Journal of Psychiatric and Mental Health Nursing: Essays and Debates Paper
May 2017: doi: 10.1111/jpm.12402

Sickness, 'sin' and discrimination: Examining a challenge for UK mental health nursing practice with lesbian, gay and bisexual (LGB) people

Sarah Carr, PhD., Associate Professor of Mental Health Research,
Department of Mental Health, Social Work and Integrative Medicine,
Middlesex University London.

Alfonso Pezzella, MSc., Associate Lecturer in Mental Health, Department of Mental Health, Social Work and Integrative Medicine, Middlesex University London.

This paper is based on a presentation originally given at the Mental Health Nursing 'Proud to be Different' Conference, School of Health and Education, Middlesex University London, 12th May 2016.

There are no conflicts of interest that the authors are aware of.

Corresponding author:
Dr. Sarah Carr,
Associate Professor of Mental Health Research,
Department of Mental Health, Social Work and Integrative Medicine,
Middlesex University London,

Hendon Campus,
The Burroughs,
London NW4 4BT
UK
s.carr@mdx.ac.uk

Introduction

Curing ‘homosexuality’ or same-sex attraction has been a recurrent trope in Western psychiatry and mental health services for over a century. Despite the progress made in the United Kingdom (UK) with equality legislation, improvements in general social attitudes and the slowly increasing confidence of lesbian, gay and bisexual (LGB) individuals and communities (Carr, 2005), it appears to pose challenges for practice in the UK even today. This was recently highlighted in 2014 when the Department of Health requested the publication of a consensus statement from major UK mental health professional bodies outlining concern about and opposition to ‘conversion’ or ‘reparative’ therapy being offered to LGB people by practitioners (often working within a religious frame of reference) claiming to be able to ‘cure’ same-sex attraction (UK Council for Psychotherapy, 2014).

Historically, in Western psychiatry the clinical ‘problem’ focus has been same sex attraction, which has often been confused or conflated with gender identity issues because of gender non-conformity in some LGB people (Drescher 2015; Bayer, 1981). The focus of this article is on LGB people and

same-sex attraction. LGB people have greater risk of experiencing certain types of mental distress, self-harm and suicidal thoughts and behaviour as well as at risk of experiencing discrimination within mental health services (Fish, 2009; Carr, 2005).

In this paper we explore some of the research evidence and service user experience in order to map out the evolution of clinical practice and thought regarding the mental health of LGB people; that is, people who are sexually attracted to and have relationships with those of the same sex as them. We argue that there appear to be some emerging new challenges to achieving safe, effective mental health care for LGB people in UK nursing practice. We assert that a type of discrimination in mental health services is appearing that has its origins in certain practitioner religious beliefs where same-sex attraction is interpreted as sinful. This has led to the re-emergence of the idea that LGB people can be cured of their same-sex attraction, but with religious rather than psychiatric conceptual underpinnings, both in the UK and in the US (Drescher, 2015; Morrow & Beckstead, 2004). We argue that this may have particular implications for mental health nursing practice generally and particularly in the UK context, where nurses express religious beliefs that bring them into conflict with the UK Nursing and Midwifery Council (NMC) Code of Conduct (NMC, 2015) and their legal obligation to work within the UK Equality Act 2010 (Legislation.gov.uk, 2010).

The UK evidence base on mental health problem prevalence, risk and 'minority stress' in LGB communities

A robust body of epidemiological evidence now shows that in the UK, LGB people experience poorer mental than the general population. A systematic review conducted in 2009 by public health academics at Birmingham University synthesized data from 2 previous systematic reviews, 11 quantitative studies and 14 qualitative studies and 9 surveys (Meads et al 2009). The study revealed marked figures when comparing rates of several different mental health conditions in LGB people and overall figures for the general population. The table below summarises the relevant comparison ranges from the study data.

[INSERT TABLE 1: Comparison of rates of mental health conditions in LGB population vs. general population (adapted from Meads et al, 2009)]

The researchers also found that LGB people had poorer health behaviours, including addiction and that homophobia, heterosexism, misunderstandings, lack of knowledge, lack of protocols, poor staff confidence and a lack of LGB resources were barriers to all health care, not just mental health care and support.

A later prevalence study looked at data from the 2007 UK Adult Psychiatric Morbidity Survey, which surveyed a representative sample of over 7,400 people. They found that the 'non-heterosexual' population is twice as likely as the general population to have neurotic disorders, depressive episodes, generalized anxiety disorder, obsessive compulsive disorder, phobic disorder,

suicidal thoughts and acts, self-harm and addictions (Chakraborty et al, 2011).

