants had attended had had any enduring impact on their work, on the way they felt about older and disabled clients, or whether it had changed their attitudes or approaches to clients. Several participants felt that it reinforced what they already knew, or normalised the way they were already working, while others felt very strongly that it had helped them become aware of things they had not previously considered. (In the quotations below, material or dots in [square brackets] and punctuation are editorial additions or omissions for clarity); dots out of brackets are respondent hesitations:

> *It definitely deepened something that I already knew. A lot of… most of my clients are men, and they are older men, and most of them either widowed or in sexless, loveless marriages. So they are seeking intimacy, right? And so, to go to the workshop, and just sort of get the bigger view, right, the societal level view of 'Oh,*

> *yeah, this is a thing'* [was] *really helpful. Yeah, just ground that in my system deeper, and have more compassion, and empathy for those people*. (Jade)

> *Yes. So it's the kind of stuff I was aware of already. And I've had a lot of elderly clients and people with different abilities.* (Maui)

> *This is why I said to you I feel like I might screw up your study a little bit. I've already done a lot of the work. Actually, in the workshop I felt I was quite useful for* [workshop leader] *and* [workshop co-leader] *who ran the workshop because I was already doing some of the work. I was actually putting some examples into the mix that were quite useful for the other participants. But like I was sort of not… I wasn't there as a newbie, it's not a new area for me.* (Amelia)

On the other hand, the workshop helped several participants become more aware of what they needed to know.

> *Oh, absolutely* [the workshop had an impact on me]*! I mean as someone that identifies as disabled, I had always been—or not always. I've already been an advocate for disability, sexuality. I worked for adult toymaker. And I wrote an article for them* […] *where I spoke about deconstructing the myth of disability and that people with disabilities have sexual desires too. But I've never actually thought about elderly people. That's something that I was quite confronted by, in a good way. Because it made me realize how much ageism I have internalized from this patriarchal colonized society we live in.* […] *A lot of my customers, my patrons, my clients, whatever you want to call them, are older men. But I felt quite confronted that I've never thought about older women. And that was quite a moment of 'Oh, wow, you know what?' And I actually, I'm friends with a lot of women in their 40s. So it's definitely it confronted a lot of internalized misogyny and ageism that I had had within myself, and I found it greatly beneficial.* (Veronica)

> *Yeah, I think it probably had a slightly negative impact, in the sense it's not necessarily a bad thing. What it made me much more aware of that I need to be a lot more aware, I need to learn a lot more, I need to work out how I feel emotionally about, you know, the potential, like, an example would be as turning to an aged care facility, and that fear of discrimination* (Angela)

> *And then I think the second thing* [I got from the workshop] *would be hearing from the customers. I think it was the man with cerebral palsy, hearing how he talked about never being touched in an intimate way beforehand, and his opinion of the service. That was really good.* (Ursula)

> [What stands out for me is] t*he need to definitely do more workshops.* […] *Also, being able to start having those conversations, even if it is within a workshop, about how you talk to people, you know, how do you talk to family members?* […] *So, yes, to your question! Do another workshop, do a bigger workshop, and to really having conversations about* […] *how do we go?* […] *especially if they're an aged care or at… there's all sorts of things like* […] *visiting an older person in their home, you have also safety issues, that,* […] *you need to talk about, but you also need to talk about the logistics of* […] *the client's safety.* (Angela)

> [The workshop] *absolutely opened my eyes to a lot […] Consenting, remembering that people who are disabled and older actually to have a sexual drive.* […] *I didn't think about it] until we started this interview, despite the fact that I'm getting older myself. I should know better.* (Karen)

It is apparent that sex worker participants took the workshop seriously, had carried the learnings and reflections with them for several months, and were open to challenging their preconceptions, and changing their attitudes and practices.

Working with older and disabled clients

As is apparent from the responses above, a number of participants were already working with older and disabled clients.

> *My very first client that was over eighty, and it was like, you know, doing the age gap. And it was like, he was actually like… 'Oh, my God, this is really weird'. But after my first booking with him it was it was great. And, we established a great, you know, relationship through work.* (Angela)

> *A lot of* [my] *sensual massage customers are aged. So that we all have the shared experience of people over 65 coming through our doors.* (Ursula)

> *I've seen people with limb differences and people with autism and mental health as a disability as well, I think so I definitely see a lot of people with mental health issues. And I give them all the same services. Whether you are all young, disabled or not, you're entitled to whatever it is you want to pay for.* (Ursula)

And after the workshop some participants changed their adverts (print or website) and work to become more inclusive of older and disabled clients.

> [After the workshop] *I edited my advert to say that I was inclusive for disabilities and elderly gentlemen. But it wasn't really excluding them prior to that, either.* (Ursula)

Participants were clear that working with older clients can be quite a different experience than working with younger clients, one that considers ageing bodies, and different expectations of physical intimacy:

> *I was getting a lot of older guys, too, actually, when I think about it, that had had prostate cancer and all that kind of stuff. And so now, you know, they weren't able to ejaculate.* […] *It doesn't have to be about ejaculation.* (Maui)

> *Erectile dysfunction has never, for me, been an issue because the men that I've seen with it have always said it in the booking process, you know, and they're like, are you okay with that? So they're worried that I'm going to be okay, or not. And it's like, you know, it's kind of cute in a way, and well no I'm absolutely fine with that.* [I ask] *What kind of ways do you like to work around that?* (Angela)

> *I think one of the things that that I think works is, is, you know, it's not a massage, but you know, moving your hands across their whole body so that it feels like it's all connected. And it doesn't matter that that little bit doesn't work.* […] I*t still blows me away about how many men really respond to kissing their whole body. It's kissing their leg and kissing their knee and stuff. So? Yeah, so there's that real dial up of the sensuality, and less focus on the fact that we need to have an orgasm.* (Angela)

> *Yes, there's more talking than sex. Basically, old people want to cuddle. I'd rather have the elderly clients than the younger ones because they just want to cuddle. They want to talk about their stories--and some of these people have great stories, so time flies with them sort of thing. Yeah, and some of it is about sex, they can still get it up. Guys in their 70s and 80s, they can still get a hard-on better than the young ones. But some of them are taking medication to get themselves hard, like I had a gentleman that injected his penis with something to get it hard.* […There are] *two groups – one's fast and furious other one's slow and they want their time. The elderly want their time! You know the young ones; you know the ones that are quite able—they come and see you. They might book for an hour they know they're going to be out before the hour, because it's about getting their rocks off. So yeah, the elderly want more time with you for cuddles, talking, yah, they might want sex in the end, but sometimes they can't get it up properly for penetrative sex, because of all the medication they are on.* (Kath)

But most agreed that it was intimate, non-clinical touch that was important.

> *My work can be very…it is very rewarding. It is very giving, and the clients that get it, they really do receive a lot from us. And when we bring it back to, say, elderly and differently abled bodies, these are people who are desperate for intimacy more than just the physicality.* (Jade)

Still, approaching or working with older or disabled clients in residential care was a daunting possibility for several participants, mostly because of expectations of staff attitudes:

> *When I first entered sex work, that* [offering services in an aged care facility] *would have been the last thing I would ever do. That would have been the worst idea. That would have been far too scary.* […] *You know, they* [residential care managers] *probably could have the same fear of the unknown. That will add prostitutes are just girls that do drugs, and you know that the stigma is there for both sides* (Ursula)

> [If I were to go into a residential care facility to provide services] *I'd need support, I would need more guidance, as well as how to have those conversations. You know, it's actually—this is probably a really difficult one—but who do you have the conversation with? As in, if you approach one staff worker, they might not be prepared to have that conversation. But the person who comes on at three o'clock shift might, you know, so how do you navigate those things?* (Angela)

If sex workers are going to provide services in residential care environments it is very clear that care staff need to be consistently prepared to work alongside the worker for the wellbeing of the

resident. Still, one participant, who had worked as an aide in a residential environment, was not so much daunted by the residential care environment or staff attitudes, but preferred to have complete control over the sensory environment of his clients:

> *But it was still interesting to hear like, especially if you were going into that environment like into the residential care type of environment, which just kind of reinforced that this is not my gig. I would tell you that I'm happy to see them if they want to come to me, into my space.* […] *I prefer people coming into my space, because then I can create the space regards to all the senses and what they see, what they smell, what they hear, and creating that whole environment*. (Maui)

Kath related a difficult first-time experience with a resident, a retired Roman Catholic priest who wanted some kind of sexual experience with a woman before he died. The issue that made it difficult for Kath and this client was the way he had been 'prepared' for the meeting by care staff:

> *I think it was he wanted some, some sort of care or something like that. A female's body more likely sort of thing. But they had already had him undressed before I got there. To me, I felt it was uncomfortable for him, as well as for me. Because he couldn't really talk. So we had to, I had to write everything down. So it was very awkward for both of us to get into anything intimate. So, I really felt for him, I couldn't even dress him afterwards, after I'd been with him for an hour because I had to go and find one of the nurses to dress him. There was…to me that was horrible. Yeah, yeah, because maybe he didn't want to be undressed, you know, for some female that he'd never known before to walk into a room, and for him to be naked, and being on ex-priest I thought that was just not right.* (Kath)

Consent

A consistent theme among sex workers was the issue of consent, particularly for workers who had worked with impaired decision-making capacity; this included clients living with dementias and clients who faced challenges in communicating. Advisory group feedback highlighted that consent is an iterative process, and that decision-making capacity to consent, and the ongoing provision of consent, needs to be assessed by the caregiver(s) at the time the request is made for sexually intimate services; at the point of service by the sex worker; and in an ongoing way during the delivery of sexually intimate services. Participants spoke of the need to have frank conversations with caregivers regarding a person's decision-making capacity to consent to sexually intimate services, as well as the way in which the particular client might communicate their preferences in circumstances where a client might communicate non-verbally.

