Religion, sexual orientation, and gender identity in older age care spaces (RESORGICH): Scoping study findings

Dr Sue Westwood, York Law School, University of York

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Introduction

Despite increasing legal protections and recognition for lesbian, gay, bisexual and queer (LGBTQ) people in many parts of the world, the tension between religious freedoms and LGBTQ rights is an enduring concern (Eskridge and Wilson, 2018). Many LGBTQ people are religious themselves, especially older LGBTQ people (Westwood, 2017; Brennan-Ing et al., 2013). However, not all are. Equally, while some religious organisations, particularly more 'liberal' arms of the major religions, are accepting and supportive of LGBTQ people; sadly, this is not the case across the board (Acker, 2017; Fisher et al., 2017).

These tensions have implications for the provision of health and social care and social work services. International and national research suggests that conservative religious beliefs inform negative attitudes towards LGBTQ people (Dorsen, 2012; Chonody and Smith, 2013; Sekoni et al., 2017; Stewart and O'Reilly, 2017; Brooks et al., 2018; Brown, Kucharska and Marczak, 2018; Ayhan et al., 2020; Bradbury-Jones et al., 2020; Jurček et al., 2021; Westwood, 2022). However, how organisations and staff with religious beliefs which disapprove of LGBTQ people deliver services to them is not yet well-understood. Whether they can do so effectively, and in non-discriminatory and anti-oppressive ways is a matter of some debate in the US (Dessel and Bolen, 2014; Crisp, 2017; Jurček et al., 2021). This has not been explored in any great depth in the UK context.

These issues are under-addressed in the UK, being "an 'uncomfortable' subject which is often ignored in analyses of health and social welfare diversity policies" (Carr, 2008, p. 113). 11 years ago, writing about UK social work, Brown and Cocker (2011, p. 80) asked: "How do we get beyond the 'love the sinner, hate the sin' mantra, or the personal values versus professional standards quagmire?" This question continues to be relevant. Schaub, Willis and Dunk-West (2017) recently examined UK social workers' beliefs and values about sexuality in everyday professional interactions within the UK, observing:

> [there are] inherent tensions between religious beliefs and sexual morals divided opinion for our respondents… the profession of social work has not adequately addressed this tension for people with conservative religious views; these views cannot be easily reconciled with critical thinking about the sexual and gender norms that can restrict many clients' everyday lives and personal relationships. (p. 440)

The issue is highly relevant to the UK context, with many religious organisations providing care services, either independently or contracted by local authorities. Over two-fifths of all social workers in England identify as Christian (Social Work England, 2021), while migrant workers, often from religious countries where LGBTQ people are oppressed, are over-represented in health and social care provision (Turnpenny and Hussein, 2021; Skills for Care, 2020), often resulting in a clash of cultures (Carr, 2008; Carr and Pezzella, 2017; Hafford-Letchfield et al., 2018; Willis et al., 2018). Four recent UK court cases highlight the relevance of this issue. In the first, a doctor unsuccessfully claimed unfair dismissal for refusing, on the grounds of his religious beliefs, to refer to trans people by the pronouns with which they identified.[1] In the second, a conservative Christian social work student from Cameroon successfully appealed expulsion from his course because of religious-based homophobic

[1] *Dr David Mackereth v The Department for Work and Pensions and Anor [2019] ET 1304602/2018*

comments he made on his Facebook page.[2] In the third, an evangelical Christian fostering and adoption agency failed to overturn the regulatory requirement preventing it from exclusively recruiting "evangelical married heterosexual couples of the opposite sex".[3] The court ruled that it could limit its recruitment to evangelical carers but not exclude non-heterosexuals. In the fourth case, an evangelical Christian nurse unsuccessfully claimed for unfair dismissal after losing her job for engaging in unwanted religious conversations with hospital patients.[4] These included interrogating them about their religious beliefs, or lack thereof; telling a cancer patient that prayer would improve his chances of survival; giving patients bibles they did not want; praying intensely over patients unrequested; and urging sick patients to sing psalms with her. According to the evidence, one patient who complained said that "he was so astounded he had sung the first verse with her; he described the encounter as 'very bizarre' and 'like a Monty Python skit.'"[5]

Research on older LGBTQ people's concerns about anticipating older age care has highlighted that they are very fearful of care which does not recognise, understand, or support their needs. Some of those fears relate to religious care organisations and/or religious carers. In the UK, Guasp (2011) quoted the following survey participant:

> There is a severe lack of understanding about the particular needs of older lesbian and gay people, especially from some faith-based organisations that provide care services. (John, 57, London, UK) (p.11)

Westwood (2017), reporting on a study of UK LGB older people, quoted the following research participants:

> I think a lot of the care homes are run by faith institutions of some sort who could be very homophobic indeed. (Tim, age 52) (p. 20)

> [I am frightened] that I would encounter homophobia, because all kinds of people work in care, from like fervent Filipino Catholics to young people who are not particularly educated, you know? So yes, that would make me apprehensive. (Rene, age 63) (p. 20)

Sally Knocker (2012) quoted the following from her study of UK older LGB people:

> To send a religious fundamentalist care worker to visit a gay man is like sending a member of the BNP[6] to a black person.' (Spike, older gay man) (p. 10)

Knocker (2012) also quoted the following respondent:

> In one doctor's surgery, there were Jesus posters over the wall. I don't think it is appropriate to bring religion into the workplace, into a public workplace. I would like these kinds of public places to be neutral places. They can practice what they like at home, but I don't want to know. (Older lesbian) (p. 10)

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[2] *R (Ngole) v The University of Sheffield [2019] EWCA Civ 1127*

[3] *Cornerstone (North East) Adoption And Fostering Service Ltd, R (On the Application Of) v The Office for Standards In Education, Children's Services And Skills [2020] EWHC 1679 (Admin) (07 July 2020) [2021] PTSR 14, [2020] WLR(D) 396,*

[4] *Kuteh v Dartford and Gravesham NHS Trust Employment Tribunal Case Number 2302764.2016: Kuteh v Dartford and Gravesham NHS Trust [2019] EWCA Civ 818, [2019] IRLR 716*

[5] *Kuteh v Dartford and Gravesham NHS Trust Employment Tribunal Case Number 2302764.2016*, Para 28.4.

[6] The BNP (British Nationalist Party), is a far-right, fascist political party in the UK.

Brooks et al. (2018), in a review of the UK literature on LGBTQ inclusiveness in healthcare, found that several studies had reported that the display of religious symbols or icons were barriers to LGBTQ people being open about their identities, whereas the display of LGBTQ materials (posters, leaflets, rainbow symbols, etc.) made disclosure more likely.

UK-based research projects of older LGBTQ people's actual experiences of health and social care provision are rare, and their experiences of religious care are almost never reported. However, Almack, Seymour and Bellamy (2010) and Westwood (2017) described disenfranchised grief experienced by bereaved (older) partners in same-sex couples, whose relationships were discounted by faith leaders. A UK study on LGBTQ staff's experiences in the NHS quoted a gay nurse as saying: 'I was told I should be hanging from a tree by a nurse from Nigeria with strong religious beliefs' (Somerville, 2015, p. 6). Knocker (2012, p. 10) reported that an older disabled lesbian woman in the UK was given leaflets by religious care workers suggesting that she could be 'saved,' which Knocker observed "has made her feel unsafe and alienated in her own home." Westwood and Knocker (2016) quoted two trainers who were delivering LGBTQ training to health and social care workers:

> One woman said that if her daughter was lesbian she'd have to "exorcize the demon out of her" and another man just starting from the point of "where does this perversion come from?" on the training and then wanting to go into the whole spiel about how the male and female anatomy are meant for each other. (Joy, UK Activist) (p. 18)

> It can be hard . . . you know one guy came in and said, "what causes this perversion," and I've been prayed over, and there's been this uprising in the room with people saying, 'Oh if my daughter was . . .' and all this gay conversion stuff, and it's been pretty, pretty tough, yeah. But… you've got to hear the hatred, actually, and sort of expose it, rather than it just staying as subtext. (Sarah, UK activist/ trainer) (18)

Hafford-Letchfield et al. (2018) reported that one of the action researchers on their staff training project described the following:

> One staff member declared to a CA [Community Adviser] that they "knew how to deal with that disease" and "One woman [care staff member] stated she would ban her son from the house if he came out as gay." (e318)

They commented that:

> This observation suggests, despite emphasis on person-centred care, persistence of ingrained homophobia and partial tolerance of LGBT individuals in a setting where care is provided for vulnerable, older individuals. Such anxieties were animated by tensions between religious beliefs and sexuality. (e318)

However, these are only peripheral observations and give no indication as to the scale of the problem, if indeed there is one. The subject has not yet been the focus of research, and there are many knowledge gaps. This project aimed to begin to address this dearth of literature by identifying and understanding the key issues and gaps, building a research network, and developing a research agenda for a future larger-scale collaborative research project.

