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"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

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ABSTRACT

Older lesbian, gay, bisexual, trans and queer (LGBTQ) people are concerned that their needs will not be recognised, understood or met in older age care spaces. Some are especially worried about care provided by religious care organisations and/or staff with negative beliefs about LGBTQ people and their lives. While these issues have been raised at the margins of previous research, there has not, until now, been a study which has focussed upon them. This article reports on a recent UK preliminary scoping consultation research project, which explored older LGBTQ people's views about possible care from religious organisations and/or carers. The findings highlight four key fears about: 1) inferior care quality; 2) a lack of affirmative, anti-oppressive care; 3) religious-based prejudice and discrimination; 4) religious conversion attempts. Each theme is considered in relation to social justice, i.e., equality of resources, recognition, representation, and relationality. The need for open dialogue and debate is highlighted and a research agenda is proposed. There is an urgent need to understand what happens in the delivery of care to LGBTQ people by religious care organisations and/or staff, place the concerns identified here in their proper context and determine the appropriate responses.

KEYWORDS

LGBTQ; sexuality; transgender; religion; care

Introduction

One of the challenges of ageing is that it can compound minority group marginalisation, especially in the later stages of old age when cognitive and/or physical disabilities may increase reliance upon others for care and support (Westwood, 2016a). For some, religious affiliation and religious-based community networks can mitigate social isolation in older age (Manning et al., 2019). For others, exclusion from religious networks can exacerbate it (Kevern, 2018). For lesbian, gay, bisexual, trans and queer (LGBTQ) people, religion has been, and continues to be, a source of both potential inclusion and exclusion (McCarthy & Das Nair, 2018; Westwood, 2017), some seeking and finding

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religious communities of support, some feeling alienated from them. Many older LGBTQ people are worried about needing care in later life (Mahieu et al., 2019). Peripheral findings from research projects suggest that some are particularly concerned about care from religious organisations and/or staff (Butler, 2017; Guasp, 2011; Hunter et al., 2016; Jihanian, 2013; Knocker, 2012; Robinson, 2016; Villar, 2019; Westwood, 2016b, 2016c, 2017).

There are over 11,000 care homes accommodating over 400,000 older people in the UK (Competition and Markets Authority, 2017). Over 2,000 of these homes are run by religious organisations (Collinge, 2020). The Methodist Homes Association (MHA, 2021) provides care home services to over 4,400 older people. The Catholic Orders of St John Care Trust (OSJCT, 2021) runs 66 care homes for older people. The Christian evangelical Salvation Army (2021) and Jewish Care (2022) run 12 care homes for older people respectively. It is not yet known how and in what way these organisations' religious values inform their delivery of care to residents, including LGBTQ residents.

Research suggests that religious health, social care and social work staff are more likely to hold negative attitudes towards LGBTQ people than non-religious staff (Caceres et al., 2020; Dessel & Bolen, 2014; Hafford-Letchfield et al., 2018; Jihanian, 2013; Jurček et al., 2021; Stewart & O'Reilly, 2017; Villar, 2019; Westwood, 2022a). This is particularly so among highly religious staff, i.e. those who take a literal approach to religious texts and frequently engage in religious rituals and events (Westwood, 2022a). The religious profiles of health and social care staff working with older people in the UK are not yet known. However, an example of potential sites of tension is the UK and Ireland Christian Medical Fellowship, which comprises 5,000 doctors, 900 medical/nursing students and 300 nurses and midwives. Its website contains articles which express opposition to same-sex marriage ('marriage is the union of one man and one woman', Saunders, 2012) and which dismiss trans rights, such as stating: 'those who experience gender dysphoria need compassionate care, including encouragement to identify with their birth sex' (Thomas, 2017).

UK case law has highlighted situations where tensions between religious freedoms and LGBTQ rights can be problematic in the delivery of health and social care services. In 2010, a Christian Relate counsellor failed in his claim for unfair dismissal for refusing to provide counselling to same-sex couples, the grounds of his religious beliefs.[1] In 2013, a trainee psychotherapist with the British Psychodrama Association (BPA) was removed from its register because he was (and still is) head of the Christian organisation, Core Issues Trust, which delivers gay conversion therapy – not yet banned in the UK.[2] In 2019, a Christian doctor was dismissed for refusing to use the correct pronouns for trans patients, subsequently unsuccessfully claiming for unfair dismissal on the grounds of conscientious objection.[3] That same year, an evangelical Christian social work student from Cameroon was expelled by the

University of Sheffield for posting homophobic statements on his Facebook page.[4] He was reinstated on a legal technicality, arousing considerable controversy (Mason et al., 2020; Westwood, 2022b). Also in 2019, a Christian evangelical nurse unsuccessfully claimed for unfair dismissal after being dismissed for engaging in unwanted religious conversations with eight hospital patients.[5] This included: interrogating them about their reasons for their religious beliefs, asking those who said they were not religious "why not?",[6] telling a patient about to undergo major surgery for bowel cancer that 'if he prayed to God he would have a better chance of survival',[7] giving patients bibles and telling them she would pray for them, and asking them to sing psalms with her. She had given her employers assurances that she would stop, but had not, and the courts upheld her dismissal on the grounds of misconduct.