One participant talked about experiences with clients with dementia, and an instance where, although the services had been arranged with the client and caregiver ahead of time, at the time of service delivery the client appeared confused about who she was. As a result, she chose not to provide sexually intimate services, instead engaging in the low-risk social activity of playing cards.

> *Then usually the caregivers will give me what to look out for, especially with the ones with dementia. That's really quite difficult because they're looking for someone similar to their partner, so the caregiver has to look at photos and stuff. If they do this close enough to* [be like] *the partner, the person can freak out. I went to one* [client] *because I looked a bit like his partner. But he knew his partner had passed away. But I was dressed up, I didn't get undressed. Nothing really happened with us two— we played cards. Because he had dementia, I don't think he realized what I*

> *was really, when I got there. He didn't understand that I was an escort* […] *Caregivers have a lot on their plates when it comes around to consent, 'cos they need to pass a lot on.* (Kath)

One participant spoke about the way she obtained ongoing consent during her encounter with two non-verbal clients, noting that she would check for ongoing consent by stopping the activity to check that the client wanted it to continue:

> *Yes,* [I] *consistently* [check for consent]. *So I'm going to talk about the two clients that have this disability because they can't speak. So the whole thing around verbal consent… I try and be 100 percent present in my work in general. But it's almost like you have to be there 120 percent. I have asked them for body language signs.* […] *But it's not so much a verbal thing, because if they're non-verbal* […] *I would probably do something quite general like take the touch off, stop the action, maybe put my hands on their feet--that's generally quite a grounding kind of thing.* (Amelia)

One participant said she monitored the eyes of a client with communication challenges, and stopped the action if the client's eyes communicated reluctance.

The workshop was helpful in that it gave workers the confidence that consent may be understood differently for people whose decision-making capacity was impaired:

> [Something I took from the workshop was] *definitely the dementia, being able to give consent sort of thing. That's after working in aged care facility, previously, or just as a caregiver, not as a sex worker. I didn't think that it was possible for them to give consent.* […] (Ursula)
>
> *Beforehand, I was always in the space of if someone had, like a mental disability or something like that—neurodivergent that type of way—that I wasn't able to fully get consent. I wasn't sure where I stood with it. I. But after the workshop, I realized like, No, they weren't…they need this type of touch and that type of intimacy.* (Terisa)

Setting boundaries

Offering sex work is not only about the clients' comfort and safety; the worker, and particularly women workers, needs to feel safe. One of the key things to ensure safety is for the worker to set boundaries around what they felt comfortable with, what they are willing to do, and what they will and will not do:

> *On the other side of generosity is also that the tendency of over-giving, particularly as women, the whole thing about people-pleasing. It's all about the client, and in some ways, it is about the client. But it's like generosity* [on one hand] *and my boundaries here* [on the other hand], *that would be something that I think is actually quite important.* (Amelia)
>
> *Maybe if we bring it back to generosity and boundaries, like, what is my personal space. You know? What is the stuff that I don't want to give out in my work? Cause I think if we're clear on our noes, the yeses can be a lot more clear.* (Amelia)
>
> *There's ways to make them* [disabled clients] *feel involved, without revoking them of their autonomy, but also making sure that they're safe, but also first and*

foremost. I mean, my safety is important, too. And that's something else I gained from the workshop, is that, yes, they're the clients and they have needs that we need to meet. But also, we're still people, and our boundaries and needs to be met, too. (Veronica)

It's not about me. It's not about like, yes, there's my personal desires and boundaries, and that it's, it's not about me, it's about letting this person heal and receive through their body. (Jade)

For me, the biggest thing will be working out what my boundaries are, you know. […A]*n interesting psychological thing for me to work out was—how when* [an activity] *was a part of the booking and the schedule and the planning, it's okay, because we know how it's all operating. When it's not operating the way it's meant to and you get this nasty surprise, my brain couldn't cope with it.* (Angela)

Sex worker participants were consistently clear that with experience comes the worker's ability to monitor and maintain their personal, physical, and emotional safety by establishing clear boundaries, and that maintaining their boundaries helped them to provide a better experience for the client. Boundaries also related to the relationship that the sex workers had with caregivers, and also to the use of condoms, even, or perhaps especially, when the (male) older client were reluctant to use condoms.

Education

A key role that many sex worker participants found themselves taking on was that of educator. This could mean educating themselves, or providing education to the client, their family members, to residential care staff:

Because what I tried to do with my activism is humanize sex workers. (Veronica)

So the piece that I remember that really stuck with me is when [workshop leader] was talking about the brain changing with age. The man that I'm already working with prior to the workshop… [Facility staff] *approached me because he has been exhibiting inappropriate behaviour towards some of his female staff. The carers and the team that looks after him, the support people* [were concerned]. *But the request actually came through someone who runs an* [escort] *agency in town. So this older man used to go there. But somehow, he's too old, so now they can't, you know, they can't take him there anymore. So they were looking for someone who was local who was willing to do a home visit. But I guess* [facility staff] *were just like, you know, the typical kind of 'Old people don't have a sexuality anymore. That's not needed'. Because he was exhibiting this kind of behaviour that made people uncomfortable—you know the carers or the support people, they're well, 'Well, now we have to do something about it'. So, I got a message from* [Name]. *And she established the contact. So, it wasn't actually the retirement village.* […] *They didn't reach out to me. So, there was already someone making the bridge.* […] *So, there was something visible about his behaviour that was disruptive, that made the staff uncomfortable. So, they're basically fending that off to me and said, 'Oh, could you talk to him about it?'. And I was like, yeah. I mean, education is part of my job. Yeah, sure, I can talk to him about it. But also, I think the main piece is that actually, that desire was being met now. So, it's kind of like being hungry. And then you offer somebody some food, and then there's a sense of satisfaction.* (Amelia)

However, talking with families requires a special set of skills that at least one worker was eager to acquire:

> [I want to learn] *how to talk properly with the family, with people's* [clients'] *families. So, I know of a* [sex worker] *down south who was confronted by an elderly family. So, she's been seeing him for about six months, and they'd basically bombarded her, and said 'Well you're taking all my Dad's money'.* [I want to learn] *how to navigate that how to, you know, have those conversations about 'We're not here to steal your dad's money, we're here to offer a service in exchange for money. And this is what he gets in return'.* (Angela)

One participant was particularly interested in educating herself about the historical origins of sex work, and the spirituality associated with cultic sex:

> *And definitely the lineage of where I've dived deep into my own trainings and fascinations has been around the sacred prostitute* [in] *the temples back in the day, where it was about 'how do we channel that infinite love into this being in front of us', where the temple used to be a part of a part of the society? You know, when there was a temple to the gods and the goddess, before monotheism?* (Jade)

There were some contexts where a participant felt inhibited about providing education or talking about sex work services with residents. One participant who had worked in residential care before she moved into sex work found that institutional silence about resident sexuality restricted the conversations she could have with residents:

> [When I worked in a residential care facility] *It was a cleaning staff member that told me about some of the service users having sexual relationships, and the family being very upset about it.* […] *If I was to catch anyone having sex, I had to stop them from having sex. And I was like, 'Oh wow, why is the cleaning staff telling me this? Why was that not talked about when I got the job from the person who runs the place?' This man* [a resident] *was talking about how good his dick was, and what he did in the shower* [… I was] *Like, oh, well, I guess we're not supposed to talk about that sort of stuff. So I didn't really pass it on to any of my peers or supervisors or the manager because what was going to happen for him? I didn't know that I could have said, 'Oh well if you are interested, we could get an escort to come and show you that your dick is so that good'.* (Ursula)
>
> *But if they are in a home and they have caregivers and stuff like that, support people, then those people all need to know what's going on, when and how long for. Not just one or two members of the staff but all staff that wander around the building and could knock…and wonder why the door is closed, and things like that so.* (Kath)

Intimacy and heart

By far the most consistent messages by sex workers about sex work is the need for all people to have access to intimacy, and intimate touch.

> *Look, I actually am a strong advocate that sex work is a very beautiful tool for people with disabilities. And I said* […] *imagine if the only touch you receive is medical.* (Veronica)

It was equally clear from participants that such intimate touch was not simply a mechanical paid response, but an intimacy, even a spiritual experience, that came from the heart. These observations were unprompted, but emerged in the course of the interviews, and since they are particularly powerful some are quoted at length.