Similarly, recent analysis of 12 UK population surveys found that 'in the UK, LGB adults have higher prevalence of poor mental health and low wellbeing when compared to heterosexuals, particularly younger and older LGB adults' (Semlyen et al, 2016 p.1). Unfortunately, the data sources did not allow the researchers to disaggregate ethnic or gender differences for the LGB sub-sample.

So why is the prevalence of mental health problems higher for LGB people in the UK (and possibly elsewhere)? To begin to understand, it is very helpful to draw on the 'minority stress' theory originating with the psychologist Ilan Meyer, who offered 'a conceptual framework for understanding this excess in prevalence of disorder in terms of minority stress - explaining that stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems' (Meyer, 2003 p.674). Reflecting on Meyer's concept and explanatory framework, in interpreting their research findings, Chakraborty et al (2011) reasoned that:

> 'Perceived and actual discrimination may act as a social stressor in the genesis of mental health problems in this population.' (Chakraborty et al, 2011 p.147).

Again, drawing on Meyer's (2003) theory, they concluded by arguing for a social and clinical understanding of the social impacts of discrimination on

mental health. They cite the following as being potentially damaging sources of social or 'minority' stress that may have long term impacts on the mental health and wellbeing of LGB people:

- 'Experience of prejudice
- Expectations of rejection
- Hiding and concealing
- Internalised homophobia
- Ameliorative coping processes.'

(Adapted from Chakraborty et al, 2011)

Chakraborty et al's (2011) application of Meyer's (2003) minority stress theory as a potential explanation for their findings is supported by evidence from an earlier US prevalence study on LGB people's risk of developing 'stress-sensitive psychiatric disorders' and the role of perceived discrimination in generating that risk (Mays & Cochran, 2001). The authors conclude that 'higher levels of discrimination may underlie recent observations of greater psychiatric morbidity among lesbian, gay and bisexual individuals' (Mays & Cochran, 2001 p. 1869).

[INSERT FIGURE 1: Meyer Minority Stress Process among Lesbian, Gay, and Bisexual Populations (Meyer, 2003, p. 679)]

The evidence suggests that LGB people are at higher risk of experiencing

mental health problems, including suicide attempts, self-harm and addictions, so it is likely that a disproportionately high number of LGB people will use mental health or addictions services at some point. Therefore the next question is, given the historical role of psychiatry and therapy in attempting to 'cure' same-sex attraction, is mental health practice, including nursing, replicating patterns of damaging social and minority stress that have been experienced in the wider world?

Current experiences of LGB people in UK mental health services

Unfortunately, research is suggesting that, despite social and legal progress for LGB civil rights in Britain and the inclusion of sexual orientation as a protected characteristic in the UK Equality Act 2010 (Legislation.gov.uk, 2010), the answer to the question posed above remains 'Yes'. There is consistent evidence from UK research sources from over a number of years to strongly suggest that, as well as experiencing poorer mental health, LGB people in the UK can also experience poorer mental health practice and support.

In 2009, it was reported that 'in [UK] mental health provision lesbians and gay men have reported insensitive and sometimes hostile treatment by professionals despite being proportionally greater users of services' (Fish, 2009 p.47). Ten years ago the UK Government Department of Health recognised that 'the "double jeopardy" associated with being BME [black and minority ethnic] and LGB may increase the likelihood of adverse experiences

in mental healthcare' (Department of Health, 2007 p.4). More recent evidence for poorer experiences of mental health care came from a very large study looking at mental health risk and resilience in LGB (and transgender) populations in England published in 2015. The researchers surveyed 2,078 people and interviewed 58, focusing their questions on risk and resilience in mental health, particularly suicide and self-harm and addictions. They found that bad experiences with mental health nurses and other practitioners could pose a risk to resilience and recovery, particularly for lesbian and bisexual women:

> 'Negative reactions from professionals can limit lesbian and bisexual women's engagement with treatment and support, including causing them to disengage with treatment altogether' (Nodin et al, 2015, p.6).