These are extreme examples of practice issues, serving to highlight the effectiveness of regulatory controls for overt discrimination. However, some older LGBTQ people are concerned that such problems may be more widespread. This article seeks to explore these concerns, analysing the findings of a recent UK preliminary scoping consultation research project, which explored balancing religious freedoms, sexual orientation and gender identity rights in older age care contexts. One of the questions in the project's survey, completed by 70 older LGBTQ people and their families and/or friends, was about religious organisations and care staff. This article reports on the responses to that question, which highlighted four key fears about: 1) inferior care quality; 2) a lack of affirmative, anti-oppressive care; 3) religious-based prejudice and discrimination; 4) religious conversion attempts. The findings are analysed from social justice perspectives, considering equality of resources, recognition, and representation (Fraser, 1997, 2003), affective equality (Lynch et al., 2009) and relational justice (Lynch et al., 2021). An urgent research agenda is proposed, particularly the need to understand what happens in the delivery of care to older LGBTQ people by religious organisations and/or staff, in order to place the concerns raised here in their proper context.

Background

There are long-standing tensions and newly emerging competing claims relating to the balancing of religious freedoms and LGBTQ rights (Cooper & Herman, 2013; Eskridge & Wilson, 2018). Acceptance of LGBTQ social inclusion has grown in the UK, both among religious and non-religious individuals, although it is greater among the latter, with the gap widening in the past decade (Park & Rhead et al., 2013, p. 18). Christianity is divided over the issue (Cornwall, 2022), with more liberal Christians supportive of LGBTQ rights and more evangelical and fundamentalist Christians opposed to them (Evangelical Alliance, 2011; Pew Research Center, 2022). According to the

Christian Institute, one of the leading UK fundamentalist Christian campaign organisations, same-sex marriage is 'not real marriage', 'blasphemous' and 'sinful' (Christian Institute, 2017, p. 22), and 'a transsexual is living in defiance of their Creator and "sex change" surgery desecrates a God-given body' (Christian Institute, 2016, p. 3).

Catholicism's official doctrine is opposed to same-sex marriages, however the views of Catholics around the world varies (Damant, 2020). There is a similar spectrum of views between orthodox and more liberal Judaism (Keshet, 2021). Traditional Islamic doctrine is opposed to "homosexuality", and reportedly over half of UK Muslims think it should be against the law (Perraudin, 2016). However, again, there is greater support at the more liberal non-orthodox margins. Zara Mohammed, the first woman leader of the Muslim Council of Britain, recently stated that there should be greater tolerance towards LGBTQ people (Linklater, 2021).

Older LGBTQ people are concerned about older age care, especially residential and nursing home care. They fear that their lives, relationships, and identity-based needs will not be recognised, understood or supported and that they may be subjected to prejudice and discrimination (Almack, 2018; Caceres et al., 2020; Guasp, 2011; Hunter et al., 2016; Knocker, 2012; Löf & Olaison, 2020; Putney et al., 2018; Westwood, 2016b, 2016c; Willis et al., 2021, 2017). For some older LGBTQ people these concerns are heightened by issues of religion (Westwood, 2017, 2022a). For example, in a Stonewall study of lesbian, gay and bisexual (LGB) ageing in the UK, a survey participant stated that:

> 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; Guasp, 2011, p. 11)

Westwood (2017), also reporting on a study of UK LGB older people, quoted participants who said:

> 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)

Knocker (2012, p. 10) described a disabled lesbian in the UK who reported 'being given leaflets by religious care workers suggesting that she could be "saved"'.

Westwood and Knocker (2016, p. 18) quoted the following UK trainers delivering training to health and social care staff working with older people:

> 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)

> 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)

According to a UK action research project delivering training to care home staff:

> One staff member declared . . . 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.' (Hafford-Letchfield et al., 2018, p. e318)

The project researchers commented:

> 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 (Hafford-Letchfield et al., 2018, p. e318)

It is not yet known to what extent these concerns reflect actual practice (Westwood, 2022a).

Regulations relating to the provision of care to older people prohibit discrimination. The UK Equality Act 2020 prohibits discrimination on the grounds of nine protected characteristics, including sex, sexual orientation, gender reassignment, and "religion or belief". Local authorities (the main commissioners of older age social care provision) are required by the Care Act 2014 to deliver non-discriminatory services (Department of Health and Social Care (DHSS), 2021, S 2.45). Skills for Care is responsible for the strategic development of support workers and adult social care staff in England. Its Code of Conduct (Skills for Care, 2013, p. 10) instructs staff to:

(1) Respect the individuality and diversity of the people who use health and care services, their carers and your colleagues
(2) Not discriminate or condone discrimination against people who use health and care services, their carers or your colleagues
(3) Promote equal opportunities and inclusion for the people who use health and care services and their carers; and
(4) Report any concerns regarding equality, diversity and inclusion to a senior member of staff as soon as possible.