Methodology

Ethics approval

This project was granted ethical approval by the University of York's Economics, Law, Management, Politics and Sociology Ethics Committee (ELMPS).

Aims and objectives

The aim of the study was to develop a research agenda and build a research network to explore the intersection of religion, sexual orientation and gender identity rights in older age care spaces. There were three main objectives:

(1) *Scope* how religious freedoms, sexual orientation rights and gender identity protections intersect in UK care services for older people, and what the tensions and Equality Act 2010 implications may be
(2) *Identify* what needs to be understood about the navigation of religious freedoms and sexual orientation/gender identity rights in UK older age care.
(3) *Develop* a collaborative network involving key actors (policy makers, service commissioners, care providers, older LGBTQ people, their families/friends, and LGBTQ organisations) to be involved in a full-scale research grant application to investigate these issues in depth.

To meet these objectives, the following research questions were asked:

(1) How do religious freedoms, sexual orientation rights and gender identity protections intersect in care services for older people in the UK? What are the tensions/Equality Act implications? (Objective 1)

(2) What are the knowledge gaps regarding: how religious freedoms, sexual orientation rights and gender protections intersect in care services for older people; the associated tensions and how they are navigated; the role of tolerance in that navigation? (Objective 2)

(3) Who will be part of a collaborative network involved in the subsequent larger scale grant application? (Objective 3)

Data collection

The data collection comprised of a survey, focus groups and interviews. Each involved the following questions:

1. Do you think religion is relevant to providing care to older people?
2. Do you think sexual orientation is relevant to providing care to older people?
3. Is gender identity relevant to providing care to older people?
4. Do you think there are any issues in relation to people with faith-based objections to lesbian, gay, bisexual and/or trans (LGBTQ) people, their lives and/or lifestyles, providing care to LGBTQ older people?

5. Do you think there are any issues in relation to people with faith-based objections to lesbian, gay, bisexual and/or trans (LGBTQ) people, their lives and/or lifestyles, providing care to LGBTQ older people?
6. Do you think that people with faith-based objections to lesbian, gay, bisexual and/or trans (LGBTQ) older people, their lives and/or lifestyles, should be allowed to refuse to provide care to older LGBTQ people, on the grounds of conscientious objection?
7. Do you think older LGBTQ people should be allowed to refuse to receive care from people with faith-based objections to LGBTQ people, their lives and/or lifestyles, based on those beliefs?
8. Do you think there is any difference between care where a person is 'tolerated' and care where their life is celebrated and/or positively affirmed?
9. What would you like to see addressed in a research project on how religious freedoms, sexual orientation rights and gender identity protections intersect in care services for older people?
10. Is there anything else you would like us to know and/or think we should address in relation to this topic?

Research participants

The survey was completed by LGBTQ people aged 65 and over (n=63), and their family and friends (7). Participants comprised 36 women, 31 men, and 3 people who declined to state their gender. Of these, 5 identified as bisexual, 23 as lesbian/gay women, 30 as gay men, 2 as asexual, and 10 as 'other sexuality'(pansexual, queer, 'asexual lesbian', for example). 56 participants identified as White British, 9 White other, 2 mixed or multiple ethnic groups, and as 3 as 'other ethnic group' (not specified). 39 respondents had no religion or belief, 12 identified as Christian, 4 as Jewish, 2 as Buddhist, 1 as Sikh, and 12 as 'other' (Atheist; Unitarian; Pagan; Pantheist; Quaker; not specified). 22 said they had a disability.

A further 14 people (both LGBTQ and non-LGBTQ) who were healthcare and social care workers also completed an adapted version of the survey (11 women and 3 men; 1 bisexual, 2 lesbian/gay women; 1 gay man; 10 heterosexual individuals). 11 identified as White British, 1 as belonging to mixed or multiple ethnic groups, and as 2 as 'other ethnic group' (not specified). 8 had no religion or belief, 5 identified as Christian, and 1 as 'other'. 2 participants reported having a disability.