> *And I also think that we as sex workers can sometimes… It's fear, you know, it's survival, like I compartmentalize with my clients, and I try not to humanise them too much in the sense of I can't take on all of their emotional baggage. But I think sometimes in doing that I can become quite robotic and mechanical. And I think* […] *hearing from the* [client with] *cerebral palsy, hearing from the experience that he had really made me feel, it reminded me why I'm a sex worker. Like, yes, I'm in it for the money. Yes, I'm in it because I have disabilities. And it's such an accessible job for me. But I actually genuinely am passionate about sex and intimacy and making sure that people leave feeling like they've got what they came to me to seek, and seeing those* [workshop] *videos, humanised my clients, again, for me and reminded me why it is I'm a sex worker, because I care about people. And I love to make people feel good in their bodies, because I think we all deserve that. And I'm an advocate for intimacy.* (Veronica)

> *I look at sex workers as beings* [who] *were sacred, were very sacred. You look at ancient societies that viewed us as this link between the divine and the human. And I really resonate with that. I struggle with* […] *survival sex workers out there that can get quite frustrated with sex workers like me* [where] *this is my means of income, and I genuinely rely on it.* […] *And for me, when I have had clients who have cried at the end, and said, 'It's been a long time since I have felt received by someone', my cup feels full* […] *It was also doing this workshop* [that] *made me realize that I don't need to feel ashamed for enjoying being a sex worker. Because I view myself as a healer, I view myself as a sex therapist or a sex healer in ways. And what's so wrong with that?* (Veronica)

> *For me it's not about their shell, it's about connecting with their wairua, connecting with the inner person. And that's the same, regardless of our exterior of our gender or race or ability, blah blah blah! All that kind of stuff.* […] *I think that ultimately that's what everyone wants, but many of them don't even know it, they don't even know it themselves. They didn't even realize it themselves. I know that's what people are wanting, and it's just like taking them through their process and just allowing the shifts to happen.* (Maui)

> *But you know, ultimately, it's actually all the same, it's actually intimacy. I find everyone wants that intimacy, I would say. But how you want to get to that—and some of them, say, might be a different kind of way—but ultimately, at the core of it, I find it's intimacy that people are wanting, and it's human contact, and let's say, to touch another person and to be touched*. […] *I find often, actually, it's the korero it's the interaction, that stuff often that people are wanting. Well, not everyone, some people don't want the talk, some people just want the fuck. And that's fine, too.* (Maui)

> *I feel a lot of them say that the touch is actually receiving touch, and it's like, maybe they've had a partner. And then the partner died, and then maybe they've just put*

> *the whole intimacy thing in the* [too hard] *basket. And they often say, you know, if I don't have an orgasm that's fine. So it is something that reveals itself. Some write all of that stuff to me prior. But then they turn up and then you realise what's needed is a different thing, skin to skin contact. I don't know. It makes sense to me, you know, because we are kind of creatures that when we were little hopefully, there was a lot of touch. We know from studies that that's important. So why would that not be important when our bodies start deteriorating? There's pain. There's loneliness, like all of those things that it's a moment in time, where it's not just giving youthfulness back, but it's like coming back to like a holistic self of wellbeing or like, I don't know, like feeling good about yourself and good about life and feeling seen.* (Amelia)

Some participants found that clients wanted to explore new, dormant, or suppressed parts of themselves:

> *I found with a lot of clients in that* [older] *age group they might have had some male-to-male contacts when they were like, say, young, exploring, they come puberty, that sort of stuff. But they'd never had any kind of male-to-male intimacy. Then they'd done the rest of their life, gone off and done the married thing. And now they're older in life, and more open to retry the stuff like—a lot of guys like that.* […] *So that was really beautiful, too, to be able to take men through that process, and to be able to offer that service.* […] *Or might be the first time ever. They've never had any male-to-male contact. They've been married, done all the this and that, they've got kids, and I think they just at this stage of life with they're more open and they're more.* (Maui)

> *I used to be more like that., not wanting that intimacy so much. But now I see it as a big part of my job that can do the most healing.* […] *So it's more upholding the mana of the person in front of me. So going into te ao Māori and learning about like, wairua, the spirit, and how it's connected to your tinana and yeah, and upholding that mana of the other person.* (Terisa)

> *I have a lot of* [male] *clients, older clients, that are widowed, right, whether they're widowed because of many years, or like many, many years together, or they're more recently widowed, and I've had the honour of being the first person that they've received touch from a woman from, you know, since their partner died. And that's a very intimate and tender space because they want to go see a professional. And so I think these stories aren't spoken about at all* […] *I have had one of those where I didn't check. I don't know why I didn't check how long previous their partner had passed, but apparently it was only two months. Yeah, and they had an emotional regression in the scene in the session. So what was meant to be 90 minutes turned into three hours.* […] *Particularly with elderly people, differently abled, like, what is their life like? What are the considerations that they have to move through to the sex worker? And what are things that a sex worker needs to consider?* (Jade)

> *I need to come with heart, and I need to come with generosity.* […] *You need to come in with heart. It needs to be there.* […] *I feel like I approach people in my work a lot from the heart, and I think that kind of caringness and the authenticity and the love that comes through that is something like 'She's not just going to be sitting there and wanking the person off' whatever. It has care about it.* […] *So that is definitely*

> *also a piece there is that actually, genuinely caring. Yes, this is important: everyone has a right to sexual expression, exploration, satisfaction, all of that with a whatever up with our bodies, or whatever our minds. But for me there was definitely that piece as well that I could soothe the waves a little bit towards coming out to my mom about it.* (Amelia)

> *I'm definitely interested in connecting and, and feeling like there's a connection between us both, you know, even if it's not, like, fireworks, it's you know, there's a sort of soul connection happening. Yeah, so definitely more of a therapeutic approach.* (Angela)

Finally, one of the things that a number of sex worker participants mentioned was the need for support around marketing their services to residential care facilities, and to older and disabled clients who were living in their own homes. Currently, sex workers are contacted by individuals from care facilities, family members, or the clients themselves, but because of their fears regarding stigmatising attitudes of care staff they do not approach care facilities directly to advertise their services.

Summary of sex worker participant interviews

Sex worker participants learned much from the workshop, and those learnings were enduring. One of the important things was normalising the experience of sex work, particularly with older and disabled clients. Most sex workers were too familiar with the experience of being stereotyped, and this experience often prevented their engagement with RACF staff, and with clients in residential care. Nevertheless, participants were adamant about the importance of intimate, non-clinical touch to support the wellbeing of clients of all ages and abilities. Participants were creative in the way they engaged with the body experiences of older and disabled persons. Key to the positive experiences of encounters was establishing and respecting boundaries, both by ensuring client consent—often in creative ways— by being sensitive to the abilities of the client, and by being aware of their own boundaries. Participants were aware of the educative nature of their work, and were willing to educate themselves, clients, RACF staff, and even families where appropriate. One thing that at least one participant would like to see added to the workshop was skills-building on how to communicate with family members about providing services to their relative. One of the clearest and most consistent messages to emerge from participant interviews was the healing nature of sex work that comes from the heart; while some clients 'just want the fuck', it was the heartfelt and spiritual nature of sex work that provided the most satisfying and healing experiences for both these workers and their clients.

RACF Staff

As noted above, we were able to interview four of the five RACF staff participants in Phase 2. Staff interviewees came from all over the motu, although mostly from the North Island. All were women, some identified as European, and some as Asian. All worked for large national residential care providers. The project, with its sample of convenience, attracted RACF staff, often managers or nurse managers, who were largely already sympathetic to the aims of the project. Unsurprisingly, then, most staff participants continued to report generally positive reactions to the workshop intervention, although it had a relatively small impact on their own attitudes. For instance, when asked whether the workshop had an impact on the way Lydia thought about older and disabled persons' sexuality, she replied:

> *I want to say no, just not to be disrespectful to the people all in any shape or form. I thought it was really lovely to have people talking very openly and very consciously about it, you know, and I guess* [it was] *normalizing, which I really like. So I enjoyed that, because I think it just helps to reaffirm probably where I sit.* [...] *I've always really supported that all the people and people with disabilities should be able to engage in a full and healthy life in all aspects.* […] *And actually, sexuality or issues around sexuality or expression of that, were not an uncommon reason for me to go be referred to, you know, and I found myself having very interesting conversations around sexuality.* [Like] *Do we provide lubricants?* (Lydia)

Responding to the same question, Suki said:

> *I don't think so. Only because I think from the start it's been an area that I feel is so important and that we, you know, probably at the moment, don't address in a way that I feel like I could confidently say, is best practice. It was validating, I guess you know, talking to people who are particularly in a disability space and what that brings to those people's lives, right?* (Suki)

Nevertheless, two other participants felt that the initial workshop was both novel and a very important experience:

