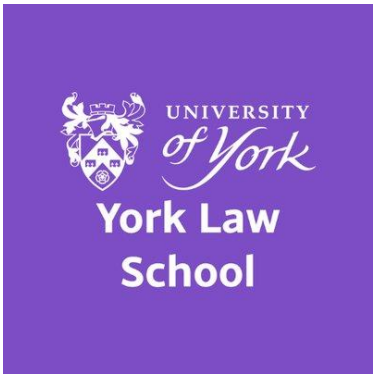

Religion, Sexual Orientation and Gender Identity in Older Age Care Contexts

Report on a one-day consultation event held at York Law School, University of York on 7th July 2022

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ACKNOWLEDGEMENTS

Many thanks to the following attendees: Paul Atkin (Senior Research Nurse Public Health and Social Care, LCRN Yorkshire and Humber Core Team, National Institute for Health Research (NIHR)); Sarah Crockett (Representative of MHA); Robbie De Santos (Director of External Affairs, Stonewall); Luke Dowding (Executive Director, OneBodyOneFaith); Bob Green (LGBT Housing Consultant); Debbie Ducille (Church Lead, Anna Chaplaincy For Older People); Dilwar Hussein (Research Consultant, Centre For Trust, Peace & Social Relations; Associate Professor, Coventry University, and Member of Global Interfaith Commission on LGBT+ Lives); Ella Guerin (Mental Health Nurse and Teaching Associate, Faculty of Medicine & Health Sciences, University Of Nottingham); Sally Knocker (Trainer and Author); Olivia Luijnenburg (Postdoctoral Researcher Kings College London); Kathleen (Kate) Morris (Service Improvement Team, Anchor Hanover Housing); Rob Newby (Head of Workforce Inclusion, Leadership & Development, Skills For Care); Tricia Pereira (Director of Operations, Skills For Care); Andy Quinn (CEO, Father Hudsons); David Rubin (Chair of the Jewish LGBT+ Group); Mpazi Siame, EDI Manager, MHA); Chris Swift (Director Of Chaplaincy and Spirituality, MHA);Steve Thompson (Representative of MHA); Ed Teeger (Warden, New London Masorti Synagogue).

Special thanks to Tricia Peireira and Sally Knocker for their help on the day and to Sally Knocker for acting as last-minute rapporteur.

This event was funded by York Law School, University of York.

Introduction

This report describes the key themes and ideas, which were discussed at a collaborative consultation event held at York Law School, University of York, on 7th July 2022. The event followed on from a pilot research project, funded by C & JB Morrell Trust, which explored the issues associated with religion, sexual orientation and gender identity in older age care, and, more specifically, the delivery of care to older LGBTQ people by religious providers.[1] That project had identified that many older LGBTQ people are very anxious and concerned about receiving care from religious organisations and/or staff in later life, fearing religious-based prejudice and discrimination during times when they are at their most vulnerable.[2] A review of the international and national literature as part of that project highlighted that healthcare, social care and social work students and practitioners with strongly held religious beliefs, especially highly religious individuals aligned with conservative arms of the main world religions, are more likely to hold negative attitudes about LGBTQ people.[3] However, there is a vast knowledge gap about whether and how those attitudes inform practice, although there are accounts of it sometimes doing so.[4] The purpose of the event reported here was to start a conversation about these issues, promote future dialogue, and embed a future research grant application in the views of key stakeholders.

The event opened with introductions and a light-hearted ice-breaker. It was then followed by three sessions facilitated by volunteers and members of the project team, initially in small groups followed by full group plenary discussions. The facilitated sessions were on the following topics:

1. What does religion mean to me?
2. Discussion of briefing document outlining research context – What do attendees consider to be the key issues and concerns?
3. Discussion about the challenges and opportunities in addressing these issues.
4. Focussed discussions on one of the following:
    - What are the key research questions the project should ask?
    - What research design and methodology would be most effective for the project?