Similar issues about negative staff attitudes towards LGB people emerged from a 2015 UK survey of over 3,000 people working in health and social care commissioned by the British LGBT rights charity, *Stonewall* (Somerville, 2015). In terms of assessing the health care environment for the 'minority stress' associated with poorer mental health for LGB people, the survey findings suggest that there could be risks for both LGB service users and staff. The survey found that 25% of LGB health and social care staff respondents (including nurses) in London experienced discrimination; 24% of participating patient-facing staff had heard colleagues make negative comments or use derogatory language, with 5% reporting witnessing active discrimination against LGB patients and 26% of LGB staff respondents

reporting discrimination or bullying from colleagues. Over half of the health and social care practitioners surveyed said they do not consider sexual orientation to be relevant to a person's health and social care needs. In qualitative findings, Chris, a nurse working in the North West of England reported in an interview "I was told I should be hanging from a tree by a nurse from Nigeria with strong religious beliefs" (Somerville, 2015 p.10). Finally, of particular relevance to the focus on mental health and sexual orientation in this article, the research found that:

> 'One in ten [respondents]…witnessed staff within their workplace expressing the belief that someone can be "cured" of being lesbian, gay or bisexual' (Somerville, 2015 p.6).

So what are some of the emerging contemporary challenges for promoting empathy, dignity, respect and equality in person-centred mental health nursing practice (RCN, 2010; NICE, 2011) that in turn supports personal mental health recovery and resilience for British LGB people?

From medical to moral; from a sickness to a sin?

The UK evidence base points to LGB people being at higher risk of certain mental health problems and at risk of experiencing discrimination in mental health services (potentially, both LGB patients or services users and LGB nursing and other staff). There is evidence for the argument that even today, psychiatry and mental health nursing practice are affected by the legacy of the

pathologisation and ‘treatment’ of same-sex attraction as a clinical psychiatric problem to be ‘cured’ (Bartlett et al, 2009). Up until the 1970’s treatment in NHS psychiatric hospitals often involved brutal physical interventions such as electric shock or emetic aversion therapies (King et al, 2004; Carr, 2005). Research into the history of psychiatric nursing gives a critical overview of the role of nursing in administering aversion therapy to gay men, many of whom were referred for ‘treatment’ via the criminal justice system when male homosexuality was illegal in England before 1967 (Dickinson, 2015; Bryce, 2016). None of the aversion therapies were evidence based, and there is no proof that they were effective in the long term. However, there is evidence to show that the treatments were damaging, and had lasting negative effects on quality of life, mental wellbeing and relationships (Bartlett et al 2009; Dickinson et al, 2012).

Aversion treatments were offered in the context of mid-twentieth century psychiatric diagnostic practice. In 1952, the first edition of the Diagnostic and Statistical Manual (DSM-1) classified same-sex attraction as a mental illness. After a highly strategic and continuous eight-year campaign by American gay liberation activists and civil rights allies, the American Psychiatric Association (APA) finally declassified homosexuality as a sickness in the 1973 DSM-II-R (Carr, 2017; Bayer, 1981). However, it was only in 1994 that the DSM-IV omitted reference to same-sex attraction as a disorder altogether and it was finally removed as a mental illness per se from the World Health Organisation (WHO) International Classification of Diseases (ICD) in 1990 (Drescher, 2015; World Health Organisation, 1992). Despite this, the pathologisation of same-

sex attraction and gender non-conformity continues in the form of the WHO ICD-10 'F66' disorders relating to sexual orientation and gender identity which still allow for the possibility of pathologisation depending on individual clinician (including their personal or religious beliefs) or dominant social and moral culture or legal frameworks of the particular country. Outlining some of the social, moral and legal issues in their country, the authors of a paper on contemporary LGB rights and psychiatry in India note that 'religious and social orthodoxy and patriarchy complicate the issues in many conservative and tradition-bound countries' (Sathyanarayana Rao et al, 2016 p. 242). An example of how religion functions with psychiatry to address homosexuality outside the Western Christian paradigm can be found in Sabry & Vohra (2013) who explore the role of Islam in the management of 'psychiatric disorders'. They classify homosexuality as a psychiatric disorder and advise that 'in Islam homosexuality is considered "sinful"…Homosexuality degrades a person and the family structure and hence the society' (Sabry & Vohra, 2013 p. 212).

Homosexuality is still illegal in 79 countries, with laws in 10 countries providing for the death penalty (see: ILGA, 2016). The WHO review committee for ICD-11 2017-18 has concluded that:

> 'From a human rights perspective, the F66 categories selectively target individuals with gender non-conformity or a same-sex orientation without apparent justification' (Cochran et al, 2014 p.676).