> *Absolutely. I think it was an eye opener. I was just talking to [project researcher] yesterday. And I said to her that there are two factors. First thing, the stigma related to this, you know. We don't talk about that subject [sex] in detail. I've done my nursing in New Zealand. We are taught about this, but we don't talk about that in that detail, and they obviously don't see that is as important subject as anything else, like medical conditions and everything else we talk about in depth and figure out an intervention for it. But this is also a subject that needs intervention. But we don't talk about it because of the stigma related to it. Plus, it's a gender specific thing. Maybe males might be a little bit more comfortable talking about it. Most of the female nurses—and nurses are mostly females—are not comfortable talking about it, especially with a male client, about this kind of thing. So it was an eye opener, really, for many of my staff members. It was an eye opener for me*. (Rashmi)

Even though the participant was still reluctant to name sex as a subject ("this, you know", "that subject"), they still felt that sex was a subject that ought to be named. Two participants discussed this issue at length in the context of actual cases[1] they were working with in their facilities. Interestingly, Rashmi reached out to a project researcher because she was attempting to organise a sex worker visit for a resident in their facility, and she was doing so because they felt that the resident's problematic behaviour could be alleviated if he engaged with a sex worker:

> *So he agreed that* [I could organise a sex worker (interviewee uses the word 'companion') to visit him]*, and I was surprised to myself that if I hadn't asked him I would have never known that he actually had these needs. And that might fix half of the issue that he has. You know he might drink less. He might start living a better life. you know, if he has a companion, a friend.* (Rashmi)

Gadadevi said about the workshop:

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[1] Not presented in this report because of privacy and length

> *It was my first the workshop I attended specially for this type of topic, because it's really* [something] *people* [are] *hesitant to talk* [about]. *I think it's really impacted* [me] *because I started to open up conversations, especially with my clinical team. First, because they do have more understanding, and the way of their thinking, it's different compared to non-clinical people. That's what I found out, because the clinical [staff], especially registered nurses who have registration, they are hesitant, because they think [about] duty of care and responsibility. They are taking into consideration [that] they have a practicing certificate to protect. So they do not think out of the box. They will go step-by-step; they will follow the rules and regulations.* (Gadadevi)

Gadadevi had shared some of the workshop material and her learning with her clinical care staff:

> *I only showed one video and shared [some] of the information. And the communication about how a resident can communicate what they need. So [even] only a little I shared. But I'm hoping to do the same thing for my level four carers. I think I'm organizing a session end of this month. So then it will remain for me as well. So the knowledge what I have gained, yeah, I would like to apply to the practice. At least, there's one little initiative, not the big thing from the organisation level. They must do. But I can only raise awareness.* (Gadadevi)

For residential staff who were new to the topic, then, this was clearly an important experience, one most of them felt was important to share with their nursing and direct care staff.

Consent, privacy, and Enduring Powers of Attorney

RACF staff participant concerns were largely focussed around discussions of consent, privacy and Enduring Powers of Attorney (EPOA), especially for residents who had impaired decision-making capacity. Other key issues were quality of life and person-centred care. One staff participant talked about the differences between working in clients' homes and in institutions, and how people other than the client may play a significant role in the types of intimate care they receive:

> [I believe that] *We work in people's homes: they don't live in institutions. But I don't know if we always adhere to that, you know. So for me is around and showing* [that] *people have privacy* […] *And I think it is a really interesting space around the EPOAs; they often have quite loud voices. And they are trying to instil their beliefs well along the way about their parent or partner and how that impacts on the individual. So for me, we should be looking at the wellbeing of the person engaged in the relationship* […] *I think that staff feel sometimes between a rock and a hard place. And I think the rock is about doing what's right for the person. And 'I don't want my mom to have a say'. But the assumption is that the EPOA has the right to say that*. (Lydia)

Quality of life

Quality of life was a major concern for all RACF staff participants. What the workshop did was help these participants to foreground quality of life against the constraints that may be presented by EPOAs (Schouten et al., 2021; Schouten, 2023) and the challenges presented by institutional silence and staff attitudes:

> *You were talking about the issue of consent, but just around, you know, the interesting conversations around EPOAs and what we should look for about*

> *consent. So for me, I would always look at the case of wellbeing, and whether the person seems distressed or not. Does it seem to be mutual? Does it seem to be enjoyable? […] So I think we get caught in nuances, and what consent looks like. And then there's, adult children. We don't know our parents are sexual* […] *We need to stop being so risk-averse around things. We need to be open to talk about these things, even if it's uncomfortable or not, our domain is to be able to put it out in the open. Actually, what we see is a really lovely relationship. And we think it seems to be mutually consensual. And we see no harm. So actually, why, are we trying to stop that? Because we're trying to encourage people to live with best life. They can live, and, you know, be the best version [of themselves], and if that is that, then should be. And actually, we spend more time and distress people more by trying to separate people*. (Lydia)

> *Of course, once you get either cognitive or not even cognitive impairment, but maybe if there's any concerns in that direction, that if there's even any kind of little thing, then they get quite nervous, and part of that is to do with experience impacting them, and also family… Family guidance, I guess, is the word EPOAs, or family less formally. EPOAs are very risk-averse, I guess.* (Suki)

> *We have instances where residents may have moved into care because of progressing needs, whether that's cognitive or otherwise, and maintaining or starting a relationship with an independent person who's fully, cognitively there, the relationship becomes sexual as that decline progresses. Maybe the resident is calling them by their old husband's name, or you know, it's hard to identify that the residents still knows who they're dating.* […] *Not necessarily that she doesn't know that John is Sam now, and she's in a relationship with Sam. But she's happy. No one's that worried, although the kids do quite often say she thinks she's sleeping with my dad. She's not. Therefore, please separate them.* (Suki)

However, one resident was relocated to another facility because staff felt unable to manage the relationship that the resident was developing with another resident, against the wishes of the adult children of the couple who held the EPOAs:

> *But it's kind of… I felt it was a kind of prison environment, you know? It's not like homely, you know? Community support environment is like restricting. 'You should not do that.' 'You should not express this.' 'This is because of your dementia', like that. It was really hard for the people to differentiate what's actual sexual needs* [what his real sexual needs were]. *And what's dementia? I felt sorry for the resident, but I had no control* [other than] *sending him to another place.* (Gadadevi)

The workshop also helped one staff person to recognise sexuality and resident sexual expressions where they might not have noticed it previously:

> *Recently* [there was] *talk about lady who'd like to get washed. And she asked her carer to wash her, you know, quite a few times in a certain area, I guess, and then they realised it's because actually, she gains some pleasure. So for me, then, that opens up a whole conversation. If that's the need that she has, and that's the only way she can get that, what can we do? Because that opens up another doorway. She's only getting pleasure from being washed. Bless. Then she's got needs that we're not meeting, and we keep talking about needs, and that need is actually*

> *sexuality… One of my friends did tell me, which I thought was very interesting, that she came across a lady who used the* [staff call] *alarm. Because it vibrates.* (Lydia)

A major quality of life issue is iatrogenic loneliness (Cook et al., 2021). When a resident moves into care, they are not merely changing living quarters, they are changing their entire social structure:

> *From the staff, what I get is loneliness. Right? So the majority of stuff that I hear is about loneliness. We survey residents and their families about six weeks after they move in, just to try and get a sense of how's everyone settling in? Yeah, I would say loneliness and addressing loneliness is a huge issue in here.* (Suki)

> [If I were an older person in residential care] *I'm looking for someone to physically help me to have sex. And maybe I just need somebody to physically help me because I can't physically do that. That's been probably the primary thing. And I think just sometimes it's just some people just want companionship, and they want somebody to spend some time with as well. So it's more about that interaction. They've always had a partner, and then they've lost their partner, or they've now moved. And now, you know, they want that intimacy…. Give people hugs, and they're comfortable doing that, if people ask. and you know, do that. But that's not the quite the same as lying down with somebody and being held for a while just in that moment, and especially, I think, at night as well for people. If you are used to sleeping in bed with someone, and are now in a single bed, that's actually quite a lonely experience for people.* (Lydia)

Building staff awareness about loneliness and intimacy from the moment of intake would be one way to address staff attitudes and to develop a comprehensive and meaningful care plan:

> *So you know, when I, when they're having an interview with the resident for the first time they can ask them all these questions. And don't leave out this question because it's often left out. They don't ask like, even. I don't know how much you know about the nursing assessments, but we don't often ask residents do you smoke? Do you take drugs. And similarly, we don't ask, what are your sexuality and intimacy needs? We don't, even, you know, go there.* […] *And I have kind of figured that out that not just for couples, but for every resident that's admitted. I will make it a compulsory assessment, that this assessment is done as part of all the other assessments. if the resident doesn't want to talk about it, then that's fine, you know you can say I refuse to talk about it. But just make it as a compulsory assessment for everybody.* (Rashmi)

Similarly, in Gadadevi's facility,

> *We started to open up this conversation for the staff at the moment. For the residents and families we are touching base, not like going deeper and offering those services, but we are kind of starting to have that conversation. So when we are doing a long term care plan, there is a section to complete* [about] *sexuality and intimacy. Initially, most of the time they will just write one or two sentences, not going deeper because they don't know what to talk* [about] *there. So I shared all the resources. I even shared the video I have learned from the workshop.* (Gadadevi)

The context of intimate interactions between caregivers and residents also sent conflicting signals, noted Lydia. For caregiving staff, sexualised intimacy is completely off-limits, but for residents, nakedness may be a precursor for exactly that kind of intimacy:

> *I keep trying to say to people, 'How often in your life do we see people naked?' Usually, when we see people naked, we're in a relationship with them…If you just come in, if you're if you're asking somebody to get undressed and saying, 'Hey, can you take your clothes off?' Then actually what you have? Maybe* [the] *signalling to that person is, 'Hey, we're going to have sex, because I must get your clothes off'. So in that person's world, it makes perfect sense that actually, they'd be going 'Oh, well, I'm gonna touch you because we're gonna engage in sex, because that's the only time that anybody would normally see me naked'*. (Lydia)

Engagement with sex workers

There was not always alignment between policies (Cook et al., 2018) and practices in respect of sex workers, and one staff participant seemed to express a lack of clarity about access:

> [Do we] *Support engagement with sex workers? Our policies that say we do. And definitely in our policies, we talk about that. We say we* [provide access]. *We definitely support that. But like, yeah, we just kind of had that, you know, we just arrange it, and we just kind of add that onto a bill somewhere, and she kind of gets paid.* (Lydia)

Direct care staff would not always have the confidence to act on a resident request on their own authority.