The UK Nursing and Midwifery Council (NMC) Code (NMC, 2018) mandates professional standards for nurses, midwives and nursing associates and these include:

- 'Treat people with kindness, respect and compassion' (1.1)

- 'Respect and uphold people's human rights' (1.5)
- 'Act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care' (3.5)
- ' . . . treating people fairly and without discrimination, bullying or harassment' (20.2)
- 'Treat people in a way that does not take advantage of their vulnerability or cause them upset or distress (20.5) and;
- 'Do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way' (20.7)

These regulations have been used to address concerns relating to the expression of religion or belief by staff in health and social care contexts, as in the previously mentioned case law.

The literature suggests that religious staff opposed to LGBTQ individuals and their lives take, at best, a "tolerant" or compassionate approach to working with them (Dessel & Bolen, 2014; Ngole, 2016). However, tolerance has been criticised for granting moral superiority to the tolerating person and objection to the person being tolerated (Brown, 2009; Fredman, 2020). Tolerance often involves 'mere civility' (Bejan, 2017), falling short of mutual respect (Adenitire, 2020) necessary for affirmative, anti-oppressive services, which validate minority identities and advocate for minority rights (Cocker & Hafford-Letchfield, 2014; Mendoza et al., 2020, p. 31). Respect is foundational to the effective delivery of care and to care ethics (Sevenhuijsen, 1998; Tronto, 1993). As Barnes (2012, p. 118) has observed:

> At both individual and collective levels, people need to experience positive recognition to feel that they are being properly and justly treated. Care is not possible without respect.

Respect is also implicated in the recognition dimension of Fraser's and Honneth's respective models of social justice (Fraser, 2003; Honneth, 2005) which posit that a lack of respect, or mis-recognition (Fraser, 1997) is a key site of social injustice and exclusion. Fraser's tripartite model of social justice comprises resources (economic), recognition (social value and inclusion) and representation (having political voice, both locally and nationally). Lynch et al. (2009) have argued that affective equality – equal access to love, care and support – should be a fourth dimension to supplement Fraser's model, described more recently by Lynch et al. (2021) as 'relational justice'. The key question raised in this article is whether religious care organisations and staff who hold beliefs which disapprove of LGBTQ people and are opposed to their rights can deliver equitable services to them and, as such, also deliver them relational justice.

Methodology

This project was granted ethical approval by the University of York's Economics, Law, Management, Politics and Sociology Ethics Committee (ELMPS). The aim of the study was to develop a research agenda and build a research network to explore the intersection of religious freedoms and sexual orientation and gender identity rights in older age care spaces. The project comprised a small-scale Qualtrics© scoping survey, focus groups and interviews, all conducted in 2021. The survey questions, reported in this article, were as follows:

(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?

For each question, participants were also given a free-text option to expand on their views.

Survey participants were recruited via personal and professional networks, targeted invitations via advocacy groups and social media.

Qualitative data were analysed for meta-themes, using qualitative content analysis, with a close reading of responses and collation into pragmatic categories (White & Marsh, 2006). Unlike grounded theory, content analysis aims to identify core thematic categories, but not extend this to analyse relationships between categories, or extrapolate from such cross-analysis to develop theory (Cho & Lee, 2014). Categories were identified for their frequency, significance, any tensions/contradictions, and saliency (Buetow, 2010).

Survey respondent profiles

70 people living in the UK responded to, and fully completed, the scoping survey. These comprised 63 LGBT+ people aged 65 and over, three family members/ friends of older LGBTQ people and four advocates working for organisations supporting older LGBTQ people. Family and friends were included to contribute insights on behalf of older LGBTQ people who may be unwilling/unable to participate in an online survey (Seifert et al., 2018).

Age

Eight respondents were aged between 50–59; 36 were aged between 60–69; 20 were aged between 70–79; and six were aged between 80–89.

Gender

36 respondents were female, 31 were male, and three identified as 'Other'. No-one identified as 'non-binary'.

65 respondents indicated their gender was the same as that which was assigned at birth; 5 people indicated it was not.

Sexuality

Five respondents identified as 'bisexual'; 23 identified as 'lesbian/gay woman'; 30 identified as 'gay man'; two identified as 'asexual'; and ten identified as 'Other' [Pansexual (2); Queer (2); 'MTF trans attracted to women'; 'Do not identify'; 'Asexual Lesbian'; not specified (3)].

Ethnicity

65 respondents identified as White British/White Other; five identified as belonging to mixed, multiple, or other ethnic groups.