However any recommendations for changes to the ICD-11 must be ratified by health ministers from the 194 WHO member states, including those where homosexuality is illegal or could be subject to imprisonment or capital punishment. The challenge is exemplified by an event in February 2016, when the Indonesian Psychiatric Association (IPA) classified homosexuality as a mental disorder, a move directly challenged by the APA in a letter to the President of the IPA:

> 'With all due respect to you and to the Indonesian people, we advise that classifying homosexuality and gender expression as intrinsically disordered will only lead to coercive "treatments" and violence against those who pose no harm to society and cannot change who they are' (Binder & Levin, 2016).

As the research shows, the pathologisation of homosexuality and idea that LGB people can be cured of same sex attraction influenced UK mental health and psychiatric practice for a long time, and arguably continues to do so today. In 2009, a UK survey of 1328 practitioners (psychiatrists, psychologists, therapists and counsellors) concluded that

> '…treatments to change sexual orientation do not appear to have become completely a thing of the past. Guidelines on appropriate approaches to clients who are confused or upset about same-sex desires could be useful as a reliance on clinicians' inherent attitudes may still leave the door open to discrimination, which in gays and

lesbians is itself linked with psychological distress' (Bartlett et al 2009, p.1).

Despite the fact that the 'gay cure' concept appears to have shifted in mainstream Western psychiatry, it appears that a new moral and religious dimension could be emerging in mental health practice – that homosexuality is a 'sin' and can be cured in the context of mental health services, particularly with 'reparative' talking therapy. In what could be called a 'post-psychiatric' context for same-sex attracted people in Britain, are we seeing a return to the search for a 'cure' with religious connotations and a return to the association of mental health with moral control (Szasz, 1974)? Reflecting on the shift from the scientific-medical to the religio-moral in US after the depathologisation of homosexuality, Drescher (2015) argues that 'debates about homosexuality gradually shifted away from medicine and psychiatry and into the moral and political realms as religious, governmental, military, media, and educational institutions were deprived of medical or scientific rationalization for discrimination' (Drescher, 2015 p.572). Further, and with specific reference to mental health practice, it has been argued that

> 'despite a long history of viewing homosexuality as pathological and in need of change, the majority of mental health professions have, during the past 30 years, adopted statements that have depathologised lesbian, gay, and bisexual individuals. However, concurrent with these advances has been a rise in religious and therapeutic approaches to sexual reorientation (conversion or "reparative") therapies' (Morrow &

Beckstead, 2004, p.641).

An example from the UK came in 2014 when the Core Issues Trust (CORE), a Christian-based gay cure organisation, lost its legal case to promote the message “Not Gay! Ex-Gay, Post-Gay and Proud. Get over it!” in response to the LGBT rights charity *Stonewall*’s “Some people are gay. Get over it!” bus advertising campaign. The Trust offers clinicians advice on treating clients who experience ‘unwanted’ same-sex attraction, and their position is explicitly religious in nature, with the organisational vision stating that ‘CORE seeks to provide support for relationally and sexually damaged and wounded adults who seek wholeness, and desire to walk in obedience to the Gospel of Christ…and promotes the idea that change is possible’ (CORE, 2014). Similar ‘ex-gay movement’ campaigns are well documented in the US, prompting organisations like the American Psychological Association and associated bodies to publish evidence-based educational primers about sexual orientation (Just The Facts Coalition, 2008).

There is a question to be raised about whether ‘gay cures’ like ‘conversion’ or ‘reparative’ therapy are moving from a clinical towards a religious underpinning; and if so, does this have potential implications for mental health nursing practice in the UK and elsewhere?

Legal frameworks, case law and professional nursing standards: Ensuring equal treatment and inclusion of LGB people in UK mental health services

In the UK context, there is legislation, case law, as well as professional practice standards and codes of conduct and National Health Service (NHS) or organisational policies to prevent discrimination and unequal treatment of LGB people in mental health services. However, it still seems difficult to address situations when the personal moral or religious views of mental health staff compromise professional practice and the ability to provide equal treatment to LGB people. This has been highlighted for medical, nursing, health and social care teaching in a number of English Higher Education Institutions in research where 'the evidence presented suggests that LGBT content teaching is often challenged at various points in its delivery', including challenges with 'balancing curriculum with cultural differences', explicitly religion and belief (Davy et al, 2015 p.1). A respondent to this research reported that:

> 'We've had problems in the past where people are not coming for multiple sessions because of their beliefs, you know (laughs). I don't want to come along to this session because it's not consistent with my beliefs [...] You know and we try and get around that by talking all the time about how in the module we're are not going to change your beliefs, but are just trying to make you recognize that it's ok to hold beliefs, but as a doctor you can't let those beliefs affect your [provision of] care. If you've got issues with gay people then now is the time to find ways of dealing with that' (Susan, Health Studies lecturer, in Davy et al, 2015 p.151).