Zoom interviews were also undertaken with 13 individuals: two academics, one independent researcher, five community advocates and activists, and five community members who indicated on the survey questionnaire that they wished to be interviewed. They comprised five men and eight women, one of whom identified herself as trans. All identified themselves as White. Two interviewees identified as heterosexual; all the other interviewees identified as lesbian/gay. Invitations to interview were also sent to senior managers at religious care organisations, including the Catholic Orders of St John Care Trust (OSJCT), Jewish Care, Methodist Homes Association, the Salvation Army, Muslim Care, and the Sikh Elders Service. None responded.

Four online focus groups were run, in collaboration with the Manchester-based LGBT Foundation (LGBTF). It had been intended that one focus group would have been run with each organisation involved in the project: the LGBTF, Opening Doors London, Brighton

Switchboard, and SAND. However, due to COVID pressures, the other three organisations were unable to support the project beyond sharing information with their members when the survey was launched. LGBTF kindly stepped in and offered to recruit via its membership, as well as organise and co-facilitate all four focus groups. Unfortunately, again due to COVID, attendance at the groups was low, with only two people in each group. They comprised four men (three gay, one bisexual, aged 58, 68, 73 and 75) and four women (all lesbian/gay, aged 24, 27, 66[7]). All were White.

Results

Relevance to providing care to older people

Religion

Participants acknowledged the significance of religion and/or spirituality for the lives of some older people, and some thought this was particularly important at the end-of-life stages. Others emphasised that people's belief systems are highly personal and that it is important to understand what religion/spirituality means for each individual. Several participants felt religion had the potential for good (to promote ethical care) and for harm (such as when religious prejudice affects care). Some individuals expressed concerns about how some religious doctrines might create conflict in relation to sexual orientation, gender identity and other religious beliefs.

Sexual orientation

Heterosexual carer participants highlighted the importance of recognising that sexuality can still be important to older people. LGBTQ participants and their families and friends, focused more on marginalised sexual identities and the implications for care. They emphasised that minority sexual identities are intrinsic to who a person is and how a person identifies, going far beyond issues of sex and sexual activity. This group of participants also expressed concerns about potentially being excluded by care homes where all the residents are assumed to be heterosexual, and that this lack of recognition may lead to inferior care. The importance of LGBTQ- inclusive and affirmative care was highlighted. Concerns were also raised about possibly encountering prejudice and discrimination among fellow residents, their family and friends, and among care home staff.

Gender identity

Participants emphasised that gender identity is central to how individuals, especially trans people, see and understand themselves. They highlighted the importance of a person's gender identity being recognised, respected, and validated in older age care, and that this was essential for good care planning and foundational to person-centred care. Concerns were raised about

[7] One person declined to give their age.

issues of social exclusion and marginalisation in older age care contexts, including a failure to respect a person's gender identity, mis-gendering them, and discriminating against them due to transphobia. The importance of older age care providers understanding and meeting the specialised care needs of older trans people (particularly in relation to health issues associated with transitioning and/or personal care) was also highlighted.

Intersections

Significant concerns were expressed about potential religious discrimination in older age care contexts. This was in terms of many of the major religions, particularly their more conservative arms, not being LGBTQ inclusive; and evangelical Christian groups being explicitly opposed to same-sex marriage and/or LGBTQ rights. There were concerns that religious disapproval of LGBTQ people was simply homophobia and/or transphobia concealed under the guise of religious beliefs. Several participants acknowledged that not all religions, or more liberal arms of religion, and not all religious individuals, were hostile towards LGBTQ people. However, others were emphatic that religion had no place in the delivery of care to older LGBTQ people. Several respondents had experienced religious exclusions in earlier life, while some were still excluded by their religious families. These individuals were among those most vehemently opposed to receiving care from religious organisations or staff in later life.

Carers with faith-based objections to LGBTQ people

Some respondents expressed concerns about receiving inferior care based on religious care providers thinking less well of them than the majority population. The concern was also expressed that strictly religious staff with strongly held negative attitudes towards LGBTQ people would not be able to deliver them affirmative, anti-oppressive, person-centred care. While some respondents thought that religious care staff might be able to separate their religious beliefs from their caring practices, others thought this would not be possible: especially in relation to evangelical Christian staff. Concerns were also raised about possible religious conversion attempts by some care staff.

Several respondents expressed the opinion that carers with faith-based objections to delivering services to LGBTQ people should not work in care services at all, because such attitudes are not conducive to delivering high-quality person-centred care. By contrast, others thought such staff should receive training/education to try and improve their attitudes towards LGBTQ people, while others thought it was a performance management issue.

