

Research paper

Sexuality and religion: a challenge for diversity strategies in UK social care service development and delivery

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What is known on this subject

- There are challenges in balancing the interests of different groups in a diverse society, particularly in the context of single equalities approaches in local government and social care.
- There are potential conflicts between religion and belief and sexual orientation which can affect social care provision.
- Lesbian, gay, bisexual and transgender (LGBT) people experience discrimination in social care services.

What this paper adds

- It tackles an ‘uncomfortable’ subject which is often ignored in analyses of social care diversity policies.
- It gives a clear overview and acknowledges the complexity of the current situation in social care.
- It provides an evidence base designed to encourage social care stakeholders to take the LGBT equality agenda forward and to tackle discrimination at all levels.

ABSTRACT

This paper is an exploratory and critical discussion of a particular aspect of the mainstreaming equalities social policy agenda and local authority diversity strategies in social care. The specific example of the potential difficulties involved with engaging both religious groups and sexual minorities in community engagement, service user participation initiatives and social care service development and delivery is investigated. The discussion includes an overview of the possible effects of institutionalised homophobia on strategic level activity and future research into cultural competency of social care

practitioners to work with lesbian, gay, bisexual and transgender (LGBT) service users and carers. The paper concludes by exploring the potential impact of the new LGBT equality regulations and the personalisation agenda on the development of more equitable social care services.

Keywords: bisexual, communities, cultural competence, discrimination, diversity, equality, gay, lesbian, local government, religion, sexuality, social care, social work, training, transgendered people, user participation

Introduction

This paper is partly written in the spirit of *standpoint epistemology* which ‘asserts that life experience of subordination or exclusion can give people greater knowledge about certain realities that those in positions of relative power and privilege cannot easily know about in the same way because they lack that life experience’ (Tew *et al.*, 2006:8). Elsewhere I have discussed my experiences as a gay mental health service

user from a Roman Catholic background, and examined some of the wider problems lesbian and gay people can have in obtaining appropriate, supportive mental health services. I wrote that ‘I have met with practitioners whose religious, moral and social prejudices have prevented them from recognising me as a human being trying to manage difficult and complex experiences’ (Carr, 2005:170–1). Applying the lens of

standpoint epistemology to personal experience I began to examine the conflict between religion and sexuality in mental health services, discovering:

... a large US study on the attitudes of social work and counselling postgraduates [which] revealed that a significant minority still expressed negative attitudes towards lesbians and gay men, with 'males, heterosexuals, African Americans and conservative [Christians] reflect[ing] the demographics who tended to express the least acceptance' (Newman *et al*, 2002:175).

This paper represents a further investigation and discussion of those two areas of potential conflict when developing inclusive, personalised social care services that are sensitive to the needs of the individual and responsive to the demands of an increasingly diverse society, yet maintain their value base in anti-oppressive practice within a human rights framework. It highlights some of the difficulties in coping with the often conflicting demands of religion and sexuality in the development and delivery of social care services within the public equality and diversity duties.

Government policy now makes it imperative for the people who use health and social care services to be involved in their delivery and production (Department of Health, 2006), yet those who are least engaged in social care services or who are underserved by them are most likely to be marginalised in participation processes:

Attention to the diversity of service users in terms of race, culture, sexuality ... was lacking in mainstream services and participation initiatives. This relates to both diversity within user groups and the relative lack of knowledge about user participation for marginalised people (Carr, 2004:21).

Diversity has become a common term in discourse about user participation and community engagement in public services in England over the past decade. It has been defined as 'taking account of the complexities of the lives of individuals and of groups of people, and the impact of these complexities on their experience of discrimination and disadvantage' (Butt, 2005:9). Diversity strategies are part of a 'mainstreaming equalities' social policy agenda which seeks to avoid seeing people in relation to single equalities groups, according to disability, gender, race, sexual orientation, class and so on. While this can be seen as a good thing in theory, implementing strategies aimed at promoting diversity in participation is not without its difficulties:

The strength of this definition rests with the fact that simultaneous or compound discrimination and oppression can easily be accommodated and addressed. Nevertheless, critics argue that by promulgating the idea that all types of differences and inequalities come under one roof, there is a danger that it waters down or diverts attention from the specifics of the distinct types of inequalities and what is required to tackle them (Begum, 2006:8).