This theme is also emerging in a forthcoming study by the authors on barriers and facilitators to LGB and Trans* health and social care curriculum inclusion in English Higher Education Institutions, where one nurse educator reported that they 'have become increasingly concerned by aspects of religious fundamentalism that create oppressions…and resistance to engage in consideration of how this applies to professional practice' (Health and social care educator in Carr & Pezzella, forthcoming).

The remarks from the research respondent above highlights the need to enforce the UK Nursing and Midwifery Council (NMC) Code of Conduct (NMC, 2015) to which registered nurses must adhere. To be able to register to practice in the UK, nurses have to follow this Code, which should ensure best practice with LGB people:

- 'Act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment;
- be aware at all times of how your behaviour can affect and influence the behaviour of other people;
- keep to the laws of the country in which you are practising;
- treat people in a way that does not take advantage of their vulnerability or cause them upset or distress;
- stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers' (NMC, 2015 p.17).

The NMC (2015) are very clear that:

> 'UK nurses and midwives must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing and midwifery practice in other roles, such as leadership, education or research. While you can interpret the values and principles set out in the Code in a range of different practice settings, they are *not negotiable or discretionary*' (NMC, 2015 p.1) (italics, the authors').

The UK Equality Act 2010 (Legislation.gov.uk, 2010) includes both sexual orientation and religion and belief as 'protected characteristics' and this has lead to the establishment of case law regarding the provision of public services to LGB people in the implementation of the act. This case law almost exclusively deals with public sector staff who, because of the professed religious beliefs, refused to provide services to lesbian or gay clients. Two of the most prominent are *Ladele v London Borough of Islington* [2009] EWCA Civ. 1357 (see also: *Ladele v London Borough of Islington* [2009] ICR 387) and *McFarlane v Relate Avon Ltd* [2010] EWCA Civ.880. In both cases the claimants refused to carry out their duties to people in same-sex relationships because they claimed it conflicted with their Christian beliefs and were dismissed by their employers for doing so. The court held that both employers had policies to promote equal treatment and were pursuing the legitimate aim of securing that equal treatment for lesbian and gay clients.

The court's decision indicates that employers need to strike a fair balance between religious beliefs and the requirements of the workplace. A legal summary of the workplace implications concluded that:

> 'The court's decision indicates that employers should accommodate an employee's expression of their religious beliefs in the workplace as long as it is reasonable and does not impact on the rights of others' (Norton Rose Fulbright LLP, 2013).

Therefore in the cases of Ladele and McFarlane, the employers were not disciplining an employee for their beliefs, but rather for an inappropriate manifestation of those beliefs in the workplace that resulted in discriminatory behaviour in the course of carrying out their professional duties. Maintaining this balance has been further clarified by the Equality and Human Rights Commission (EHRC) for England and Wales (EHRC, 2016). The Commission recently issued guidance on the legal frameworks and case law regarding religion and belief, following claims that there should be 'reasonable accommodations' (Evans, 2015) made for people who wished to discriminate against others with protected characteristics in the workplace or in the course of their duties on the grounds of their religion or belief. They are very clear that:

> 'Individual employees should not be permitted to opt out of performing part of their contractual work duties due to religion or belief where this would have a potential detrimental or discriminatory impact on others'

(EHRC, 2016 p.7).

In terms of legal frameworks, case law and professional standards, it is becoming increasingly clear that, in a mental health context, a mental health nurse registered to practice in the UK must not manifest their religion and belief in a way that discriminates against or has a negative impact on LGB service users or patients. Nor can they use the protected characteristic of religion and belief to 'opt out' of working with LGB people. This legal point is underpinned for nursing by the UK NMC Code of Conduct being 'non-negotiable' (NMC, 2015).

LGB mental health nursing care in the UK: a composite, fictional 'worst case' scenario?

Despite the research, legislation, case law and codes of professional conduct discussed here, there are still qualified, accredited and registered nurses working in the UK may pose a risk to LGB people using mental health services. To consolidate the main issues, a fictional, composite practice scenario is given below. While the scenario is extreme and unlikely to happen in a single incident, it is based on the teaching experiences of the authors and their colleagues, research and third party practitioner or service user accounts shared with them.