Conscientious objection

Respondents had mixed views about carers who might wish to not work with older LGBTQ people on the grounds of conscientious objection. They thought some religious carers might feel this way but would not act on it because it is against the law. However, while some respondents thought religious care providers should not be allowed to conscientiously object, because this would be discriminatory; others thought they should be allowed to, because this

would be preferable to them delivering care that would not be LGBTQ- inclusive or affirmative.

In terms of whether older LGBTQ people should be allowed to refuse services from carers with religious objections to them and their lives, respondents expressed mixed views. Most reported that they thought a person should be allowed to refuse to receive care from someone who has behaved in a prejudicial/discriminatory way towards them. However, while some respondents thought it would be discriminatory towards a religious person to refuse care from them when they had not behaved in such a way, others thought a care recipient should not be exposed to the risk that they might, and so should be allowed to refuse. Respondents felt that an older LGBTQ person should be allowed to refuse to be placed in a care home run by a religious provider. However, there were concerns that by the time someone is being admitted to a care home, their ability to advocate on their own behalf would likely be compromised, and they would need others to support them in making such a refusal.

Tolerant vs affirmative care

The respondents felt strongly that there was a difference between care based on religious tolerance and care which was LGBTQ affirmative. Tolerance was seen as involving something less than respect. Tolerance was understood to mean that someone was 'putting up' with LGBTQ people, whereas affirmative care celebrated and validated LGBTQ people and their lives. Tolerance was also perceived as being likely to involve inferior care, delivered reluctantly and under sufferance. Several respondents also highlighted that it was not enough to not treat LGBTQ people badly, that they also needed affirmative care to compensate for the harms done to them previously. This was felt to be especially true for those older LGBTQ people who had experienced historical abuse in the form of religious and/or psychiatric 'cures.'

Future research agenda and additional comments

Respondents highlighted the need for research conducted on the actual care experiences of older LGBTQ people. Many respondents also emphasised the need for regular LGBTQ training for all care staff. It was felt that this training should include reflective practice, where care providers can be supported in exploring how their personal values and beliefs might impact their delivery of care, not only to LGBTQ people, but to a range of minority/marginalised groups.

Employment issues were also raised – specifically the need to determine through the recruitment process – potential carers' attitudes towards LGBTQ people (beyond 'politically correct' answers) and whether those attitudes meant they were suitable to deliver care to them. It was felt that taking a 'we treat them all the same' approach was insufficient to deliver appropriate care to older LGBTQ people.

Some respondents emphasised the importance of not seeing all religions or all religious individuals as being the same. Others pointed out that religious people themselves are often subject to discrimination in older age care contexts, and that this can also be compounded by racialised discrimination as well. One respondent suggested that there should be some sort of

'truth and reconciliation' process between the major religions and (older) LGBTQ people, addressing the religious harms they have experienced.

Respondents also suggested the need for wider dialogue between leading religious and humanist organisations and LGBTQ people, and that this should include religious care providers. Other respondents highlighted how care provision is poorly paid and that greater investment in care services would promote better educated, better-informed, and better-supported carers to deliver services to older people, including older LGBTQ people. Other respondents made reference to kite-marks for LGBTQ- inclusive services, and for such services to be mandated by care commissioners and regulators.

Conclusion

The findings raise important questions about the place of religion in the care of older LGBTQ people. However, while this study has unpacked what underpins some of the key concerns older LGBTQ people have about religious-based care, several voices have yet to be heard. Crucially, we need to understand what older LGBTQ people's experiences are of older age care in general and religious older age care (delivered by religious organisations and/or carers) more specifically. Until we do, it is not possible to understand how the fears and concerns about such care resonate with actual experiences. Equally importantly, we need to understand how attitudes towards LGBTQ people among providers inform their experience of delivering care to LGBTQ people. More specifically, we need to understand whether staff with negative religious beliefs about older LGBTQ people can effectively deliver LGBTQ inclusive and affirmative care, and if so, how. This, in turn, might inform training and educational interventions whose outcomes should be evaluated.

Next steps

The findings raise several important issues which need to be considered further. Journal articles on the findings are in the process of being published, including one setting a research agenda. Further research consultations are now underway, with religious leaders, religious care organisations, and LGBTQ faith groups, and a one-day workshop will be held with them in July 2022, funded by the York Law School, University of York. The aim is to submit a large grant application later in autumn 2022.

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