There is also a risk that certain approaches to participation and working definitions of *diverse communities* can result in hierarchies of equality and conceptual misunderstandings (Aspinall and Mitton, 2008). When the Office of the Deputy Prime Minister (ODPM, now Communities and Local Government) looked at the implementation of equality and diversity strategies in local government, it found that there was a tendency to equate diversity with race and that:

... for many councils, however, the absence of a strategic, coordinated and corporate response seems to be hampering further progress. It is clear that many councils lack a shared organisational understanding of equality and diversity and the breadth of issues that are relevant in this area (ODPM, 2003:2).

This led the report authors to question the readiness of local authorities to address the 'whole range of equality and diversity issues, including newer aspects such as age and sexual orientation' (ODPM, 2003:4). This paper examines sexual orientation and religion as an example of where this seems to have occurred in social services, and the complexities surrounding the issue.

Diversity, religion and sexuality: a case study in complexity

Although a number of factors influence the mainstreaming of public sector equality and diversity policies in England, it appears that some motivation has derived from an often white, middle-class heterosexual liberal optimism in both central and local government about marginalised people and those with experience of oppression being mutually supportive of each other. This has often been demonstrated in national and local diversity strategies aimed at developing public services that are more accessible and responsive to the needs and demands of a diverse society. However, for various reasons, this ideal of solidarity and shared values among the oppressed and marginalised has not always translated into practice, a specific example being the difficulties involved with engaging both religious groups and sexual minorities in public service diversity schemes. Some of the difficulties that have arisen as a result of equating socio-political groups were concerned with equality with religio-moral groups whose value base can sometimes be at odds with general diversity agendas.

Part of the New Labour diversity strategy has predominantly come to focus on religious identity rather than the secular and political issues of racial inequality. It has been observed that 'religion-based communities are considered to be exemplars of social capital ideals of reciprocity, integration, socialisation,

activism and voluntarism, which are thought to solidify the community and benefit the individual' (Leavey and King, 2007:97). Consequently, participation and consultation approaches for people from black and minority ethnic (BME) groups have often sought to engage 'communities of interest' centred on religious belief. Similarly so-called 'community leaders' are often consulted with the assumption that their views are representative of a particular minority community. This has been partly due to a genuine commitment to include some of the people identified as 'seldom heard' in decision-making processes in health and social care. The 2001 ODPM National Strategy Action Plan for neighbourhood engagement asserted that 'faith groups may offer a channel to some of the hardest-to-reach groups. A pragmatic approach will be taken to funding faith groups, recognising that they may be the most suitable organisations to deliver community objectives' (ODPM, 2006:82). Therefore, since the late 1990s, faith-based groups have routinely become part of participation initiatives and service delivery partnerships in local authorities.

In a recent study of the effective implementation of the public sector equality duties in race, disability and gender, 64% of respondents indicated that consultation with and involvement of service users and employees contributed to successful implementation (Schneider-Ross, 2007). However, in social care, policy makers and practitioners often consult with BME professionals and community leaders, rather than going directly to service users themselves, even though 'proxy participation is unlikely to yield an adequate understanding of BME service users' lives and what interventions (if any) are needed to ensure their safety, respect and dignity to promote choice and independence' (Begum, 2006:14). It may also fail to truly reflect the diversity of BME people themselves, particularly if the community leaders are related to religious groups with certain beliefs about gender, mental health, disability and sexual orientation. For example, research carried out in Bradford, England, indicated that 'minorities within the South Asian minority can face high levels of stigma from their own communities, as well as the wider population. This is particularly so for the lesbian, gay, bisexual and transgender (LGBT) community, but also applies, for example, to mental health problems' (Blakey *et al*, 2006:1). More specifically, in relation to participation, 'mosques play a key role ... giving statutory organisations the opportunity to work with Bradford's South Asian community. However, those who did not find the mosque enabling (for example, some women, the LGBT community, those from lower caste backgrounds) might not be heard' (Blakey *et al*, 2006:1). Black researchers have been clear about the fact that 'respecting cultural diversity should not be confused with supporting oppressive family practices' (Mir, 2007:6), which may arise from religious values and

cultural customs. An investigation by the Safra Project into the difficulties experienced by gay and transgendered Muslim women highlighted the shortcomings of social and legal services that misunderstand cultural sensitivity:

Whilst it is important that service providers are culturally sensitive, some so-called multicultural practices or policies can contribute to the problem by ignoring diversity within Muslim communities. This is exacerbated by a lack of understanding of the differences between religious, cultural and patriarchal norms' (Safra Project, 2003:5).

More widely, it has been recognised that:

... many lesbian, gay, bisexual people remain minorities within a minority and, as such, invisible and marginalised. These can include those who are disabled, parents, young, old, poor, asylum seekers, or those from black and ethnic minority communities. These people may experience multiple discrimination, including from within their own communities ... Many of these hidden lesbian, gay and bisexual people may have the greatest needs, in terms of support and services. They may also be in a position to make invaluable input into the development of effective policies and strategies' (Local Government Association (LGA), 2007:10).

Recently, the Department of Health for England and Wales published briefings for health and social care staff on issues for LGBT people, which recognised that 'while religion has a central, positive function in many BME communities, it can also play a role in supporting homophobia' (Department of Health, 2007:6). So, in approaching BME people through faith communities and religious or community leaders, public sector service user participation initiatives can risk further marginalising and silencing LGBT people, particularly those from BME communities themselves.

A recent government review of the evidence base on faith communities conceded that there is an emerging difficulty with 'mainstreaming diversity' and the faith-based approach to participation:

Although the rate of increase in the number of ethnic minority councillors is low, research conducted in 12 local authorities that were involved in work on sexualities and equality between 1990 and 2001 disclosed conflicts between 'different equalities areas – sexualities, disability and gender, but especially between race and faith equalities and lesbian and gay equalities' (Carabine and Monro, 2004:319)' (ODPM, 2006:78).

The conflicts concerned Christians as well as Muslims. This research suggests that local authorities now face the challenge of finding ways to mainstream diversity without giving priority to some claims of equality and influence over others. This is consistent with the observation that 'there is some basis for regeneration officials' fears of conflict between secular views of equal opportunities and the traditional values of some

faith communities (Farnell *et al*, 2003:36)' (OPDM, 2006:78).

If one examines the research on the intersecting social relations and community participation in new local authority diversity frameworks for lesbian and gay people, it shows the emerging consequences of a shift away from the emphasis on discrete equality issues, and highlights the difficulties with balancing the interests and influence of different communities of interest. Even at the highest ministerial level, there have been issues regarding conflict of interest around religious belief and sexuality. There was considerable public concern (*The Guardian*, 28 June 2007) over the appointment of Ruth Kelly MP, who is not only a practising Catholic but also a member of the rightwing Catholic society Opus Dei, to the post of Education Secretary, then Minister for Equality, and later Secretary of State for Communities and Local Government. She allegedly refused to work for the Department of Health because of her religious beliefs on abortion and had failed to support any measure of gay rights since Labour came to power in 1997 (*The Independent*, 10 May 2006). There was concern from gay rights organisations that her religious beliefs would interfere with her capacity to exercise the political authority needed to take forward a strong equalities agenda and undertake her job in a way that was accountable to the electorate (*The Independent*, 10 May 2006). At local authority level, researchers found that:

... faith communities, particularly Catholic and Muslim, were described by local government officers and community actors as 'having a problem' with sexuality, making the recognition of lesbian and gay issues particularly fraught ... Although local government appears to have routinised lesbian and gay work to a certain extent, it continues to remain a marginalised and often well-hidden aspect of local authority work hampered by insufficient resourcing, political nervousness and institutional homophobia (Carabine and Monro, 2004:319).