> [Care staff would] *refer* [a resident request for a sex worker] *on. They'd go ahead and make the arrangements. And what would happen, I think—and this is, you know, sort of guessing, just based on the conversations that we had— I think they would escalate it. So I don't think they would shut it down. I think there are situations where that's happened, or they've seen it happen. You know, where people have come in and provided that service. I think they would escalate it to their manager, and just say that this person wants that, what do I do? It is in our policy that that is a thing they can have like.* (Suki)

Similar to the issues raised by sex workers about directly approaching facilities, staff participants also felt that the practical challenges of making arrangements for a sex worker with the currently available resources was complex:

> *A centralized [contact system] would be great, I think, for us, I think. I just think as we're a national company. So we cover basically all of New Zealand. I think that'd be really good cause. I think that also helps our conversation, doesn't it? Because if you have that conversation and say, Hey, Bill, would you like sex? And you have to think about work, and I'm like,* […] *who? Where do I go? Who do I talk to? How do I arrange it. How do I ensure that they're going to be right?* […] *I think centralizing* [a contact system] *is good, because I think then we could use that to like launch some kind of conversations* […] *I think it's also the misperceptions of sex workers as well, isn't it? So? People have got massive misperceptions about how* [a sex worker] *is going to turn up. You know, wearing high heels looking sleazy, then everybody's gonna be like... Oh, well, you know, I mean. I think there are some ideas in lots of people's heads that we need to demystify. It will be like anyone else walking in each*

day. They'll probably be like any other visitor who walks into the building, you know. It's an understanding about reputational management. Like we were saying, we need to normalise it. And it just becomes another part of their plan of care. It's not anything old or deviant, or weird or unusual. (Lydia)

Of concern to at least one participant was that any worker providing sexual services was competent and safe to do so:

Well, that's the that's the other side of this, of course, is making sure that sex workers themselves are trained. (Suki)

Cultural issues

Engaging with sex workers was a new idea for some staff participants. Interviewees who were in a managerial role also commented on the complexity of balancing staff personal, religious, and cultural attitudes about sexuality and intimacy with their expected approaches in the workplace. There is a variety of complex cultural issues in respect of sex and sex work; these issues include not only ethnicity and religion, but also age group (Henrickson et al., 2022; Henrickson et al., 2021).

I had a great chat with a woman in [City]. *It was at their training, actually, and they were just becoming caregivers. And I said something along the lines of 'what do you do in a situation where resident does want to engage with external…you know, maybe a sex worker or da da da?' And she was right away, 'Oh, I can bring up the website we can choose together', you know. Go! But, yeah, many of our staff are sort of maybe in that forties range. Yeah, either new migrants or just culturally, background is sort of seen as* […] *not their thing.* (Suki)

Despite regular inservices, some care staff attitudes remain shaped by cultural norms that constructed sex and intimacy as 'naughty behaviour', rather than a human need:

We have taught our staff members about sexuality and intimacy over the years. You know this is a part of education training every two years, but to be honest with you, it was more about compliance needs that you have to do this training, just to tick a box. But not knowing the depth of what are we doing, and what the real meaning of this is […] *They will see [resident expressions of intimacy as wrong, and separate them, tell them off. You know that sort of thing. That's what are they doing* […] *because they were thinking more of this as a naughty behaviour rather than their needs* […] *If people [could be taught] to appreciate it, that I would like that kind of training for all my staff, so we change their thinking. That it's okay. You have to just make sure that people are safe.* (Rashmi)

Most staff participants were clear that the future of sexuality, intimacy, and sexual identity in residential care would be quite different from the past:

What are we looking [at] in the future? We do have diversity and inclusion group in our organization. So we are opening up the difficult conversation like rainbow, the lesbian, how many ethnicities, and in the audit we open up staff, and [ask] the residents to talk [about how they want to be addressed] he, him, or her, whatever they like. […] *Because now we are opening up to talking about a rainbow community, and what some of the future looks like, and the very diverse environment, and it after 20 or 30 years, we will have different kinds of community sectors. So they expect they will have that needs. And technologically, they* [the

staff] *are no more expert compared to our current* [residents'] *generation,* [and they know in the future residents] *will demand for the needs they will request. It's because* [it's not for another] *20 or 30 years they are not worried at this stage. But it will happen gradually* (Gadadevi)

We've kind of been joking about where the boomers are coming, right? The boomers with their high [expectations], just like exactly the next generation coming through is going to really highlight these issues. Yeah. But it's not even necessarily the boomers. But it's their kids are like, really aggressive. We're just really noticing that like a big change in so they have very strong feelings about whether their parents should be sleeping with people. […] *Me, having read enough research, and particularly, I guess, from the queer community, for example, feeling like they cannot be open or out in an environment where they live—we just can't have that.* […] *We have already transgender residents. We have, of course, gay and lesbian residents, but they come in or have been coming in, I guess, over the last 10 years with varying degrees of openness.* (Suki)

Personal and workplace attitudes and education

Staff attitudes are perhaps more complex to manage than resident behaviours and relationships. Education is key to this, they note, but too often education about sexuality and intimacy has been presented in a kind of 'tick-box' way, or is mostly theoretical rather than knowledge applied in practice. Education should also be available to family members as well as staff:

That's what we've been trying to say to staff, is you need to leave [your personal stuff] *at the door. You need to leave your belief system at the door to some extent, because you're here to work, but we know that that's not that easy*. (Lydia)

When you say 'sex worker', you know, people are picturing a lady hanging off the pole on the street, and her underpants, or whatever the case may be. Whereas the reality is, these people are coming in fully clothed. They could look like physiotherapists. Right? Like they don't look like sex workers. So for us, I think that's fine, totally. (Suki)

What we need is education, whether it's the staff and the family. If we're doing education about what we actually mean when we say sex worker. You know, meeting those [sex workers] *I think they showed a video in the first* [workshop] *we had with them where one of the staff was working with someone with cerebral palsy. I think they showed a little clip from a movie, and that was useful.* (Suki)

I had [conversations about sex workers] *with my* [clinical nurse] *team. Initially they were surprised, but they put on their professional hat. I think that's the beauty of them. And when they receive more information and awareness, when they put themselves* [in the place of future residents] *after couple of years, after 20 or 30 years, they have ability to understand. But I think the care team and the non-clinical team will have the different perspective. So we need to find a way how we can open up the conversation. And I think the mind-extender, the target team, will be a level for care givers. When I do the training for them* [about] *the resident centred care. So that's part of the discussion and the resources I received from the workshop. It's really helpful.* (Gadadevi)

Rashmi highlighted that staff education is at the heart of changing staff behaviours about sexuality, intimacy, and sex work:

> *It's to change the mindset of lot of staff members, to help them be comfortable coming to us and talking to us about how they feel. And you know, maybe we can change the way they think with the training. And you know, I think education is the key, whatever whether it's to do with something that society see as stigma or any other topic. Education is the key. I feel* [if] *we educate people* [then] *they think differently.* (Rashmi)

Finally, Suki was eager to get beyond the talk and just get on with providing access to sex workers, because it was becoming an urgent issue in the sector:

> *I guess I mean for me, it's just how do we get on and do this? You know we have all of this knowledge. As you say, our front-line staff are challenged for various reasons about whether they, you know, promote or accept or understand. And all of that kind of stuff. It might just be more discussion with our clinical team about how we can get some more traction on some of that stuff, because I do just see it continuing to grow. You know, we've got more memory care that we're building. We've got more people waiting longer to go into care. So that they are coming in with much higher health needs, which doesn't interfere with the sexuality and intimacy needs of their lives, but makes it more complex for them to do it themselves. So I guess it's just our next steps as a business. How do we prioritize them and move through that? Yeah. One of the challenges is that it's, in fact, happening throughout the sector. I guess you could think of sex is like dirty, gross it up. But this is, as you say, positive, affirming touch for people who, you know… Why shouldn't you get the benefit of intimacy just because you have physical impairments or cognitive decline, or whatever the case may be? Right? So if we're educating on that, it does move, you would hope it moves away from that kind of sensationalisation.* (Suki)