A woman who is experiencing a mental health crisis, is assessed for possible admission to hospital under the Mental Health Act 1983. Her primary carer and nearest relative is her legal female spouse, as they were married in

accordance with the Marriage (Same Sex Couples) Act 2013. The 'nearest relative' is a legal entity recognised in s.26 of the Mental Health Act 1983, and a person's spouse is the first individual on the list of recognised nearest relatives in the Act. The sexual orientation of the woman and her female spouse is protected under the Equality Act 2010 and therefore they must be treated equally. They are seen by a registered mental health nurse who must adhere to the NMC Code of Conduct which should ensure the woman and her female spouse are treated with equality, dignity and respect in the context of person centred practice, as also determined by NICE guidelines (NICE, 2011). The nurse trained and qualified at a UK university.

The nurse tells them that, despite what it says in the Mental Health Act 1983, she cannot recognise the woman's legal female spouse as her nearest relative, as her faith prohibits same-sex marriage. When challenged by the woman's spouse, the nurse tells them that 'people are not born homosexual or lesbian, it's their CHOICE. The word of God, the Holy Bible states clearly this is SIN! So does the Jewish Torah and the Islamic Qur'an'[1]. The nurse then asserts that her culture and beliefs are protected by law, which means she is exempt from working with people who she regards as offensive and sinful. She says she is therefore entitled to pass the woman and her female spouse onto another colleague whose faith does not prevent them from working with a same-sex couple.

In her assessment of the woman's mental health, the nurse then suggests that her distress is because of her sinful sexual orientation and that she

[1] Direct practitioner quote from Somerville, 2015.

should seek the help of a religious therapist who can cure her and make her become heterosexual. The nurse offers her the details of a counsellor from her church and says she will pray that the woman be delivered from her sin.

Conclusion

So, how can we prevent even elements of this extreme fictional scenario from happening in mental health nursing practice, or address overt or subtle instances of staff discrimination against LGB people using mental health services, justified by religion or belief? This paper has set out the specific legal framework and professional codes of conduct for UK, but there will be similar equality and diversity policy and legislation established for mental health practice in most Western countries with developed equality policies and healthcare systems.

In general, it is important to remember that LGB people have a higher risk of experiencing mental health problems but also have a higher risk of experiencing discrimination in mainstream mental health services: 'these elevated levels of psychiatric problems in non-heterosexual people are very worrying and call not only for a response by professionals in primary care and mental health services but also efforts at prevention' (Chakraborty et al, 2011). The culture of discrimination outlined in this paper is partly due to the historical legacy of the pathologisation and treatment same-sex attraction in psychiatric practice. Although same sex attraction is no longer classified as a mental disorder per se, this does not prevent therapists from offering 'conversion therapy' or mental health practitioners with particular religious beliefs from discriminating against LGB people. The consensus statement on

conversion therapy commissioned by the UK Department of Health provides a clear and internationally transferable message that it is unethical and wrong to offer ‘a treatment for which there is no illness’ (UK Council for Psychotherapy, 2014).

In the UK there are clear legal frameworks, case law and professional nursing standards and codes of conduct that must be enforced to ensure the equal treatment of LGB people in mental health services. The NMC Code (2015) and the Equality Act 2010 (Legislation.gov.uk, 2010) already provide positive protection for LGB people, but those responsible for education, professional conduct and care quality must have the courage and commitment to enforce it. All responsible parties in nursing student recruitment, education and training; professional and registration bodies (like the UK NMC and the Royal College of Nursing [RCN]), representative organisations such as trades unions, as well as the NHS and other mental health provider organisations must be confident to use the available legal frameworks and professional codes to challenge discriminatory behaviour against LGB people by mental health nurses and other staff where ever it occurs – in the classroom, ward or community – even if this is justified by reference to religion or belief. LGB awareness is important for health and nursing education and requires investment in time, imaginative teaching methods and resources, as well as opportunities to practice what is learned supervision.

Compassion, courage and cultural competence are at the heart of nursing and mental health nurse practice must reflect this for all patients and service

users, even where there is conflict with practitioner personal religious beliefs (Papadopoulos et al, 2016). The conclusion of the study of nurses who had administered aversion therapy for same-sex attraction in the UK NHS remains highly relevant for mental health nurses everywhere:

> 'Nurses need to ensure that their interventions have a sound evidence base and that they constantly reflect on the moral and value base of their practice and the influence that science and societal norms can have on changing views of what is considered "acceptable practice"' (Dickinson et al, 2012 p.1345).