[1] Westwood, S. (2022) *The intersection of religion, sexual orientation and gender identity rights in older age care spaces (RESORGICH) : Scoping study findings.* York: York Law School, University of York. https://eprints.whiterose.ac.uk/186248/

[2] Westwood, S. (2022). "People with faith-based objections might display homophobic behaviour or transphobic behaviour": Older LGBTQ people's fears about religious organisations and staff providing long-term care. *Journal of Religion, Spirituality & Aging*, http://dx.doi.org/10.1080/15528030.2022.2070820

[3] Westwood, S. (2022) Religious-based negative attitudes towards LGBTQ people among healthcare, social care and social work students and professionals: A review of the international literature. *Health and Social Care in the Community,* http://doi.org/10.1111/hsc.13812 https://doi.org/10.1111/hsc.13812

[4] Ibid.,

- What would be the best way to work collaboratively with key stakeholders (regulators, commissioners, providers, managers, staff, faith groups, members of the LGBTQ community)?
- How can the project address both the benefits and challenges of religion contributing to the care of older LGBTQ people?

What does religion mean to us?

The term 'religion' was recognised as having widely different meanings to different people, and there was some discussion in several groups as to whether 'faith' or 'belief' or 'spirituality' would be better terms use. However, each of the groups eventually decided, through separate discussions, that 'religion' was the right term to use, partly because it engaged with the organisational elements of religious beliefs and the idea of collectivised faith/belief systems, and partly because of the power 'religion' holds. Attendees emphasised the importance of community, of religion as a thing *that is done*, and *done together*. Religion can be a tremendous source of support to people, particularly at key life stages, one of which is older age. In older age, and in different phases or experiences that people go through in later life, older people may turn/return to religion as they reflect on the meaning of life and death and look back on the meanings they assign to the lives they have lived.

It was acknowledged that religion is and can be a tremendous support to many people, especially those from marginalised groups. Many LGBTQ people, including older LGBTQ people, are themselves religious individuals and are connected with religious communities and organisations.[5] Some of these are the more liberal arms of the leading world religions, some of these are LGBTQ-specific religious organisations. It was also recognised that many people (again, including LGBTQ people) find tremendous meaning and support from humanist organisations as well.

Many people spoke of religion's power, and that its power could do great good but could also cause great harm. The religious underpinnings of charitable works, worldwide and in the UK,[6] and of early social work were highlighted by several attendees. Many religious organisations provide community-based care and support to people in need, including older people, for whom they also provide domiciliary care and/or residential care. Many thought that at its 'best' religion(s) could form the basis of optimal health and social care delivery, being based on compassion, kindness and non-judgementalness. [7, 8]

[5] Westwood, S. (2017). Religion, sexuality, and (in) equality in the lives of older lesbian, gay, and bisexual people in the United Kingdom. *Journal of religion, spirituality & aging*, *29*(1), 47-69.
[6] Bull, D., de Las Casas, L., and Wharton, R. (2016). *Faith matters: understanding the size, income and focus of faith-based charities*. London: New Philanthropy Capita.
[7] McSherry, W., Boughey, A., & Attard, J. (Eds.). (2021). *Enhancing Nurses' and Midwives' Competence in Providing Spiritual Care: Through Innovative Education and Compassionate Care*. Berlin/Heidelberg: Springer.
[8] Collins, M. E., & Garlington, S. (2017). Compassionate response: Intersection of religious faith and public policy. *Journal of Religion & Spirituality in Social Work: Social Thought*, *36*(4), 392-408.

However, some LGBTQ attendees spoke of the profound religious-based rejections they have experienced, both in early life and across the life course.[9] They spoke of religious 'cures' in their earlier years, of being expelled from church groups, of rejection by their religious family members (sometimes some of their family, sometimes all of their family).[10] They talked about the deep pain this had caused them, both retrospectively, and in the present day. Yet, at the same time, things are not always fixed, and examples were given of reconciliations with religious family members who had softened their attitudes in recent years.[11]

Some attendees spoke of conditional religious inclusions, e.g., when a gay man is accepted by the church providing he does not engage in same-sex activity. The idea of 'love the sinner not the sin' was discussed and how some religious organisations and/or individuals try to distinguish between LGBTQ people and their 'lifestyles'.[12] Many of the LGBTQ attendees spoke of finding this very difficult, as their sexualities and/or gender identities are fundamental to who they are, rather than simply being lifestyle choices.