Summary of staff participant findings

In a way similar to that of some of the sex worker participants, two of the staff participants felt that the workshop had not impacted their attitudes because they were already positively disposed towards sex work in residential care; still, they were grateful for the experience. The other two staff who were relatively naïve to the topic felt that the workshop was an important and powerful experience, one they wanted to share with their own staff and colleagues. In findings similar to previous work on the topic it is the personal attitudes and preconceptions of the staff that are the strongest influence on the ways RACF staff think about and manage resident expressions of sexuality and intimacy (e.g., Bauer et al., 2019; Henrickson et al., 2022; Henrickson et al., 2021; Henrickson et al., 2020; Howard et al., 2019; Shuttleworth et al., 2010; Villar et al., 2014; Villar et al., 2018). A similarly powerful influence is the attitudes of adult children and holders of EPOAs. Not surprisingly, participants felt that more education in the sector—serious, not merely 'box-ticking' education was the way forward. This education and changing staff behaviour is increasingly important to prepare for the future, when the Boomer generation and increasingly sexually and gender diverse residents enter care. This education should also be offered to adult children, spouses, and holders of EPOAs. With the increasing availability of pornography on the Internet, resident expressions and expectations of the management of sexuality and intimacy will be higher than any previous generation. Expressions of intimacy are understood as good person-centred care, provided all individuals involved in those expressions are voluntary participants, and feel those expressions enhance their quality of life.

At least from the four participants in this study, participants suggest that there is room for increased access for residents to workers. The sexual services they have access to, including the likelihood of intimate touch, may go some way in assisting the management of complex residents, increasing their quality of life, and decreasing problematic behaviours. Sex work should be considered a kind of paraprofessional service that can augment existing relationships the resident has. Still, the practical arrangements of organising access to sex workers seem daunting for staff participants, and some kind of centralised point of access that at the same time ensures that the workers are sufficiently trained in self-awareness and providing best-practice services for older or disabled clients would be very useful.

Post workshop activity

Since the workshop, sex worker participants have spoken to Dr Morgan about wanting help contacting residential facilities, including questions on how best to market their services, how to avoid negative responses from facilities, and how to find out who to contact in the facilities. A member of the project advisory board has provided some suggestions, and this information has been sent to the group. One of the sex worker participants sent information about a facility in the South Island that has an understanding manager who is supportive of sex workers seeing residents in her facility. Participants have also spoken about the benefits of sharing information and have discussed online methods to do this, including a private Facebook group, and creating a group on Discord, a text and voice messaging social media site. Some sex worker participants have raised concerns about privacy, particularly with the proposed Facebook group, and to date no active group has been created. One of the participants who is currently working with aged care facility residents has spoken about sharing the advertising material that she has created with fellow research project members. Also, a member of the research project's advisory board has created a private Facebook group: https://www.facebook.com/groups/accessintimacy. NZPC contacted the sex worker research participants to see if they would like to be on a list of specialist sex workers who provide services for older and differently abled people, as NZPC occasionally receives requests from facilities. Currently, there are three people on that list.

There have been a number of meetings between NZPC, a member of the advisory board, and a person who works in government in the field of disability about the possibility of creating something like Touching Base New Zealand, though Touching Base Australia has asked that another name is used. The suggestion has been to use 'Access to Intimacy New Zealand' (AINZ). Issues discussed in these meetings have included the governance structure of such a group, funding for the group, and funding that differently abled people can currently access to pay for sexual services. Support for the creation of the governance structure and funding has been offered by a member of the advisory board but despite interest from two sex workers (not research participants) Access to Intimacy New Zealand (AINZ) has not yet been created.

NZPC was contacted by an RACF staff research participant who was looking for a specialist sex worker to help with one of her clients. Initially she misunderstood NZPC's work, thinking that it was a type of agency for specialist sex workers. This misunderstanding was cleared up and she was put in touch with a specialist sex worker (not a research participant). This staff participant spoke of the need for something like AINZ and for more education for her staff; this concern was reiterated by a member of the project advisory board. We are aware that there are a number of educators already working with RACF staff, and the possibility of coordinating with them should be considered.

Conclusion and Recommendation

It is abundantly clear that the workshop-based Touching Base training was effective, and endured for at least the three months of the follow up period for both sex workers and RACF staff. The project attracted some sex workers who were already working with older and disabled clients, and RACF staff who were already sympathetic to increasing access to sex workers for residents in their facilities, but all participants reported some benefits. Some experienced sex workers amended their marketing materials, felt more confident in their work with older and disabled clients, or felt more confident in the ways they could work with staff and clients in residential care settings. Some workers, however, will continue to prefer working with older and disabled clients in spaces over which they have complete control. For these workers and for RACF staff with experience with the issue, the workshop was a validating experience where they could share their experiences and frustrations.

For naïve sex workers and staff, the workshop was a significant experience. Both a sex worker and some RACF staff found the workshop an 'eye-opener' and staff were eager to share their learnings with other nursing and other care staff in their own facilities. At least one RACF staff participant reported making an effort to arrange a visit with a sex worker for a resident, and expected that such a companionship would go some way to addressing the resident's negative and disruptive behaviours.

Both sex workers and staff took the issue of consent very seriously. Consent, however, should not be constructed as routine notification of family or designated EPOAs (when a client is fully capable of making decisions, or when an EPOA is not activated) when a resident requests or organises a sex worker, or enters a relationship, as such notices create the risk of over-notification and compromising resident privacy. The safety of all residents is important. But just as important is the quality of life of all residents. We heard stories of residents being chided, scolded, or separated by staff at the behest of family members because they developed relationships that strengthened intimacy. Such approaches are infantilising and may be detrimental to resident wellbeing. Several staff participants said that they would now take intake assessments related to relationships, sexuality, and intimacy more seriously, so that resident needs and wishes could be incorporated into long-term care plans. It is important that sex workers feel safe and supported when working in RACF. Participating in non-judgemental, non-stigmatising communications was suggested as a strategy to create supportive environments that honours all persons engaged in the transaction. Sex worker participants also spoke about the different strategies they had developed to assess consent, particularly in circumstances where a client's ability to communicate was compromised.

A key concern raised by both workers and staff was RACF staff attitudes about sexuality, intimacy, and sex work. This issue in Aotearoa New Zealand has been well-explored elsewhere (Henrickson et al., 2022), and there is international literature cited elsewhere in this report. Concerns raised include staff attitudes towards gender and sexually diverse residents, sex workers, and sexuality in older persons more generally. Staff education is seen as a key towards shaping staff behaviours, and some staff managers said that they now planned to take mandatory education around sexuality and intimacy more seriously and take less of a tick-box approach, since they were talking about real-life concerns with real individuals.

Sex worker participants reported that they had developed an array of strategies to work with older and disabled clients in order to accommodate different body responses and abilities. An unexpected finding was the near-universal emphasis on intimacy: attention to wairua, acknowledging and respecting previous relationships and bereavements, and coming with heart to intimate

relationships with older as disabled clients was reported in some way by all sex worker participants. While we do not have the data to support that this is a universal approach by all sex workers across the motu, for the experienced workers who choose to work with older and disabled clients and participate in this study, it is clearly a norm. Understanding sex work as paraprofessional therapeutic intimacy may be a way to normalise that experience.

This pilot study was designed to answer the question 'Does providing education to sex workers and care facility staff improve access to intimacy for people in supported residential facilities?'. While the response to this question cannot be unequivocal in a limited pilot study, we can say that there was some increase during the three-month period between the workshop and the follow-up interviews. Sub-questions asked how effective the workshop was, whether it resulted in changes in knowledge, attitudes, behaviours, and beliefs in participants; and whether any changes were enduring over time. We can say that these questions can be answered uniformly positively. While the project attracted participants who were already largely sympathetic to outcomes and that changes were therefore relatively minor, both Phase 1 and Phase 2 findings demonstrate that the workshop was effective; that there were minor but positive changes in knowledge, attitudes, behaviours, and beliefs in both participant groups; and that these positive changes and positive attitudes towards the workshop endured for at least the three-month follow up period.

One of the common concerns expressed by both participant groups is how to make the connections between RACF and sex workers. There has been some informal work done on this already, but creating more formal marketing and publicity structures is an obvious next step for the Intimacy Access advisory group.