References

Just The Facts Coalition (2008) *Just the Facts about Sexual Orientation and Youth: A Primer for Principals, Educators and School Personnel* Washington DC: American Psychological Association

Bartlett, A., Smith, G., King, M. (2009) The response of mental health professionals to clients seeking help to change or redirect same-sex sexual orientation *BMC Psychiatry 9* (11) doi: 10.1186/1471-244X-9-11.

Bayer, R. (1981) *Homosexuality and American Psychiatry: The Politics of Diagnosis* Princeton, NJ: Princeton University Press

570 Binder, R. & Levin, S. (2016) *Letter to Dr. Tun Kurniasih Bastaman*
571 *Indonesian Psychiatric Association*, March 8th 2016 Arlington: APA
572
573 Bryce, C. (2016) Tommy Dickinson, 'Curing Queers': Mental Nurses and their
574 Patients, 1935-74. *The British Society for Literature and Science* Available at:
575 http://www.bsls.ac.uk/reviews/modern-and-contemporary/tommy-dickinson-
576 curing-queers-mental-nurses-and-their-patients-1935-74/ (Accessed:
577 29/12/2016)
578
579 Carr, S. & Pezzella, A. (forthcoming) Lesbian, gay, bisexual and trans* (LGB
580 and T) Health and Social Care Curriculum Inclusion in England: Survey
581 Findings.
582
583 Carr S (2005) 'The sickness label infected everything we said': lesbian and
584 gay perspectives on mental distress in Tew J (ed.) *Social perspectives in*
585 *mental health* London: Jessica Kingsley pp168-183
586
587 Carr, S. (2017) Homosexuality, psychiatry and 'diagnostic politics':
588 Madness and gay liberation *Asylum: An International Magazine for*
589 *Democratic Psychiatry* (in press)
590
591 Chakraborty, A., McManus, S., Brugha, T.S., Bebbington, P., King, M. (2011)
592 Mental health of the non-heterosexual population of England *The British*
593 *Journal of Psychiatry 198* (2) pp.143-148 doi: 10.1192/bjp.bp.110.082271
594

595 Cochran, S.D., Drescher, J., Kismodi, E. et al (2014) Proposed declassication
596 of disease categories related to sexual orientation in the International
597 Statistical Classication of Diseases and Related Health Problems (ICD-11)
598 *Bulletin of the World Health Organisation 92* pp.672–679 doi:
599 http://dx.doi.org/10.2471/BLT.14.135541
600
601 CORE (2014) Vision and Ethics, *Core Issues Trust*. Available at:
602 http://www.core-issues.org/vision-and-ethics (Accessed: 29/12/2016)
603
604 Davy, Z., Amsler, S., & Duncombe, K. (2015). Facilitating LGBT Medical,
605 Health and Social Care Content in Higher Education Teaching *Qualitative*
606 *Research in Education, 4* (2) pp.134-163. doi:10.17583/qre.2015.1210
607
608 Department of Health (2007) *Briefing 12: Lesbian, gay and bisexual (LGB)*
609 *people from Black and minority ethnic communities*. London: Department of
610 Health.
611
612 Dickinson, T., Cook, M., Playle, J. & Hallett, C. (2012) 'Queer' treatments:
613 giving a voice to former patients who received treatments for their 'sexual
614 deviations' *Journal of Clinical Nursing, 21* (9-10) pp.1345-1354.
615
616 Dickinson, T. (2015) *Curing Queers': Mental Nurses and their Patients, 1935-*
617 *74* Manchester: Manchester University Press
618

Drescher, J (2015) Out of DSM: Depathologising Homosexuality *Behavioural Sciences 5* pp.565-575.

EHRC (2016) *Religion or belief: Is the law working?* London: EHRC

Evans, S. (2015) The unreasonableness of 'reasonable accommodation' *National Secular Society Blogs & Opinion* Friday 16th October 2015. Available at: http://www.secularism.org.uk/blog/2015/10/the-unreasonableness-of-reasonable-accommodation (Accessed: 29/12/2016)

Fish J (2009) Invisible no more? Including lesbian, gay and bisexual people in social work and social care, *Practice 21* (1) pp. 47-64

ILGA (2016) Sexual orientation laws in the world – Overview, June 2016. *International lesbian, gay, bisexual, trans and intersex association*. [online] Available at: http://ilga.org/downloads/03_ILGA_WorldMap_ENGLISH_Overview_May2016.pdf [Accessed: 29/12/2016]

King M, Smith G & Bartlett (2004) Treatments of Homosexuality in Britain since the 1950s – an oral history: the experience of professionals *British Medical Journal 328* (7437) 429.