Religion or belief

39 respondents identified as having no religion or belief; 12 identified as Christian; four identified as Jewish; two identified as Buddhist; one identified as Sikh; and 12 identified as 'Other' (Atheist; Unitarian (2); Pagan (4); Pantheist; Quaker (2); 'Raised in the Baptist church but no longer practising'; 'a spiritual person'; not specified)

Disability

22 responded reported having a disability; 48 reported not having a disability.

Findings

One of the survey's questions was '*Do you think there are any issues in relation to people with faith-based objections to lesbian, gay, bisexual and/or trans (LGBT+) people, their lives and/or lifestyles, providing care to LGBT+ older people?*' The responses to this question are analysed here. Four key themes were identified related to fears about: 1) inferior care quality; 2) a lack of affirmative, anti-oppressive care; 3) religious-based prejudice and discrimination; 4) religious conversion attempts. Each will be addressed in turn.

Fears about inferior care quality

Respondents expressed anxieties about potentially receiving inferior care from religious care providers:

> Certain care providers could have certain religious views that influence their provision of care. This could result in the care not being as good as it should be for the person. (SPLF078)

> Unfortunately, there are staff working with faith-based objections who allow this to influence their clinical care and approach and . . . there is no place for it. (SRC019)

> If something doesn't fit with staff's own beliefs/lifestyle, [it] can and does result in inferior care at times. (SPL045)

These respondents raise concerns that religious care staff's personal beliefs may inadvertently undermine the quality of their professional activities, as can happen with unconscious bias (Marcelin et al., 2019).

Concerns were also expressed in relation to religious tolerance:

> I suspect being tolerated means one might receive a minimum standard of care rather than a standard which looks towards excellence. (SPL068)

> 'Tolerated' can mean completing the basics of care but people should not be tolerated, they should have personalised care and be treated as people not a number or a bed. (SRC021)

> Someone being tolerated will likely show in the care, and lack unconditional positive regard, a cornerstone of what it is to be person centred. (SRC014)

As noted earlier, tolerance is a contested concept (Adenitire, 2020; Bejan, 2017; Brown, 2009; Fredman, 2020). The respondents perceived tolerance as implicated in "minimum-standard" and "basic" care, that is not person-centred and lacks unconditional positive regard. In other words, care based on religious tolerance was understood to be inferior care delivered under sufferance rather than with respect (Oberdiek, 2001).

One respondent drew on their professional experiences:

> Having worked in a general hospital setting for many years, had first-hand experience of the ongoing derogatory comments made by some staff, always around sexual orientation of any and all who lived a different lifestyle to their own, and/or religious beliefs resulting in inferior care been passed on as a result … And in more recent years, on the rare occasion I have disclosed my sexual orientation, met with visible and practical inferior care. (SPL045)

This respondent's comments echo the Stonewall study's findings relating to 'unhealthy attitudes' (Somerville, 2015) towards LGBTQ staff in the NHS.

Some respondents called for carers to separate off their religious beliefs from their professional practice:

> Some religions do not condone LGBT+ people and thus they may have problems when being asked to care for them, however I believe they should put these views aside and treat everyone with the respect and dignity that they deserve no matter what their religious beliefs are. If they are unable to do this then they shouldn't be in the healthcare profession. (SRC018)

The compartmentalisation argument is central to how religious carers propose that they can work effectively with LGBTQ people even if they disapprove of them/their lives (Dessel & Bolen, 2014; Ngole, 2016). However, several participants thought that negative religious views about LGBTQ people, even when concealed, would leak into practice.

> While I respect another person's religious views, it has been my experience - more often than not - that the majority of religious-minded people have neither time, empathy or patience with older LGBT+ folks. Political correctness may well prevent them from being openly bigoted against us, but many carry and practise it, albeit discreetly. (SPL052)

> Fine if there is no speaking of, or distinguishing in, care but there is always a risk of discriminatory behaviour, speech or general sense of being disapproving of the individual or their family and friends and hence subtle or not so subtle ways of creating discomfort for a vulnerable person. (SPLF077)

> Some religions are very hostile towards homosexuality and gender fluidity, and care workers who are members of those religions may carry that hostility into their work. (SPL062)

What the respondents are referring to here are microaggressions, i.e. 'subtle forms of discrimination, often unintentional and unconscious, which send negative and denigrating messages to various individuals and groups' (Nadal et al., 2015, p. 147). LGBTQ microaggressions include demonstrating unease, discomfort or disapproval when in the company of LGBTQ people; discourse which presumes their deviance, pathology, and/or 'sinfulness'; denial or discounting of LGBTQ prejudice and oppression; not recognising LGBTQ relationships or dismisses them as being 'less than' non-LGBTQ relationships; and misgendering trans people (Clucas, 2019; Nadal et al., 2016). Microaggressions

have a powerful detrimental impact on LGBTQ people, both because of their intangibleness, and their "dripping tap" effect. Religious microaggressions, which can include any of the above and the "love the sinner, detest the sin" approach (Lomash et al., 2018), have added impact because of their perceived moral/spiritual authority and for some, their association with rejection by religious family members.