It was agreed that religion was a complex issue. There was recognition that religion is not a monolithic thing, that there are many different religions, and various arms to those religions across the liberal/conservative spectrum. An attendee brought to the group's attention Theological Action Research[13] which approaches religion from four levels – formal liturgy, academic, espoused theological voices and operant – and which might be relevant to research emerging from this project. It will be important to distinguish between religious doctrine and 'everyday theologies.'[14]

What are the key issues and concerns?

Religion as a potential for good as well as harm

The overriding observation regarding the briefing document was that it over-emphasised the negative aspects of religious care and under-emphasised its positive aspects. The important contribution religious organisations made to the provision of care and support, including to older people, was again highlighted, as was the ways in which religious belief can inform, and indeed underpin, much of compassionate care. At the same time, there was also acknowledgement that some religious beliefs can be harmful to the delivery of compassionate care. This can be at the doctrinal and/or the personal level. The importance of how particular religious groups and individuals interpret religious doctrine was emphasised, and also how this then translates into practice. Individuals often mediate doctrine with their own personal

[9] Westwood, S. (2019). Abuse and older lesbian, gay bisexual, and trans (LGBT) people: a commentary and research agenda. *Journal of elder abuse & neglect*, *31*(2), 97-114.
[10] Super, J. T., & Jacobson, L. (2011). Religious abuse: Implications for counseling lesbian, gay, bisexual, and transgender individuals. *Journal of LGBT issues in counseling*, *5*(3-4), 180-196.
[11] Westwood, S. (2017). Religion, sexuality, and (in) equality in the lives of older lesbian, gay, and bisexual people in the United Kingdom. *Journal of religion, spirituality & aging*, *29*(1), 47-69.
[12] Lomash, E. F., Brown, T. D., & Galupo, M. P. (2018). "A whole bunch of love the sinner hate the sin": LGBTQ microaggressions experienced in religious and spiritual context. *Journal of Homosexuality,* 66(10), 1495-1511
[13] Cameron, H. (2013). *Talking about God in practice: Theological action research and practical theology*. SCM Press.
[14] Francis, L. J. (2016). *Exploring ordinary theology: Everyday Christian believing and the church*. Routledge.

translations and/or aim to compartmentalise their religious beliefs and their professional practice. It was recognised that there can be some excellent practices among people with strongly held religious beliefs, including those which disapprove of LGBTQ 'lifestyles' who nonetheless deliver high quality services to LGBTQ people receiving their care. However, it was also recognised that this is not always the case.

Religious attitudes and care practices

There was some discussion about the thorny issue of whether it is both possible and/or sufficient to try and separate off religious beliefs from care practices.[15] There was acknowledgement that religious disapproval could 'leak' into care and be sensed by LGBTQ care recipients. Some attendees described religious disapproval of LGBTQ people as "prejudice." However, it was acknowledged that many people who hold such religious beliefs do not consider themselves to be prejudiced, but rather simply being true to their beliefs.[16] For many such individuals, expressing those beliefs can be an act of faith, and being prohibited from doing so and infringement of that faith. The dilemma of how this is balanced with the need to deliver not only non-discriminatory, but also LGBTQ-affirmative and inclusive care was recognised. It is hard to see how someone whose religious beliefs tell them that LGBTQ lives are wrong can then go on to celebrate those lives in their professional practice.

Some of the attendees felt strongly that a tolerant, 'professional' service was insufficient for LGBTQ-inclusive care, and that many older LGBTQ people need a sense of LGBTQ-specific "psychological safety"[17] especially when they are vulnerable and needing care and support. Some attendees also heightened the role of care planning in including spiritual needs as core to wellbeing and that meeting these needs is fulfilled in a variety of ways not just through formal religious observance.

There was a generally held view that part of the way forward is a pastoral one, and that it is essential to engage the leading religious organisations on these issues, and to explore doctrinal, religious-interpretative and personal approaches to beliefs about LGBTQ people and their lives. Some religious denominations are LGBTQ-inclusive. Among those which are not, many religious practitioners travel a spiritual journey, from awareness to acceptance of LGBTQ people across time (often after engaging with them in their everyday lives and/or professional practice). Often, using a pastoral approach can encourage peaceful and rewarding relationships with LGBTQ people in the everyday life of faith groups. Beginning with our shared humanity and leaving ideology/theology aside for a while can produce important discoveries for both the LGBT+ people and their faith groups (both actual and potential). There is much to be learned from their journeys and how this might be used to

[15] Westwood, S. (2022) Can religious social workers practice affirmatively with LGBTQ service recipients? An exploration within the regulatory context. *Journal of Social Welfare and Family Law.* https://doi.org/10.1080/09649069.2022.2067652

[16] Jowett, A. (2017). 'One can hardly call them homophobic': denials of antigay prejudice within the same-sex marriage debate. *Discourse & society*, 28 (3), 281–295.