To quote directly from a senior policy officer from a district in the north of England with a large Muslim population as well as a comparatively large lesbian and gay community: 'sometimes dealing with race issues and the views of faith communities ... has been a reason for not tackling lesbian and gay issues: needing support of the Council of Mosques in condemning riots could be used as an excuse for not tackling more sensitive issues such as sexuality with the Council of Mosques' (Carabine and Monro, 2004:325). The LGA has warned local authorities against maintaining institutionalised discrimination and cultural and political inertia where 'lesbian, gay and bisexual equality risks being sidelined because it is seen as unrelated to local political priorities and an optional extra in the face of more "deprived" communities' (LGA, 2007:11). Such institutionalised homophobia, maintained by the

personal and political prejudice, ignorance or cowardice of some officials, can have direct consequences for frontline social care service provision and the development of innovative practice with marginalised groups. For example, a study examining sexuality in UK local government equalities work revealed that homophobia was a major factor affecting sexualities initiatives in local authorities, and in some instances this was so marked that 'people did not even want to use the words lesbian or gay' (Monro, 2006:26). This type of institutionalised homophobia led, in one case, to an Asian gay youth project being shut down:

An Asian youth worker who was working with quite a well-developed and well-attended lesbian Asian youth group, and somehow some people in the local community found out about it, and basically it just kicked off ... and she had to go into hiding and there were death threats made against her. The group had to disband, and importantly, the council did not back her up (quoted in Monro, 2006:27).

Given that there appear to be difficulties with understanding diversity and the potential conflicts around religion and sexuality at local authority level of service planning and commissioning, it is questionable whether frontline workers are being supported to deal with such complexities at the service delivery level. The extent to which social care practitioners are able to deliver culturally sensitive, innovative and personalised services to a diverse population without marginalising the needs of LGBT people is also a matter of concern.

Diversity, cultural competency and the social care workforce

It has been argued here that mainstreaming diversity strategies for user participation and community engagement may risk creating a hierarchy of equality where LGBT interests are marginalised to accommodate the views and interests of faith communities. To date, 'sexual identity issues are rarely considered to be of sufficient importance to merit a place on decision-making agendas' (Fish, 2006:197). If the needs of sexual minorities are being under-represented at the level of service planning and development, this may then have an effect on the experience of the social care service user if they identify as lesbian, gay, bisexual or transsexual (LGA, 2007). It has been argued that 'the workforce acts as a mediator between the state and vulnerable individuals, and needs to bridge the discord in public policy' (Roche and Rankin, 2004:6) and that 'public policy is, in practice, heavily influenced by frontline workers, who exercise discretion in the way that policies are implemented' (Monro, 2006:31). However, in the UK, there is no co-ordinated or systematic approach to health and social care equity for LGBT

people (Fish, 2006), and an overall lack of recognition about the complex ways in which discrimination and identity can intersect at the level of service delivery. The question thus arises as to whether the social care workforce is competent to bridge this particular discord in public policy and deliver equitable, personalised services to LGBT people.

Despite the outward commitment of social care to promoting anti-discriminatory practice in general (General Social Care Council (GSCC), 2002), LGBT issues are not specified or are an integral, standard consideration for social care service delivery and practitioner training (Mulé, 2006; Commission for Social Care Inspection (CSCI), 2008). Very recent work by the CSCI (2008) shows that 45% of lesbian, gay and bisexual people using social care services said they had experienced discrimination, with only 9% of registered services reporting specific action on equality for lesbian, gay and bisexual people. Research carried out by a group of disabled lesbian, gay and bisexual service users into their local service provision highlighted the fact that 'there is little information to tell if an organisation and its staff are LGB friendly', and that 'monitoring and evaluation of service provision, in relation to disability and sexual orientation needs to be strengthened' (Rainbow *et al*, 2006:3–4). More specifically, LGB disabled people who use personal assistants need to be provided with 'a culturally competent' service ... [which] includes recognising the need for interaction with LGB communities' (Rainbow *et al*, 2006:6). Similarly, LGBT people who use mental health services or family services, and older LGBT people who may need to use home support or residential services have emphasised the need for a 'culturally competent' social care workforce (Age Concern, 2002; PACE, 2005; Polari, 2005) able to undertake person-centred, anti-discriminatory practice. However, confidence in the social care workforce appears to be low, as a study of LGB people who were aged over 50 years revealed that:

... participants generally believed that health and care service providers a) operated according to heterosexual assumption, and b) failed to address their specific needs. Considerable concerns were expressed about care provision and special housing. There was notable distrust about respect for their sexual identities and relationships in such contexts (Heaphy *et al*, 2003:3).

Age Concern, a voluntary sector organisation at the forefront of promoting cultural competency for staff working with LGBT older people, has undertaken careful research into the needs and requirements of service users. Their report *The Whole of Me* emphasises the need for LGBT people who receive domiciliary care to feel 'safe in their own home' (Age Concern, 2006); that is, to have workers with whom they feel comfortable enough not to hide indications of their sexuality (such as books and pictures) in their home.

Despite this stated need for cultural competence with regard to LGBT issues from the LGBT community, little diversity training focusing specifically on sexual orientation and gender identity appears to be taking place (Trotter and Gilchrist, 1996; Mulé, 2006). This may change with the new equalities legislation (The Equality Act [Sexual Orientation] Regulations 2007), but currently, social work and social care teachers and trainers can experience conflicts of interest about race, religion and sexual orientation similar to those of their colleagues in local authority management. The LGB disabled researchers were clear that the 'mandatory training of all social care staff ... should include training on LGB equality and disability equality issues, alongside other equality issues' (Rainbow *et al*, 2006:6). LGB researchers investigating the provision of family welfare services concluded that 'mainstream services need to develop their practice to make services more accessible to lesbian, gay and bisexual service users and their families. All managers, frontline ... staff should be provided with training in order to develop their practice' (PACE, 2005:14). Further, managers are advised to 'keep lesbian, gay and bisexual equality issues on your agenda through regular supervision, team meetings and training events' (PACE, 2005:14). Similarly, those providing services to older people are being urged to include LGBT issues in their diversity and equality training (Age Concern, 2002; Polari, 2005). Writing in the context of anti-racist social work practice in the US, Potocky-Tripodi (2002) has defined cultural competence as the attributes and beliefs, knowledge and skills of the individuals delivering services. Social care professionals must examine and acknowledge their own attitudes and beliefs, based on the premise that everyone has some social prejudices. Integral to this is examination by practitioners of their own ethnicity and racial and cultural heritage. A similar model of reflective training, practice and supervision could be translated for work with sexual minorities.

Although the research is not yet conclusive in any way, recent investigations into the changing UK social care workforce have shown that it too is becoming more diverse and may have an increasing proportion of migrant workers who could belong to faith communities or cultures that have negative views of homosexuality or transgendered people. 'Recruitment and retention challenges are particularly acute in social care' (Roche and Rankin, 2004), so the recruitment of overseas workers is important. Recent figures show that 19% of social workers and 16% of care assistants and home carers were born outside the UK, and in London this figure rises to 48% and 68%, respectively (Experian, 2007). The research revealed that 'support care workers are often from Eastern Europe or Africa, whereas senior care workers or social workers are often from developed countries such as