It is clear that providing intimacy through sex work is increasingly interesting to staff in residential care. However, further research with more 'naïve' sex workers and RACF staff would be useful to determine the extent to which an online workshop creates spaces for learning and discussion. Such a study will require funding, staffing, and a clear commitment by RACF to include their staff in such training, and by sex workers to dedicate their time. This will not be easy. One way to do this will be for a governmental, para-governmental, educational institution, or national professional body to make adequate research funding available. Such a national project should include the following key elements:

- a culturally sound curriculum based in Aotearoa New Zealand and delivered by domestic trainers (which includes experienced sex workers);
- participants are compensated for their participation;
- facilities are compensated for the time that staff take for the training and participation in the research;
- some kind of centralised and accessible structure (e.g., website, office, or telephone-based service) is developed that matches facility requests and specialised worker availability. Such a structure may need to have a vetting process that ensures the capability of the sex worker to do specialised work;
- the project must gain support from the RACF sector and also sex workers to recruit an appropriate number of diverse participants (that includes at least age, gender and culture) that will yield statistically useful findings.

Such a study may yield sufficiently robust findings to assist regulators and policymakers to develop appropriate responses to allow consensual relationships between residents, and older and disabled clients more generally to introduce, maintain, or re-introduce intimacy in their lives. Such a project will not be without risk: we have seen over time that public attitudes are one of the challenges to

this work, but public attitudes should not be a key determiner to the quality of life of older persons, or adult disabled persons of all ages. Access to sex workers has already been occurring throughout the motu both privately and in residential care settings.

Public attitudes should not be a barrier to innovative and compassionate programmatic responses, and there are no objections that cannot be addressed with carefully designed process. We are also mindful that such research and programming occurs not only in social but also in political and policy contexts. We also believe that any concerns from these sectors can be addressed by sound, evidence-based policies, regulations, and programming. In short, we propose as one of our participants said, that all sectors need 'to come with heart'.

Appendix

Pre-and Post-Workshop Survey Responses (n=11) (Phase 1)

Sex Workers

Notes:

- E=Pre-workshop question only, O=Post-workshop question only; all other questions were identical
- All scale responses were based on a 1 (Strongly disagree) to 5 (Strongly agree) scale; there were three reverse-scored items (QQ10,12,14), where a low score was a 'preferred' score, and a decrease in change indicated a decrease in a negative attitudes.
- Some participants did not respond to all items. There were a total of 11 (n=11) participants; if you see an (n=9) or similar, it means that responses were missing from the total.
- One completed pre-workshop survey was removed because the participant did not complete the post-workshop survey.

Q1 asked participants to create or enter a unique identifier.

E2. I have attended a workshop on intimacy and sexuality for older persons before today.

Yes=2

No=9

O2. Overall I found the workshop enjoyable.

OMean=4.73, SD=0.467, range=4 to 5

3. I have the communication skills I need to negotiate sexual services with older clients.

EMean=4.00, SD=1.095, range 1 to 5; OMean=4.73, SD=4.730, range=3 to 5; one score decreased

Mean change=0.73, SD=1.272; range=0 to 4

4. Intimate relationships that involve pleasurable touch are a life-long human right.

EMean=4.73, SD=0.647, range 3 to 5; OMean=5.00, SD=0, range=5;

Mean change=0.27, SD=0.647, range=0-2

5. Sexual activity may improve the well-being and quality of life of older and disabled people.

EMean=4.82, SD=0.405, range 4 to 5; OMean=4.91, SD=.302, range=4 to 5;

Mean change=0.09, SD=0.539, range= -1 to 1

6. I feel confident in my ability to negotiate sexual services with an older client.

EMean=4.09, SD=0.701, range 3 to 5; OMean=4.45, SD=1.214, range=1 to 5, one score decreased

Mean change=0.36, SD=1.027, range=-2 to 2

7. I feel confident in my ability to talk with a family member about providing sexual services to their older relative.

EMean=2.73, SD=1.421, range 1 to 5; OMean=4.36, SD=0.809, range=3 to 5

Mean change=1.64, SD=1.912, range=0 to 4

8. Sometimes all clients want is someone to talk to.

EMean=4.45, SD=0.688, range 4 to 5; OMean=4.73, SD=0.467, range=4 to 5

Mean change=0.27, SD=0.786, range=-1 to 2

9. I know enough about the laws related to consent to provide sexual services safely to older persons.

EMean=3.91, SD=0.944, range 2 to 5; OMean=4.64, SD=0.505, range=4 to 5
Mean change=0.73, SD=0.905, range=-1 to 2

10. People over 65 have little interest in sexual activity. *(Reverse scored)*

EMean=1.55, SD=0.522, range 1 to 2; OMean=1.82, SD=1.401, range=1 to 5
Mean change=0.27, SD=1.401, range=-1 to 4

11. I feel confident in my ability to negotiate with residential care staff about providing sexual services to a resident of their facility.

EMean=2.55, SD=1.440, range 1 to 5; OMean=4.18, SD=0.603, range=3 to 5
Mean change=1.64, SD=1.748, range=-1 to 4

12. People living with dementias can never reliably consent to sexual intimacy. *(Reverse scored)*

EMean=3.00, SD=1.095, range 2 to 5; OMean=1.70, SD=0.949, range=1 to 3 (n=10)
Mean change=-1.40, SD=0.966, range=0 to -3 (n=10)

13. I feel confident in my ability to provide services to someone who requires help to move or to engage in sexual activity.

EMean=3.30, SD=1.567, range 1 to 5 (n=10); OMean=4.30, SD=1.252, range=1 to 5 (n=10)
Mean change=1.22, SD=1.563, range=-1 to 4 (n=9)

14. Thinking about providing sexual services to an older person makes me feel uncomfortable. *(Reverse scored)*

EMean=2.45, SD=1.563, range 1 to 5; OMean=1.55, SD=0.934, range=1 to 4
Mean change=-0.91, SD=1.221, range=0 to -4

E15. I am looking forward to the workshop.

EMean=5.0, SD=0, range=5

O15. The workshop was a good use of my time.

OMean=4.55, SD=0.688, range=4-5

E16. What is the main reason you signed up for the workshop? *[edits], otherwise verbatim*

- I'm a sex worker that would like to improve my work with older clients
- I want to learn more about how to offer services to those who are elderly or disabled, and how to make myself more appealing to those who are elderly or disabled.
- It's always good to learn new things as you never know when you may need that skill set
- Have a lot of elderly clients
- To be more knowledgeable in how to provide great service to older clients
- Continued education & training as a sex worker
- To learn and be more informed and know safe practices of how to work with older persons and disabled, especially when there are physical challenges and mental challenges, such as dementia. I wish to learn how to communicate with family and care facility staff that is inclusive and safe for everyone.
- I am a full-service worker who identifies as disabled, therefore I am an advocate for destigmatising sex while living with disabilites. I am a strong believer in the positive impact

of sex and want to learn more so I can provide my services for those who need it but may feel their needs are not valid due to age/disabilities

- Networking and expanding my knowledge
- To be able to better understand and be more equipped with working for the disabled/elderly
- To educate myself on how to provide services for older adults/ individuals that live with a disability

O16. Before the workshop were you familiar with Touching Base?

Clear Yes=3

E17. What are your expectations of the workshop? [Verbatim]

- Haven't done one yet
- Sharing of information about how to engage with those who are disabled or elderly, information about how to speak with rest home or other support workers
- None
- New tools
- To gain more knowledge in how to provide ethical services to older clients and people with disabilities.
- I will learn more skills, tools on how to navigate communication, safety, boundaries, duty of care for all involved
- To be exposed to new ideas and information on working with older persons, especially those in care facilities, and anyone with disabilities.
- I'm coming in with an open mind that it will be a safe space to ask questions without judgement
- To learn more, fill gaps, consider new situations and how to handle them

O17. Did the workshop meet your expectations? Why or why not? [Verbatim]

- Yes the workshop was great in helping me realize I was doing things correct when it come to my older clients.
- Yes, and exceeded it. All facets of aged care environments were covered, different insights from people who have received and provided sexual services to disabled and elderly clients were shared, and information about how to market myself to service users was included - approaching the care agencies involved.
- It's was amazing an a eye opener.
- Totally amazing, great info and ran well considering it's online
- Yes it did, I found it really helpful to go over all consent side of things, and to know that it is the persons right to be able choose if they would like sexual services. Family or social care shouldn't be able to withold that from them.
- More than my expectations. great combo of peer education, and knowledge of navigating family/carers/ housing.
- Yes the workshop met my expectations. Knowing that both facilitators as well as all participants are sex workers made me feel comfortable. The workshop covered working with older people and touched on working with people with disabilities, which is what I expected.
- Met them and went beyond! I felt very safe, it was formal and informal :)

- Yes to networking and reaffirmation of what I am already doing. I did realize though that I mostly knew all the information already 😅 I feel it was helpful for others that I shared from my experience in age care and disability work
- Yes, I learned a lot more than I expected too, and enjoyed listening to everyone's input on certain subjects
- Yes

O18. What did you find most helpful during the workshop? [Verbatim]