Concerns about a lack of affirmative, anti-oppressive care

Respondents also made specific reference to affirmative, anti-oppressive practice, with some questioning as to how staff with religious objections to LGBTQ people can truly understand, recognise and validate their identity-based needs:

> People with faith- based objections may lack understanding and empathy with older LBGT people. (SPLF076)

> How can we provide care if we do not acknowledge another's truth? Who are we to label and judge? Care for another is about affirming that person, listening to her/him and accepting her/his narrative with curiosity and genuine love. (SPL032)

> Affirming someone in their sexual orientation is vitally important to a sense of worth and wellbeing. (SPL057)

> If I do not accept a person's gender identity then I do not accept them. (SPL032)

Each of these respondents are expressing concerns that religious objections to LGBTQ people and their lives serve as a barrier to being able to affirm and validate LGBTQ and thence to delivering effective care services to them, echoing concerns raised in the literature (Henrickson, 2017).

Many older LGBTQ people have been sensitised to religious prejudice and discrimination, based on previous experiences (Westwood, 2017) as these two extracts show:

> We only need to look at the history of the Catholic church to confirm historically how anti LGBT they are. I myself have cousins that will not engage with me or attend any family gatherings because of their religious beliefs. If I was old and vulnerable or unable to make it clear that I was not being treated fairly, that would still be difficult, but in care settings the staff are always in control. (SPL043)

> Older LGBT have memories of harder times. As we age feelings and memories could reveal themselves, there may be regrets and memories of the past. The person might want to reveal their past in a confidential and supportive atmosphere. To be heard without the judgements and experiences of the past repeating itself. (SPL061)

So here we can see concerns located in first-hand experiences of rejection by religious family members and historical contexts. Not all LGBTQ people experience religious-based rejection. Of course, for some who do, there can be some form of reconciliation in later life (Westwood, 2017, p. 56). However,

this is not true for everyone, and for some individuals there is a fear that history will repeat itself. As the second respondent highlights, there is not only a concern about a reiteration of previous religious-based harm but also a concern that there will be a lack of opportunity to discuss and make sense of those harms in the final years of life. This is particularly under circumstances, as this respondent observes, of heightened vulnerability:

> You would have to be rather strong, as the service user, to take the lead, and many older people in the system whose lives predate the tradition of coming out, and may include decades of hiding and misery to survive, may also be more inclined to hide again and suffer in silence. More of us in the slightly younger generations who do remember at least some openness are coming through now, and may be less likely to take that cruelty, but even for us, the history is mixed. (SPL050)

As this respondent highlights, trauma can be mediated by generational differences, but only partially. Religious-based exclusions experienced by LGBTQ people are cross-generational, and the ability to resist may be compromised by older-age-related vulnerabilities (Westwood, 2016a).

Several respondents took a "zero tolerance" approach to all aspects of religion in care homes. This person objected to the default presence of Christianity in many homes:

> I have experience of care homes where there is an assumption that everyone is a practising Christian. So all Christian festivals are celebrated, non-Christian religious festivals are ignored and atheists are not considered at all. As an atheist I would not wish to live in a care home where there was any religious observance whatsoever. (SPL063)

This participant is highlighting the cultural/religious hegemony in those care contexts which privilege Christianity over other religions, and of religion over non-religion. This is particularly concerning given the decline of religious affiliation in the UK.[8] It also resonates with research by Knocker (2012) who found that some older LGB people object to seeing religious symbols, posters and the like in care contexts. Additionally, in Koh et al. (2014) who reported that the display of religious symbols in health and social care contexts created a barrier to minority sexual identity disclosure.

The following participants stated that there is no place for religion in care home provision:

> I do not believe that religion should play a part in care homes - unless they are totally funded by the church itself, it is not appropriate. I do not think religion should influence us in any way today … as most of us realise this is an outdated way of thinking. (SPL043)

> People with faith-based objections to LGBT [people] should be sacked. They always claim special privilege and rights without respecting the rights of others … I've had a lifetime of persecution enabled through the prism of religion … They should be barred from [the] caring professions. (SPLF011)

The first person's observations – that religious belief is outdated – do not, of course, reflect the views of those individuals for whom religion is important, many of whom are older people. The second person's comments show the damage that can be caused by historical religious abuse of LGBTQ people, its lasting effects on an individual, and how this can overshadow the way religious care is perceived (Bloemen et al., 2019; Burton et al., 2021; Hovey, 2009; Westwood, 2017, 2019).