Legislation.gov.uk. (2010). *Equality Act 2010*. [online] Available at: http://www.legislation.gov.uk/ukpga/2010/15/contents [Accessed: 24/04/2017].

Legislation.gov.uk (2013) Marriage (Same Sex Couples) Act 2013 [online] Available at: http://www.legislation.gov.uk/ukpga/2013/30/contents/enacted/data.htm [Accessed: 24/04/2017]

Mays, V & Cochran, S (2001) Mental health correlates of perceived discrimination among lesbian, gay and bisexual adults in the United States *American Journal of Public Health 91* (11) pp.1869-1876.

Meads C, Pennant M, McManus J & Bayliss S (2009) *A Systematic Review of UK Research on Lesbian, Gay, Bisexual and Transgender Health.* Birmingham: Unit of Public Health, Epidemiology & Biostatistics, West Midlands Health Technology Assessment Group. Available at: http://www.wmhtac.bham.ac.uk/postersx/LGBTHealth.pdf (Accessed: 29/12/2016)

Meyer, I. (2003) Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence *Psychological Bulletin 129* (5) pp.674–697.

Morrow, S. & Beckstead, A. (2004) Conversion Therapies for Same-Sex Attracted Clients in Religious Conflict: Context, Predisposing Factors, Experiences, and Implications for Therapy *The Counseling Psychologist 32* (5) pp.641-650 doi: 10.1177/0011000004268877

NICE (2011) *Clinical guideline 136: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services* London: NICE

NMC (2015) *The Code: Professional standards of practice and behaviour for nurses and midwives* London: NMC

Nodin, N., Peel, E., Tyler, A. & Rivers, R. (2015) *The RaRE Research Report: LGB&T mental health – risk and resilience explored* London: PACE

Norton Rose Fulbright LLP (2013) Religious beliefs and equality in the workplace *Norton Rose Fulbright*. Available at: http://www.nortonrosefulbright.com/knowledge/publications/74286/religious-beliefs-and-equality-in-the-workplace (Accessed: 29/12/2016)

Papadopoulos, I., Shea, S., Taylor, G., Pezzella, A. & Foley, L. (2016) Developing tools to promote culturally competent compassion, courage, and intercultural communication in healthcare *Journal of Compassionate Health Care* 63 (2) DOI: 10.1186/s40639-016-0019-6

RCN (2010) Principles of nursing practice *Royal College of Nursing*. Available at: https://www.rcn.org.uk/professional-development/principles-of-nursing-practice (Accessed: 29/12/2016)

694 Sabry, M & Vohra, A (2013) Role of Islam in the management of psychiatric
695 disorders *Indian Journal of Psychiatry 55 (Suppl.2)* pp. S205-S214.
696
697 Sathyanarayana Rao, T., Prasad Rao, G., Raju, M., Saha, G. & Jacod, K.
698 (2016) Gay rights, psychiatric fraternity and India *Indian Journal of Psychiatry*
699 *58 (3)* pp.241-243.
700
701 Semlyen, J., King, M., Varney, J. & Hagger-Johnson, G. (2016) Sexual
702 orientation and symptoms of common mental disorder or low wellbeing:
703 combined meta-analysis of 12 UK population health surveys *BMC Psychiatry*
704 *16* (67) doi: 10.1186/s12888-016-0767-z
705
706 Somerville, C. (2015) *Unhealthy Attitudes*: *The treatment of LGBT people*
707 *within health and social care services* London: Stonewall
708
709 Szasz, T. (1974) *The Second Sin* New York: Doubleday
710
711 UK Council for Psychotherapy (2014) *Conversion therapy consensus*
712 *statement* London: UK Council for Psychotherapy
713
714 World Health Organization (1992) *The ICD-10 classification of mental and*
715 *behavioural disorders: Clinical descriptions and diagnostic guidelines* Geneva:
716 World Health Organization.
717
718 **Funding**

This paper received no funding, but is based on scoping work for a Middlesex University London Small Grants supported survey of LGB and T curriculum inclusion in health and social care HEI in England.