[17] Putney, J. M., Keary, S., Hebert, N., Krinsky, L., & Halmo, R. (2018). "Fear runs deep:" The anticipated needs of LGBT older adults in long-term care. *Journal of gerontological social work*, *61*(8), 887-907.

inform and facilitate such journeys in other individuals as well, including among health and social care practitioners.

Culture and ethnicity

Culture and ethnicity were raised as important issues. Many care practitioners are originally from overseas, often from countries where traditional religions dominate and/or the state does not support, and sometimes persecutes, LGBTQ people. LGBTQ legal rights and protections and social inclusions can conflict with some migrant workers' beliefs and socialisation. There is a need to better understand how to address, and work with, clashes with the expectations and rights that people take for granted, cultural differences in how people manage their beliefs and identities, and the associated care implications. Highlighting the role of education, training and supervision in care settings is a common response to addressing and implementing equality issues. However, LGBTQ issues are often low on training and supervision agendas, and this can be compounded by educators and managers lacking confidence in addressing them.

Many migrant workers experience racism in the UK, including in the workplace, where they can feel marginalised and excluded.[18] Some trainers and managers are fearful of addressing migrant workers' cultural and/or religious beliefs in relation to LGBTQ care practice, based on fears of being accused of racism and/or discriminating against someone on the basis of their religion or belief. This can also be a problem in recruitment, i.e., in terms of whether it is lawful to include in selection criteria a person's attitudes towards delivering care to LGBTQ people, if those attitudes are based on religious beliefs. The Equality Act 2010 is limited in this regard and may currently be insufficiently nuanced to address the relationship between religious beliefs and the delivery of care to LGBTQ people.

Policy issues and culture change

There are significant policy issues, both in terms of the Equality Act's[19] ability or not to address something as nuanced as inclusive- and affirmative- care, and in terms of organisational policies. Many organisations would find policy guidance and policy templates helpful and yet these are not yet available. Many of the leading healthcare and social care professional organisations (e.g., the Nursing and Midwifery Council (NMC)) do not address inclusive practices, including in relation to delivering services to LGBTQ people.[20] Nor do they address the place of religious belief in the delivery of care. Similarly, many professional trainings do not address LGBTQ health and social care needs, issues and concerns, nor how

[18] Stevens, M., Hussein, S., & Manthorpe, J. (2012). Experiences of racism and discrimination among migrant care workers in England: findings from a mixed-methods research project. *Ethnic and Racial Studies*, *35*(2), 259-280.

[19] Religion and belief, sexual orientation and gender reassignment are three of the nine characteristics protected under the Equality Act 2010.

[20] Nursing and Midwifery Council (NMC). (2019) *Nursing and Midwifery Council submission of evidence to the House of Commons Women and Equalities Select Committee inquiry into Health and Social Care and LGBT communities,* https://www.nmc.org.uk/globalassets/sitedocuments/consultations/nmc-responses/2019/nmc-evidence-to-house-of-commons-wec-lgbt-inquiry.pdf

to work effectively with LGBTQ people.[21] There are, therefore, significant policy and educational curriculum issues to address. This includes recognising the positive contribution religion can sometimes make to the delivery of care.

The importance of 'cultural humility'[22] was raised by several attendees, i.e., care providers do not have to be fully informed or know all the answers, but they do need to have a curiosity about people, especially those who are different from themselves and a willingness to listen and learn.

There was a generally agreed sense that training was not enough, even mandatory training that is continuously cycled to respond to high turnover.[23] There has to be a wider cultural shift to promote LGBTQ inclusion in services (both those informed by religion and those that are not). While it was thought that culture change had to involve all staff in a team, from the 'bottom' to the 'top' it was thought to be especially important that managers led by example, that not only were the right policies and procedures, and training in place, but that managers modelled their application in practice.