Fears about religious prejudice/discrimination

Respondents expressed concern about religious prejudice and discrimination in older age care homes:

> As a lesbian I would be worried that there would be discrimination by staff with a religious based anti-gay ethos. (SPL062)

> Care providers with strong religious convictions such as homosexuality is sinful may treat LGBT people with less respect and dignity than they should. (SPL019)

> There is a fear that one would be treated differently by religious people. You may have to hide your sexuality. (SPL024)

Many LGBTQ people are aware of enduring religious censure of themselves and/or their lives (Westwood, 2017). While religious advocates argue that this is a rational moral objection rather than true prejudice (Jowett, 2017), other authors assert that religious-based negative attitudes towards LGBTQ people still constitute prejudice (Herek & McLemore, 2013). The concerns raised by the above respondents relate to a general non-specific anxiety about discrimination. However, other respondents were concerned about more overt discrimination:

> Even if the carer was professional and compassionate, her religion's stance and presumably her own stance viz a viz the [care recipient], would constitute her as an inappropriate person to be in a carer role for that patient … the carer could act out negatively with harmful or even fatal consequences for the [care recipient]. (SPL067)

> A lot of religions are homophobic/transphobic and don't respect the rights of LGBTQ+ people. This can lead to religious individuals being homophobic/ transphobic when required to provide care for LGBTQ+ people. (SPL068)

These concerns take on particular significance in care homes. As closed care spaces, they are perceived by many older LGBTQ people to be sites of "surround sound" heteronormativity, cisnormativity, homophobia and transphobia (Almack, 2018; Hunter et al., 2016; Westwood, 2016b, 2016c). Several respondents were concerned about the detrimental impact religious prejudice/discrimination could have on older LGBTQ people:

> People with faith-based objections might display homophobic behaviour or transphobic behaviour etc towards LGBTQ+ older people in a care setting. This might make LGBTQ+ people feel very uncomfortable or feel they cannot be themselves. Prejudice and bigotry are never a good grounding for seeing people as people, as worthy of respect. (SPL068)

> Homophobia is still rife in older generations and among staff from certain religious/cultural backgrounds (major generalisation, for which I apologise) . . . If an older LGBT+ person finds themselves trapped in a perceived (or actually) homophobic place, retreating into the closet can be seen as the only (but distressing) option. (SPL029)

These respondents highlight the discomfort and/or distress an LGBTQ resident might experience in response to witnessing/experiencing religious-based prejudiced attitudes and/or discrimination. These in turn could have a negative impact on an older LGBTQ person's physical and mental health (Fredriksen-Goldsen et al., 2017). A key concern is not only that they may feel compelled to conceal their identities, as suggested above, and echoed in the literature (Almack, 2018; Wilson et al., 2018). However, the other concern, not expressed here but raised in the literature, is that, with dementia, they may lose the ability to conceal and may "out" themselves and/or their loved ones with potentially risky consequences (Westwood & Price, 2016).

These respondents expressed concern about severe harms:

> People sometimes use their religious beliefs as a reason for not wanting to provide care to an individual and/or providing poor care and/or being abusive as they believe for example, that their sexual orientation is wrong - or a sin. (SPL066)

> [If they have] faith-based objections to LGBT+ people . . . take that discrimination and disrespect somewhere else, don't impose it on older, vulnerable people . . .. I see it as ' elder abuse'. (SPL034)

> . . . there are some religions and countries where being [a] Rainbow community member will get you imprisoned or murdered or treated badly, tortured etc. If a staff member comes from one of those countries or religions I fear that I will not be safe, or that I might be treated badly or discriminated against, but also that my life might be cut shorter by their lack of care, or judgment. (SPL043)

Each respondent is concerned about abusive care. The last respondent also raises concerns about the religious/cultural clash in relation to migrant workers originating from countries where LGBTQ people are oppressed (Harris et al., 2017). This will be considered in the discussion section.

Fears about religious conversion attempts

Some participants took a zero-tolerance approach to religion in health or social care contexts:

> . . . there should be no religious input. Especially not "I'll pray for you". (SPL030)

Other respondents raised more specific concerns about religious proselytising and/or conversion attempts:

> The "hate the sin but love the sinner" rhetoric employed by many people of faith is always exhibited in some sort of conversion-style conversation with vulnerable people. (SPL057)

> There have been reported instances of very religious carers inflicting their views on the cared for person. (SPL047)

> Some carers who are evangelical can seek to impose their views. (SPL079)

> Risk of inappropriate quoting of Bible passages that condemn same sex relationships [or] treating LGBT people as inferior sinful beings. (SPL019)

There is only very limited anecdotal evidence of religious carers seeking to convert LGBTQ people to their beliefs and what evidence there is, as outlined earlier, suggests that this is dealt with via professional regulations. However, hearing about such cases, even if they are extreme examples and/or 'one-off's, can raise anxieties among older LGBTQ people.

Particular concerns were expressed about Christian evangelicals and fundamentalists, particularly those drawing upon Old Testament references to the "sin" of homosexuality. It is worthy of note here that this concern is not about all religious individuals but about more specifically those who take a literal approach to scripture. This echoes research which suggests heightened risk of negative attitudes towards LGBTQ people among evangelical and fundamentalist Christians (Westwood, 2022a).