Australia' (Experian, 2007:6). Certain countries in Eastern Europe (Greenwood, 2007) and in Africa have very negative attitudes towards homosexuality which they regard as an offence leading to imprisonment or even capital punishment in some cases (de Jong, 2003; Ottosson, 2007). Although it would be prejudicial and dangerous to make assumptions about the attitude of an individual because of their country of origin, employers of migrant workers need to be aware of the potentially discriminatory normative cultural values or dominant religio-moral beliefs of the worker's country of origin. They need to ensure that those workers are able to deliver sensitive and appropriate services to all individuals. This is what is expected of them as social care employers by the GSCC: '[to use] rigorous and thorough recruitment and selection processes focused on making sure that only people who have the appropriate knowledge and skills ... are allowed to enter your workforce' (GSCC, 2002:4). However, in relation to equality and diversity training which includes awareness about LGBT issues for new migrant social care workers, the survey has some potentially serious implications. Although it did not include detailed investigation into anti-discrimination and diversity training to improve the cultural competencies of social care workers, the research showed that even basic induction programmes vary in quality: 'the informal nature of the induction programmes and the short time scales often involved suggest that many employers are not following the Induction Standards for each UK country' (Experian, 2007:9). One of the main difficulties highlighted by employers of overseas workers was language and culture. 'Around half those surveyed told us that language or cultural issues were some of the main difficulties in employing overseas workers' (Experian, 2007:11). Again, this raises questions about the capacity and commitment of employers to training and providing staff that are competent to work with sexual minorities, or indeed black and minority ethnic people and other service users. These difficulties may relate to semi-qualified or unqualified social care staff, but the situation is not necessarily more hopeful with fully qualified social workers or social work degree students.

There is some evidence that the boundaries between personal, private belief and professional practice in social work can sometimes be blurred in unhelpful and even dangerous ways, both for practitioners and for service users and carers (Carr, 2005). For example, one of the undiscussed aspects of the Climbié Inquiry was the fact that one of the social work managers involved in the case had used supervision sessions to discuss her faith, as Lord Laming's report records:

Two other social workers in Ms Baptiste's team gave evidence as to the irregularity and variable quality of her supervision and complained that she referred to her

religious beliefs and gave religious guidance during supervision sessions (Laming, 2003:117).

The CSCI has noted that 'one particularly difficult area is where individual staff have objections to addressing the issues of equality for lesbian, gay and bisexual people for religious reasons' (CSCI, 2008:18). Emerging anecdotal evidence suggests that in some areas, social work teachers are facing difficulties balancing anti-discriminatory approaches in the classroom. One social work teacher training students in an inner London university informally reported that around 70% of her students identified as Christian. Following a session on values in social work she received an email from a gay student who said:

During the discussions several students spoke openly about how their religious upbringing had taught them that homosexuality was a sin and wrong. They explained how they still agreed with this ... I am now left feeling that I am surrounded by students with very homophobic views that have been left fundamentally unchallenged ... At what point can we begin to say to fellow students 'Those views are unacceptable and if you can't resolve them then you need to think about what you are doing in social work?' (Cowden *et al*, personal communication, 2007).

This situation exemplifies the practical difficulties with balancing the principles of diversity with anti-discriminatory practice. While private faith may be a helpful motivator for some people to enter the profession, it should not interfere with their ability to act as competent public professionals, as Mulé states:

As practitioners, social workers are called upon to subscribe to the highest moral and ethical standards, at all times. It is necessary that this includes the right of client self-determination and respect and support regardless of their sexual orientation ... Practicing social workers need to review their own homophobia and heterosexism as individuals and professionals, regardless of their sexual orientation (Mulé, 2006:609).

In its diversity guidelines on delivering personalised services to LGBT people, the CSCI has stated that 'staff need to be professional in all their interactions, without imposing their own religious or moral values on people using the service' (CSCI, 2008:19). However, the opportunities in professional training and development to acknowledge and work through homophobia are still rare (Trotter and Leech, 2003; Mulé, 2006) and this is not helped by the fact that 'anti-heterosexist and non-homophobic practice is not made explicit in the conveniently abbreviated jargon of the anti-discriminatory discourse' (Trotter and Gilchrist, 1996:75). What emerges here is a situation where LGBT issues and concerns are again in danger of being marginalised, this time in social work training, mostly because of invisibility in approaches to diversity and lack of specificity in cultural competency

training. Again, it seems that institutionalised homophobia, or at least a lack of awareness about the complexities associated with diversity, has created a situation where a social work degree qualification has been established that 'is currently positing sweeping generalisations regarding diversity and multiculturalism in curriculum standards, that in the absence of defined specificity, risks providing inadequate training to intervene with sexual minority populations' (Mulé, 2006:617).