Diversity under the LGBTQ umbrella

There was also acknowledgement that while the 'LGBTQ' acronym can be a helpful shorthand in discussions, it can also obscure diversity among LGBTQ people, especially older LGBTQ people.[24] Many transgender and non-binary individuals and bisexual people feel marginalised by 'LGBTQ' communities (formal and informal) and groups. The experiences of older lesbians and bisexual women can be very different from those of older gay and bisexual men. While their encounters with prejudice and discrimination overlap, they are also nuanced by gender differences. Older lesbians and bisexual women experience gendered ageism in later life, while older gay men are often particularly stigmatised for their sexualities, especially in relation to prejudice associated with HIV/AIDS stereotyping and discrimination. Older LGBTQ people can sometimes have for different concerns and aspirations in relation to social support groups, housing, and care. It should also be acknowledged that some older lesbians who identify with the sex on their birth certificates, especially those who live their lives in close-knit lesbian communities are concerned about, and resistant to, receiving care with and/or from trans women, i.e., women who do not identify with the sex they were assigned at birth. Trans communities are also worth considering in isolation from the rest of the umbrella. Care for trans communities may require

[21] Hunt, R., Bates, C., Walker, S., Grierson, J., Redsell, S., & Meads, C. (2019). A systematic review of UK educational and training materials aimed at health and social care staff about providing appropriate services for LGBT+ people. *International Journal of Environmental Research and Public Health*, *16*(24), 4976.
[22] Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education*, *34*(2), 165-181.
[23] Westwood, S., & Knocker, S. (2016). One-day training courses on LGBT* awareness–are they the answer?. In S. Westwood and E. Price (eds) *Lesbian, Gay, Bisexual and Trans* Individuals Living with Dementia: Concepts, Practice and Rights*, pp. 155-167. Abingdon: Routledge.
[24] Westwood, S. (2020). The myth of 'older LGBT+' people: Research shortcomings and policy/practice implications for health/care provision. *Journal of Aging Studies*, *55*, https://doi.org/10.1016/j.jaging.2020.100880

specific awareness around gender identity services or transition, and the way long term conditions could affect trans communities can differ – for example, in relation to dementia.[25]

There is also further diversity among LGBTQ people (of all ages) across the spectrum of age, gender, sexual orientation culture, race, ethnicity, disability, socioeconomic status and, of course, religion and belief. There is similar diversity among people holding religious beliefs. All these elements can intersect to produce complex experiences of inclusion and/or marginalisation according to context.[26]

Research matters

Key areas for research

There was a general agreement that more knowledge was needed in four main areas:

- Attitudes towards LGBTQ people and towards providing them with care among all care providers in the UK
- What roles religion plays – both positive and negative – in relation to those attitudes
- How those attitudes inform the delivery of care to LGBTQ people, and how (older) LGBTQ people themselves experience attitudes among providers (both in general, and in terms of religion) and how they experience those attitudes in relation to the care they receive.
- How can care can become more LGBTQ-inclusive, including care delivered by religious care providers?

Taking a balanced approach to religion

There was a sense within the group, that it was very important for religion not to be 'demonised' both because it is not fair to do so, and because it will alienate care providers from engaging in a research project and/or addressing these issues more broadly. The possibility of approaching these issues in relation to equality and diversity more broadly (while still addressing religion, sexual orientation and gender identity) was discussed. One of the advantages of doing so that was commented on was that it would enable understanding of other issues relating to prejudice and discrimination, i.e. racism (and the protected characteristic of race under the Equality Act 2010) and also prejudice/discrimination based on the protected characteristic of 'religion and belief'.

Hearing the voices of (older) LGBTQ care recipients

In terms of engaging with older LGBTQ service users, the challenges of doing so were discussed. Many older care recipients, both in domiciliary care and residential/nursing home care contexts have memory issues, other cognitive impairments and/or a diagnosis of dementia.[27] This raises ethical issues in terms of capacity to consent, according to the Mental

[25] Hunter, C., Bishop, J. A., & Westwood, S. (2016). The complexity of trans*/gender identities: Implications for dementia care. In S. Westwood and E. Price (eds) *Lesbian, Gay, Bisexual and Trans* Individuals Living with Dementia: Concepts, Practice and Rights*, pp. 124-137. Abingdon: Routledge.