One of the major concerns among older LGBTQ people about living in care homes, as outlined earlier, is that they are living in closed spaces from which they are unable to leave and are unlikely to be able to assert their rights due to cognitive and/or physical frailties. This then heightens anticipated vulnerability, as this respondent observed:

> I have no desire to live in a care home where there are practising religious people whose attitude towards me is negative to a greater or lesser extent. Older people often feel themselves to be in a weaker position unable to stand up for themselves. No-one should be allowed to exploit that vulnerability by imposing their religious prejudices upon them. (SPL063)

This respondent highlights the power imbalance in older age care spaces, with older people being more vulnerable and less able to defend themselves (Twigg, 2000). The respondent's anxiety about such vulnerability is channelled into fears of religious exploitation. There is no evidence that such religious exploitation exists. The central issue here is the fear that it may, highlighting the important of religious care providers making explicit their commitment to LGBTQ-inclusive care delivery (Hafford-Letchfield et al., 2018).

Discussion

The data analysed here provide new and previously unexplored insights into what concerns older LGBTQ people about older age care delivered by religious organisations and/or staff. The most tangible fear participants referred to was religious speech, and that religious staff may seek to convert, or "save" them. There have been a very small number of examples of this happening documented in the literature, and there is no indication that this is occurring routinely. Nonetheless, case law indicates such poor practice is possible and this adds weight to the concerns expressed by the respondents in this study.

The concerns expressed by the respondents are animated by fear. Older LGBTQ people have experienced a lifetime of social exclusion and marginalisation, often associated with religion, and some are fearful of this happening again in later life. As Putney et al. (2018, p. 887) observed, the fear 'runs deep'. There has been a tendency in recent years to think that LGBTQ rights have been won, particularly if those rights are only understood in terms of relationship recognition and decriminalisation (Gerber et al., 2021). However, there are wider issues of inequality, and for older LGBTQ people anticipating living in care homes, older age care needs could relocate them into new terrain of potential prejudice and discrimination at a time in their lives when they may be less able to cope (Westwood, 2016b, 2016c).

The issue of migrant workers was also raised. This has previously been mentioned in the literature, with some authors suggesting that migrant workers from certain countries may be more likely to object to LGBTQ people and/or their lives on the grounds of religion (Damant, 2021; Vinjamuri, 2017). Migrant workers are disproportionately represented in UK health and social care provision (Turnpenny & Hussein, 2021), most commonly coming from religious countries with high levels of disapproval towards LGBTQ people, including (Skills for Care, 2020): Romania, the 'most religious' of 34 European countries (Pew Center, 2018); Poland, Portugal and Italy, the 8th 9th and 13th most religious respectively (Pew Center, 2018); the Philippines (93% of the population identifying as Christian); and Nigeria, which has one of the highest levels of religiosity in the world among (Pew Center, 2019). In Nigeria, same-sex sexual activity between both men *and* women is a criminal offence and same-sex marriage is prohibited (Human Dignity Trust, 2022).

Often subject to prejudice and discrimination themselves (Stevens et al., 2012; West et al., 2017), migrant nurses and care workers may experience religious and cultural tensions between the norms, values and laws of their countries of origin and those in the UK. A recent review of the literature (Balante et al., 2021) highlighted that internationally trained nurses often feel

excluded by multi-faceted processes of systemic disadvantage and cultural imperialism and that this needs to be addressed to promote their increased integration. A key area of tension can be in relation to LGBTQ issues (Balante et al., 2021; Harris et al., 2017; Westwood, 2022b), suggesting there is a need for greater facilitated dialogue, discussion and reflection in this regard.

The respondents in this study perceive religious tolerance to be insufficient for person-centred care. The concern about a lack of respect underpinning religious tolerance echoes Brown's (2009) work on tolerance as abjection. A lack of respect amounts to the social injustice of misrecognition Fraser, 1997), is contrary to the core principles of care ethics (Sevenhuijsen, 1998; Tronto, 1993), and suggests a lack of basic care (Barnes, 2012). A lack of respect also has implications for effective equality (Lynch et al., 2009) – in terms of unequal and inferior love care and support – and relational justice, in terms of potentially unequal formal caring relationships in older age care homes (Lynch et al., 2021). All four domains of social justice are implicated and overlap. The quality of care as a resource (going beyond economic resources, Westwood, 2016a) and the quality of social recognition in the delivery of that care inform, in turn, affective equality and relational justice. Care providers taking an anti-oppressive approach to the care of older LGBTQ people will ensure their voices and experiences – historical and contemporary – are advocated for and associated inequalities challenged, i.e., that older LGBTQ people are appropriately represented in older age care. A lack of such advocacy would constitute a lack of representation and thus a lack of social justice.