Some social work practitioners have been found to claim that they treat LGBT clients in the same way as they would treat any other client or service user, without considering the impact of difference and discrimination. A national user-led survey of the provision of both mainstream and specialist services for LGBT parents showed that 80% of respondents did not have a specific policy relating to LGBT parents. Overall, the report authors concluded that there is:

A duality of approach ... recognition that LGBT parents have special needs, but a belief that a 'we treat everyone on their own merits – with respect' approach is sufficient. This is a laudable and worthy aim, but the lack of awareness of particular issues suggests that this well intentioned approach is not sufficient ... Does it enable organisations to become culturally competent and meet the needs of their clients who are LGBT parents? (PACE, 2007:30).

This 'treat everyone the same' viewpoint is reminiscent of that held by white social workers who adopted a so-called 'colour-blind' approach to delivering services to BME people. Both approaches assume that being from a minority group that has experienced discrimination and exclusion makes no difference to people's identity, needs and experiences. However, 'discrimination can be institutionalised through ignorance about the needs of lesbian, gay and bisexual people and through the lack of skills amongst managers and frontline service providers. Discrimination may be direct or indirect by making the assumption that all service users are heterosexual' (LGA, 2007:35). The UK Audit Commission has made it clear that 'the diversity agenda is not about treating everybody in the same way but about recognising and valuing difference; and recognising and accounting for inequality and disadvantage' (Audit Commission, 2002:9). Such awareness needs to filter through the whole social care system to the practice level where social workers, in the name of cultural sensitivity, have sometimes failed to tackle the issues of difference for LGBT people from black and minority ethnic groups. The Safra Project research referred to earlier detailed instances of where social services failed to protect or support gay Muslim people, using a direct quote from a social worker who said:

I know of at least two cases in which a young person felt that the social worker agreed with his or her family's

homophobic views and colluded with them. This resulted directly in a worsening of the situation for that young person. There is definitely a need for training around LGBT issues for social workers, particularly on the interaction between LGBT issues and cultural contexts (Safra Project, 2003:17).

An inclusive future?

Social care continues to face the challenge of creating capable services in a diverse society, where religion and belief have come to play an influential role and where sexual orientation as a diversity issue is still inadequately understood. As this paper has argued, there have been inherent difficulties in facing this challenge for LGBT people, as many religious groups discriminate against us. This can affect LGBT participation in service development and delivery as well as seriously compromising the quality of social work training. There are questions about the fitness to practise of some social care workers who belong to religious groups that promote the oppression of sexual minorities, and who are unwilling or unable to challenge their own prejudices because of employment or management approaches that fail to promote anti-discriminatory practice. There are also difficulties with social care practitioners and public service officials who collude with the homophobic views of certain faith groups. Overall, institutionalised homophobia or lack of cultural awareness in local authorities and social work training institutions has, in some cases, made it difficult to balance the interests of different parties equitably and develop culturally competent social care services and practitioners. However, there are at least two levers that could be used for creating more equitable social services and participation strategies for LGBT people.

The Equality Act (Sexual Orientation) Regulations 2007 prevents discrimination against LGBT people who are accessing goods and services. All organisations in both the public and private sector are covered by the legislation, so this includes social services (Fish, 2007). However, there have been demands from some religious organisations to be exempted from the regulations. Cardinal Murphy O'Connor, leader of the Catholic Church in England and Wales, publicly threatened to close Catholic adoption agencies unless they were exempted from the goods and services regulations. The government has given religious adoption agencies until the end of 2008 to adapt their services (Stonewall, 2007). The governing body of local authorities in England has issued explicit guidance on adoption and fostering services, asserting that managers should 'take prompt action to address homophobia. Be prepared to discipline staff or de-register carers'

(LGA, 2007:50). The CSCI for England has recently published good practice guidelines for social care providers on sexual orientation and gender identity in its Equalities and Diversity Strategy (CSCI, 2008). This could result in lesbian, gay, bisexual and transgender issues being considered as part of general social care service inspection and practice guidance. As part of its diversity awareness programme, the CSCI has surveyed LGB service users to ascertain their needs and experiences, which has resulted in the first comprehensive overview of LGB social care issues in England, and firm indications of where social care could improve (CSCI, 2008). These data should form an evidence base for future policy and planning. The organisation also ran one of the first national conferences on developing appropriate social care services for LGBT people (CSCI, 2007).