- Consent around dementias.
- The videos sharing views from service users and providers, and the experiences shared by the male coordinator (unsure how to spell his name sorry).
- All of it is helpful. An[d] something that is well worth doing
- Information and new tools
- I really enjoyed the videos that got actual people who had disabilities to talk about their experiences with sex workers and how this has had a positive influence on their life.
- the peer education, listening to stories of other sex workers. I enjoyed the video content to see real world of what happens. having the conversation for disability and sex.
- 1. Having two facilitators who have worked with older and disabled clients is a valuable resource that offers great insight. 2. The chance to hear other sex worker's questions around the workshop topics. 3. Talking openly about what could happen.
- This isn't about the content we learnt but I wanted to note as someone with ADHD who often struggles to follow what others would perceive to be basic instructions, I found accessing the venmo [Vimeo] and links really easy as they talked us through where to locate them! The consent section was very beneficial to me :)
- Hearing real life stories about sex work, negotiations and reminders about consent
- Learning how to better communicate and get proper consent
- Talking about the more technical aspects of navigating the interaction with an older adult

O19. Tell us what the workshop should have included but was missing. [Verbatim]

- More help in contacting and consent when it comes to seeing the Edley [elderly?] in homes that are run by agencies
- Not necessarily something that "should" have been included, but something that will add to the experience: Views and perspective from the family members and support staff involved in the process, such as the family members who reach out to sex workers for their family members and how they see the change(s) in their family members, and care workers explaining how they can support the service user in the preparation, the repositioning (if required), the changes they observe in the service user after starting to experience the service provided by sex workers etc. Just having those additional perspectives shared would help provide insight into best ways to engage with these people to help meet their family member's/resident's needs and the effect our work has on their overall wellbeing.
- I thought it was great
- It felt complete to me for an intro workshop
- More stories about what other people have experienced when working with older clients and clients with disabilities. I really appreciated Saul sharing his experiences, it gave a lot of insight into the things that as sex workers we experience. Perhaps time is a issue when telling these stories, so it can't fit into a workshop, but maybe someone will publish a book or e-book. Peer to peer learning is awesome, and telling stories helps with this alot. I wanted

to hear more about how to work with disabled people, so will be doing the Touching Base course online in the near future.

- More on NZ advertising for age care clientele and options for funding etc (they may not exist)
- Maybe how to advertise to exclusively elderly and a bit more about disability and how to better work with different ones
- Most details about how to accom[m]odate for physical limitations in the booking

Residential Care Facility Staff (n=5) (Phase 1)

Notes:

- E=Pre-workshop question only, O=Post-workshop question only; all other questions were identical
- All scale responses were based on a 1 (Strongly disagree) to 5 (Strongly agree) scale; there were three reverse-scored items (QQ10,12,13,14), where a low score was a 'preferred' score, and a decrease in change indicated a decrease in a negative attitudes
- Some participants did not respond to all items. There were a total of 5 (n=5) participants.

Q1 asked participants to create or enter a unique identifier.

(Researcher note: Two participants could not remember their identifier, but through a process of elimination we were able to associate the responses to the correct person. However, the sample size is small, and therefore all responses should be interpreted with caution.)

EQ2. I have attended a workshop on intimacy and sexuality for older persons before today.

Yes=2

No=3

OQ2: Overall how satisfied were you with the workshop?

OMean=4.00, SD=1.225, range=2 to 5

(Researcher note: two respondents appear to have reverse-scored this item; that is, they scored it low on satisfaction, but in the narrative said things like 'It was great!'. On that basis I have reverse scored their responses. This item, therefore, should be interpreted with great caution.)

Q3: I have all the communication skills I need to talk with older residents about arrangement sexual services for them.

EMean=3.00, SD=1.581, range=1 to 5; OMean=4.20, SD=0.447, range=4 to 5
Mean change=1.20, SD=1.924, range=-1 to 4

Q4: Intimate relationships that involve pleasurable touch are a life-long human right.

EMean=5.00, SD=0, range=5; OMean=5.00, SD=0, range=5
Mean change=0, SD=0, range=0

Q5: Sexual activity may improve the well-being and quality of life of older and disabled people.

EMean=4.60, SD=0.548, range=4 to 5; OMean=5.00, SD=0, range= 5
Mean change=0.40, SD=0.548, range=0 to 1

Q6: I can make decisions that balance the sexual satisfaction and the safety of older residents.

EMean=3.20, SD=1.095, range=2 to 4; OMean=4.40, SD=0.548, range=4 to 5
Mean change=1.20, SD=1.643, range=0 to 3

Q7: I feel confident in my ability to talk with a family member about arranging sexual services for their older relative.

EMean=3.00, SD=1.483, range=1 to 5; OMean=4.00, SD=1.000, range=3 to 5
Mean change=0.80, SD=1.304, range=-1 to 2

Q8: Rather than sex, sometimes all a resident wants is someone to talk to.

EMean=4.80, SD=0.447, range=4 to 5; OMean=4.80, SD=1.000, range=4 to 5
Mean change=0.0, SD=1.304, range=-1 to 0

Q9: I know enough about the laws related to consent to arrange sexual services safely for older persons.

EMean=2.20, SD=1.304, range=1 to 4; OMean=4.40, SD=0.548, range=4 to 5
Mean change=2.20, SD=1.643, range=0 to 4

Q10: People over 65 have little interest in sexual activity. (Reverse scored)

EMean=1.20, SD=0.447, range=1 to 2; OMean=1.20, SD=0.447, range=1 to 2
Mean change=0.0, SD=0.0, range=0

Q11: I feel confident in my ability to communicate with sex workers about arranging sexual services for residents of my facility.

EMean=3.20, SD=0.837, range=2 to 4; OMean=4.40, SD=0.548, range=4 to 5
Mean change=1.20, SD=0.837, range=0 to 2

Q12: People living with dementias can never reliably consent to sexual intimacy. (Reverse scored)

EMean=2.80, SD=1.789, range=1 to 5; OMean=2.00, SD=1.707, range=1 to 3
Mean change=-.80, SD=1.304, range=-2 to 1

Q13: Sex work may be legal in Aotearoa New Zealand but I think it is immoral. (Reverse scored)

EMean=2.20, SD=1.304, range=1 to 4; OMean=1.40, SD=0.800, range=1 to 3
Mean change=-0.80, SD=0.837, range=-2 to 0

Q14: Thinking about arranging sexual services for an older person makes me feel uncomfortable. (Reverse scored)

EMean=1.80, SD=0.867, range=1 to 3; OMean=1.40, SD=0.548 range=1 to 2
Mean change=-0.40, SD=1.140, range=-2 to 1

Q15: I am aware of ways that my workplace can enhance expressions of sexuality in older residents.

EMean=2.80, SD=1.095, range=1 to 4; OMean=4.00, SD=0.707, range=3 to 5
Mean change=1.20, SD=1.304, range=0 to 3

EQ16: What is the main reason you signed up for the workshop? [Verbatim]

To learn about how can we enhance the sexuality aspect of care for elderly residents, what is right and what is not appropriate. Where to find info if we need to provide this service, how to gauge/assess the sexuality aspect of care.

I am working with elderly residents and experienced few incidents related to the sexuality. At the same time, I am promoting diversity and inclusion in the workplace so understanding the Sexuality and intimacy is very important part in my job role.

Wanting to understand how we can best support residents (including those living with dementia) to express & maintain their sexual lives if that's what they want, how to educate & communicate with families about these issues & help them navigate, and how we can support the frontline staff who manage the risk and scenarios in real life, ensure they're educated & comfortable & know what's expected from them and what's not.

I have had an interest in sexuality for residents for a long time and have conducted my own research and education on the topic. I find that it is a topic that a lot of people feel uncomfortable talking about, including residents, staff and families and is often seen as taboo or unrecognized. I am concerned that if there is some discomfort talking about sexuality between a married couple then there is little space to even have conversations for many others.

Had a previous situation that was ethically tricky for residents in dementia care

OQ16: What is the main reason you signed up for the workshop? [Verbatim]

to look at how we can open up conversations relating to the sexual needs of older people who reside in residential care

To learn about sexuality and intimacy in older people, find excellent resources and build confidence to make decisions, and talk to clients and family members about sex services that are available for lonely elderly people. Learning this will definitely benefit the elderly in my care.

Education, curiosity, better outcomes for older people

Understand the available resources and legal requirements

OQ17: Tell us anything you would have changed about the workshop [Verbatim]

would be good to look at how to start a conversation and places that are doing this already and how they got to that point, otherwise it was great

Jamboard was an excellent platform for sharing ideas, perhaps the discussion of the answers on the jam board can be initiated once everyone has written their answers and done some individual thinking. Some people cannot listen and think at the same time. Overall, a very informative education helped me to develop that confidence I didn't have enough before the session.

It was great!!!!

Demographics RCF staff (n=5)

E18. (Optional) What is your age group

20-30 years=0
31-40=2
41-50=1
51-60=1
60+=1

E19. (Optional) How many years have you worked in residential aged care?

10+ years=2
5<10=2
2<5=0
1<2=1
<1=0

E20. (Optional) How do you describe your ethnicity or cultural affiliation? (More than one response may be recorded per participant)

European (any)=3
Māori=0
Asian=1
No response=1

E21. (Optional) How do you describe your gender (for instance, female, male, trans woman, etc.)?

Female=5

E22. (Optional) How do you describe your sexuality (for instance, hetero, lesbian, gay, bi. etc.)?

Hetero/Straight=3
Bisexual=1
No response=1

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