[26] Valentine, G. (2007). Theorizing and researching intersectionality: A challenge for feminist geography. *The professional geographer*, *59*(1), 10-21.

[27] The majority of older people in care homes have some form of dementia. They are also more likely to be single, childless women, meaning that lesbians and bisexual women are over-represented, compared with both

Capacity Act 2005.[28] It necessitates applying for ethical approval through IRAS, which can be an arduous process. Moreover, older LGBTQ people form only a small fraction of the population of older care recipients. Some may be hidden. Others may go 'back in the closet' due to being worried about discrimination or the impact on the quality of their care. There may be a lack of monitoring of LGBTQ+ identities in care settings. For all these reasons, it can be heard to find LGBTQ care recipients who are willing and able to engage with research. So, reaching out to, and engaging with, older LGBTQ care recipients, especially those with dementia, could be challenging.[29] There is, additionally, the issue of incentivising care homes to participate in such a research project.[30] While the NIHR ENRICH 'research ready' care home initiative[31] has progressed things, care homes are often preoccupied with practical issues associated with everyday personal care. There has to be something that will make the project of benefit to care homes in order to make it worth their while to engage with it. Even so, several individuals and organisations attending on the day thought that it might be possible to do so, within the context of organisational service improvement, strengthening care communities and the valuing of care, and using co-production to achieve mutual benefits.

Methodologies

The small group reporting on research methodology advocated a mixed method project which combined quantitative and qualitative data collection and analysis, i.e.,

- Qualitative
    - Questionnaire with open-ended questions and text-box responses
    - Social media polls perhaps to generate interest in the project and/or promote ongoing dialogue and discussion.
    - Focus groups
    - Semi-structured interviews.
- Quantitative
    - Proportion of staff of with religious affiliations and also degrees of religiosity
    - Proportion of older age care recipients with religious affiliations
    - Proportion of LGBTQI staff

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heterosexual women and gay and bisexual men. The data for trans women and men is not yet clear in this regard, although it has been suggested that trans and gender non-binary individuals are at increased risk of dementia, primarily associated with minority stress and associated chronic mental health issues. See, e.g., Westwood, S. (2016). Dementia, women and sexuality: How the intersection of ageing, gender and sexuality magnify dementia concerns among lesbian and bisexual women. *Dementia*, *15*(6), 1494-1514; Flatt, J. D., Johnson, J. K., Karpiak, S. E., Seidel, L., Larson, B., & Brennan-Ing, M. (2018). Correlates of subjective cognitive decline in lesbian, gay, bisexual, and transgender older adults. *Journal of Alzheimer's Disease*, *64*(1), 91-102.

[28] Waite, J., Poland, F., & Charlesworth, G. (2019). Facilitators and barriers to co-research by people with dementia and academic researchers: findings from a qualitative study. *Health Expectations*, *22*(4), 761-771.

[29] See, e.g., Peel, E., & McDaid, S. (2015). *'Over the Rainbow': Lesbian, Gay, Bisexual, Trans People and Dementia Project. Summary Report.* http://eprints.worc.ac.uk/3745/1/Over-the-Rainbow-LGBTDementia-Report.pdf

[30] Collingridge Moore, D., Payne, S., Van den Block, L., Ten Koppel, M., Szczerbińska, K., & Froggatt, K. (2019). Research, recruitment and observational data collection in care homes: lessons from the PACE study. *BMC research notes*, *12*(1), 1-6.

[31] https://enrich.nihr.ac.uk/

- Proportion of older age LGBTQI care recipients

There was also mention of an ethnographic approach,[32] where researchers observe people in their everyday contexts.[33] The possibility of using a Theological Action Research approach was also raised.

Involvement of key stakeholders (LGBTQ older people and their advocates, religious organisations and faith groups, care providers, commissioners, regulators, educators) across the project was considered essential.

The importance of setting up peer support for those conducting interviews and running focus groups was also highlighted, especially if encountering very strong opinions which conflict with their own, to enable them to 'debrief'. It was suggested that a facilitator be costed into the project's budget accordingly.