An integral part of the recent health and social care reform bill for England 'is the commitment to promote diversity by developing a workforce that is able to challenge discrimination, by making direct payments more available and by making greater use of the voluntary and community sector' (Butt, 2005:4). Corresponding local government guidance says that:

A citizen-centred focus represents a move away from a 'one size fits all' approach to service delivery, to more responsive services that are tailored to the varied needs of users, i.e. the 'personalisation' of services. This new approach must incorporate the needs of diverse communities. Public service reform presents a challenge and an opportunity for local authorities to engage with those 'communities of interest' who have traditionally been marginalised and discriminated against, including lesbian, gay and bisexual communities (LGA, 2007:34).

The increased personalisation of services through the introduction of individual budgets, where service users have control over the services they buy, and specialist community sector input could, over time, positively influence the provision of appropriate social care services to LGBT people. The social care personalisation agenda and transformation of social care services is outlined in the multi-agency concordat *Putting People First* (HM Government 2007) and in the Local Authority Circular (LAC) of January 2008 (Department of Health, 2008). The LAC describes how local authorities need to transform so that:

... people are about to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual requirements for independence, well-being and dignity. Local priority setting will be focused on meeting local needs and playing a leading role in shaping strong and cohesive local communities (Department of Health, 2008:2–3).

The LAC indicates to local authorities how they should work with service user organisations in order to achieve transformation of social care services. There

is a clear directive to co-provide locally appropriate services with the voluntary sector and that the workforce needs to have the skills to provide personalised services to individuals. People should be shaping services at national, regional and local levels. If the personalisation agenda is to achieve its aims, it needs to engage with historically marginalised and 'seldom heard' groups. Here there are obvious questions about the role of partnerships with faith-based organisations in health and social care practice, such as those being asked about mental health services:

How should mental health professionals engage with clergy who believe that sin or demonic possession lies at the root of a person's illness? Similarly, contested normative values, such as those related to sexuality, are not easily reconciled and may require clinicians to question and challenge fundamental tenets of certain faith groups (Leavey and King, 2007:98).

Those responsible for service delivery and development, including service users, need to be bold in their approaches to testing and improving the fitness to practise and cultural competency of workers and organisations whose religious beliefs have the potential to translate into moral judgements about their clients. Sexuality has been discussed here, but this could equally apply to attitudes towards disability, mental health (especially suicide and self-harm), addictions and poverty. However, local authorities working in partnership with specialist voluntary agencies to provide personalised services and improve the market for service users have the potential to improve the situation for LGBT people.

Finally, all these recent 'directives ... [are] founded on the premise that all lesbian, gay and bisexual people should share the same fundamental rights as everyone else' (LGA, 2007:8). But, as with gender and race equality legislation and regulations from the 1970s, such directives will achieve slow-impact changes. Anyone challenging homophobia in social care services now has legislative back-up and the support of the largest public sector union (UNISON, 2007), and those promoting the participation of LGBT people have guidance and regulations to defend genuine diversity. However, even now it has been recognised that local authorities that actively pursue inclusive approaches for LGBT people 'should not be immobilised by fears of a backlash either within their own institutions or in the community' (LGA, 2007:11). Therefore, it will still take the personal courage and commitment of individuals to fight discrimination and slowly create social care services fit to serve the complex and diverse society of 21st-century England. As the authors of the Safra Project report conclude: 'LGBT issues should not be compromised in the name of cultural sensitivity or respect for religion' (Safra Project, 2003:25).

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CONFLICTS OF INTEREST

None.

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