If older LGBTQ people are accepted by health and social care providers (religious or not), their lives validated and celebrated, their relationships recognised and supported, and their oppressions challenged and mitigated, then they are in receipt of equitable, socially just, care. If older LGBTQ people and their relationships are not fully accepted, validated and celebrated, and/or their oppressions go unchallenged, then they are not in receipt of equitable, socially just, care. What is clear from the data is that some older LGBTQ people are concerned about the latter scenario. However, what is also clear from the literature is that although there are concerns about some highly religious staff's attitudes towards LGBTQ people, it is not yet known or understood whether and/or how religious attitudes – positive and negative – inform the delivery of services to older LGBTQ people. Similarly, the implications for the possible experience of moral distress (Corley et al., 2005) by some religious practitioners delivering services to LGBTQ people is not yet understood.

Limitations

The data are not indicative of the scale, number or proportion of older LGBTQ people who are concerned about religious-informed care in later life. They do not come from a representative sample (not that any sample of older LGBTQ people can be considered fully representative, given that they are a partially hidden population, Westwood, 2016a). The respondents are likely to be among those most concerned about these issues, given they self-selected to complete the survey. The data were analysed by a single experienced researcher and the findings may have been informed by her feminist social gerontological/socio-legal standpoint.

Conclusion

Despite these provisos, the data paint a very clear picture of what it is that some older LGBTQ people are concerned about in relation to religious-based care home provision. This article thus contributes to the emerging discussion about how some religious care organisations and staff can deliver affirmative anti-oppressive care to older LGBTQ people.

The thorny issue which remains unresolved is what *actually* happens in practice. The following research questions require urgent attention:

(1) What is the quality of the care delivered to older LGBTQ people by religious organisations whose ethos is underpinned by religious values which disapprove of "homosexuality" and gender diversity? Is it affirmative and anti-oppressive? If so, how is this achieved? If not, how and in what way?
(2) What is the quality of the care delivered to older LGBTQ people by nursing and social care staff who adhere to religious beliefs which disapprove of "homosexuality" and gender diversity? Is it affirmative and anti-oppressive? If so, how is this achieved? If not, how and in what way?
(3) How do older LGBTQ people understand, and experience care delivered to them by organisations and/or nursing and social care staff who adhere to religious beliefs which disapprove of "homosexuality" and gender diversity?
(4) How do leaders/managers of religious organisations whose ethos is underpinned by religious values which disapprove of "homosexuality" and gender diversity understand and experience the delivery of care to older LGBTQ people?
(5) How do nursing and social care staff who adhere to religious beliefs which disapprove of "homosexuality" and gender diversity understand and experience delivering care to older LGBTQ people?

(6) What are the social justice implications, particularly for equality of (care) resources, recognition, and relational justice?

It is only when these questions have been answered that it will be possible to contextualise the concerns which have been identified in this paper and determine what, if any, course(s) of action need to be undertaken. However, whether older LGBTQ people's concerns turn out to be reflected in practice, it is clear there a need to respond to their fears and to be able provide assurances that all older age care services – including care delivered by religious providers – are equally LGBTQ-inclusive and socially just.

Notes

1. McFarlane v Relate Avon [2010] IRLR 196 (EAT); [2010] IRLR 872(CA); Eweida and Others v. UK [2013] ECHR 37.
2. Christian Concern Legal Centre (Christian Institute, 2016) *Case Summaries 2006-2015*, Page 38. https://archive.christianconcern.com/sites/default/files/clc_case_summaries_v7.pdf.
3. Dr David Mackereth v (1) The Department for Work and Pensions (2) Advanced Personnel Management Group (UK) Ltd, Case Number: 1,304,602/2018.
4. R (Ngole) v The University of Sheffield [2019]; R (on the application of NGOLE) (Appellant) v The University of Sheffield (Respondent) [2019] EWCA Civ 1127.
5. Kuteh v Dartford and Gravesham NHS Trust Employment Tribunal Case Number 2,302,764.2016: Kuteh v Dartford and Gravesham NHS Trust [2019] EWCA Civ 818, [2019] IRLR 716.
6. Para. 31, pp. 7-8.
7. Para. 22.2.
8. Although in the 2011 census over half of the UK population identified as Christian, this is predicted to fall in the 2021 census (Sherwood, 2021). According to the British Social Attitudes Survey (Curtice et al., 2019), over half of people in the UK no longer identify with a religion, two-thirds saying they only attend religious services for "special occasions", e.g., weddings, baptisms and funerals. Also, according to the survey, only a third of the UK population identifies as Christian, with Anglicans (belonging to the Churches of England, Scotland and Wales) declining to just 12% of the population. There are now slightly more "non-denominational" Christians (13%), including those affiliated with independent churches, a third of whom attend church regularly. In terms of non-Christian religions, the largest is Muslim (5% of the population) and this is increasing.

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