Tensions and challenges

In terms of the challenges, several issues were identified to which there were no easy answers. The first is how to reconcile care providers' right to their religious beliefs, including those which involve disapproval of LGBTQ people and/or their lives, with an LGBTQ person's entitlement to inclusive, affirmative person-centred care. Narratives about negative experiences among *some* LGBTQ service users in relation to *some* religious carers show this can be a problem at times. Research also suggests that it can get in the way of training and encouraging reflective practice, especially among those staff who believe it is their religious duty to preach the word of God as they understand it, above and beyond their professional duties. This is potentially an area of irreconcilable differences which it is important to address. Care is important here, for non-negotiable standards of behaviour, as is establishing boundaries and expectations through supervision and performance review. Management and leadership practices and organisational cultures and environments play an important part in creating LGBTQ-inclusive care environments.

Additionally, tensions not only relate to care providers. Staff often feel very anxious about how to deal with service users, their families and friends if they make homophobic and/or transphobic comments and/or behave in discriminatory ways. How to you challenge someone who may be very confused and/or at the end of life? How do you challenge their family and friends during what can be a very stressful and distressing time? How do you establish and maintain associated boundaries with sensitivity, care and respect? Agreeing core values, having integrity, applying key principles to underpin care can point to ways forward even in challenging and sensitive contexts and circumstances.

Outputs

There was general agreement that the research project should be to have tangible outcomes in terms of informing best practice in this area to include a range of learning resources, best practice guides, a video library of life stories and examples of both positive and negative

[32] https://www.gov.uk/guidance/ethnographic-study-qualitative-studies

[33] See, e.g., Johnsson, A., Boman, Å., Wagman, P., & Pennbrant, S. (2018). Voices used by nurses when communicating with patients and relatives in a department of medicine for older people—An ethnographic study. *Journal of clinical nursing*, *27*(7-8), e1640-e1650.

practice. Some attendees felt that some of the resources generated should focus on leadership development more than solely direct care practice, as this was a way to generate more sustainable behavioural change.

Storytelling

Several participants highlighted the importance of storytelling as a means of encouraging reciprocal understanding,[34] in everyday conversations, in facilitating dialogue between people from different backgrounds and of different faiths,[35] and in encouraging respect for diversity, and promoting equality and human rights. Storytelling can be an important tool in staff education, training and development,[36] particularly in supporting staff to widen their knowledge and understanding of LGBTQ issues.[37] It is harder to 'other' someone when you have had direct contact with them and have listened to their story. Storytelling can also be a useful research methodology.[38]

Reflections and next steps

The day was thought to have been a positive experience for many participants, affording the opportunity to meet and engage with people with whom attendees might not usually connect. Many new contacts were fostered, and many attendees expressed a willingness to be involved and/or support a future research project in some way, and/or participate in ongoing dialogue. Attendees said they had found the event thought-provoking and said that it had given them much to go away and reflect upon and consider.

Conclusion

A draft version of this report was circulated to all attendees for comments. The final version represents its approved contents. The event, and the report, demonstrate the considerable potential for dialogue, discussion and reciprocal understanding in relation to the issues which have been highlighted. It is intended that this is the first step in a series of initiatives which will take the pilot study forward in ways which will both promote equitable care for LGBTQ people and support religious care providers in the delivery of that care.

[34] Piipponen, O., & Karlsson, L. (2019). Children encountering each other through storytelling: Promoting intercultural learning in schools. *The Journal of Educational Research*, *112*(5), 590-603.
[35] Lindsay, J. (2020). Interfaith Dialogue and Humanization of the Religious Other: Discourse and Action. *International Journal of Interreligious and Intercultural Studies*, *3*(2), 1-24.
[36] Coulter, C., Michael, C., & Poynor, L. (2007). Storytelling as pedagogy: An unexpected outcome of narrative inquiry. *Curriculum Inquiry*, *37*(2), 103-122.
[37] Willis, P., Almack, K., Hafford-Letchfield, T., Simpson, P., Billings, B., & Mall, N. (2018). Turning the co-production corner: methodological reflections from an action research project to promote LGBT inclusion in care homes for older people. *International journal of environmental research and public health*, *15*(4), 695.
[38] Lewis, P. J. (2011). Storytelling as research/research as storytelling. *Qualitative inquiry*, *17*(6), 505-510.

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