

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

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

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

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

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32 **Introduction**

33

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

46

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

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

55

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

73

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

76

77 A robust body of epidemiological evidence now shows that in the UK, LGB
78 people experience poorer mental than the general population. A systematic
79 review conducted in 2009 by public health academics at Birmingham
80 University synthesized data from 2 previous systematic reviews, 11
81 quantitative studies and 14 qualitative studies and 9 surveys (Meads et al
82 2009). The study revealed marked figures when comparing rates of several
83 different mental health conditions in LGB people and overall figures for the
84 general population. The table below summarises the relevant comparison
85 ranges from the study data.

86

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

89

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

95

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

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

102

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

109

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

119

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

123

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

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

129

- 130 • 'Experience of prejudice
- 131 • Expectations of rejection
- 132 • Hiding and concealing
- 133 • Internalised homophobia
- 134 • Ameliorative coping processes.'

135

136 (Adapted from Chakraborty et al, 2011)

137

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

146

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

149

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

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

158

159 **Current experiences of LGB people in UK mental health services**

160

161 Unfortunately, research is suggesting that, despite social and legal progress
162 for LGB civil rights in Britain and the inclusion of sexual orientation as a
163 protected characteristic in the UK Equality Act 2010 (Legislation.gov.uk,
164 2010), the answer to the question posed above remains 'Yes'. There is
165 consistent evidence from UK research sources from over a number of years
166 to strongly suggest that, as well as experiencing poorer mental health, LGB
167 people in the UK can also experience poorer mental health practice and
168 support.

169

170 In 2009, it was reported that 'in [UK] mental health provision lesbians and gay
171 men have reported insensitive and sometimes hostile treatment by
172 professionals despite being proportionally greater users of services' (Fish,
173 2009 p.47). Ten years ago the UK Government Department of Health
174 recognised that 'the "double jeopardy" associated with being BME [black and
175 minority ethnic] and LGB may increase the likelihood of adverse experiences

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

185
186 'Negative reactions from professionals can limit lesbian and bisexual
187 women's engagement with treatment and support, including causing
188 them to disengage with treatment altogether' (Nodin et al, 2015, p.6).

189
190 Similar issues about negative staff attitudes towards LGB people emerged
191 from a 2015 UK survey of over 3,000 people working in health and social care
192 commissioned by the British LGBT rights charity, *Stonewall* (Somerville,
193 2015). In terms of assessing the health care environment for the 'minority
194 stress' associated with poorer mental health for LGB people, the survey
195 findings suggest that there could be risks for both LGB service users and
196 staff. The survey found that 25% of LGB health and social care staff
197 respondents (including nurses) in London experienced discrimination; 24% of
198 participating patient-facing staff had heard colleagues make negative
199 comments or use derogatory language, with 5% reporting witnessing active
200 discrimination against LGB patients and 26% of LGB staff respondents

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

209

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

213

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

218

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

220

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

226 pathologisation and 'treatment' of same-sex attraction as a clinical psychiatric
227 problem to be 'cured' (Bartlett et al, 2009). Up until the 1970's treatment in
228 NHS psychiatric hospitals often involved brutal physical interventions such as
229 electric shock or emetic aversion therapies (King et al, 2004; Carr, 2005).
230 Research into the history of psychiatric nursing gives a critical overview of the
231 role of nursing in administering aversion therapy to gay men, many of whom
232 were referred for 'treatment' via the criminal justice system when male
233 homosexuality was illegal in England before 1967 (Dickinson, 2015; Bryce,
234 2016). None of the aversion therapies were evidence based, and there is no
235 proof that they were effective in the long term. However, there is evidence to
236 show that the treatments were damaging, and had lasting negative effects on
237 quality of life, mental wellbeing and relationships (Bartlett et al 2009;
238 Dickinson et al, 2012).

239
240 Aversion treatments were offered in the context of mid-twentieth century
241 psychiatric diagnostic practice. In 1952, the first edition of the Diagnostic and
242 Statistical Manual (DSM-1) classified same-sex attraction as a mental illness.
243 After a highly strategic and continuous eight-year campaign by American gay
244 liberation activists and civil rights allies, the American Psychiatric Association
245 (APA) finally declassified homosexuality as a sickness in the 1973 DSM-II-R
246 (Carr, 2017; Bayer, 1981). However, it was only in 1994 that the DSM-IV
247 omitted reference to same-sex attraction as a disorder altogether and it was
248 finally removed as a mental illness per se from the World Health Organisation
249 (WHO) International Classification of Diseases (ICD) in 1990 (Drescher, 2015;
250 World Health Organisation, 1992). Despite this, the pathologisation of same-

251 sex attraction and gender non-conformity continues in the form of the WHO
252 ICD-10 'F66' disorders relating to sexual orientation and gender identity which
253 still allow for the possibility of pathologisation depending on individual clinician
254 (including their personal or religious beliefs) or dominant social and moral
255 culture or legal frameworks of the particular country. Outlining some of the
256 social, moral and legal issues in their country, the authors of a paper on
257 contemporary LGB rights and psychiatry in India note that 'religious and social
258 orthodoxy and patriarchy complicate the issues in many conservative and
259 tradition-bound countries' (Sathyanarayana Rao et al, 2016 p. 242). An
260 example of how religion functions with psychiatry to address homosexuality
261 outside the Western Christian paradigm can be found in Sabry & Vohra
262 (2013) who explore the role of Islam in the management of 'psychiatric
263 disorders'. They classify homosexuality as a psychiatric disorder and advise
264 that 'in Islam homosexuality is considered "sinful"...Homosexuality degrades a
265 person and the family structure and hence the society' (Sabry & Vohra, 2013
266 p. 212).

267

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

271

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

275

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

283

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

289

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

295

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

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

303

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

319

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

326 Beckstead, 2004, p.641).

327

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

342

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

347

348 **Legal frameworks, case law and professional nursing standards:**

349 **Ensuring equal treatment and inclusion of LGB people in UK mental**

350 **health services**

351

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

365

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

376

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

384

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

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

400 The NMC (2015) are very clear that:

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

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

422

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

426

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

431

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

444

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

448 (EHRC, 2016 p.7).

449

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

458

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

461

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

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

473 *accordance with the Marriage (Same Sex Couples) Act 2013. The ‘nearest*
474 *relative’ is a legal entity recognised in s.26 of the Mental Health Act 1983, and*
475 *a person’s spouse is the first individual on the list of recognised nearest*
476 *relatives in the Act. The sexual orientation of the woman and her female*
477 *spouse is protected under the Equality Act 2010 and therefore they must be*
478 *treated equally. They are seen by a registered mental health nurse who must*
479 *adhere to the NMC Code of Conduct which should ensure the woman and her*
480 *female spouse are treated with equality, dignity and respect in the context of*
481 *person centred practice, as also determined by NICE guidelines (NICE,*
482 *2011). The nurse trained and qualified at a UK university.*

483 *The nurse tells them that, despite what it says in the Mental Health Act 1983,*
484 *she cannot recognise the woman’s legal female spouse as her nearest*
485 *relative, as her faith prohibits same-sex marriage. When challenged by the*
486 *woman’s spouse, the nurse tells them that ‘people are not born homosexual*
487 *or lesbian, it’s their CHOICE. The word of God, the Holy Bible states clearly*
488 *this is SIN! So does the Jewish Torah and the Islamic Qur’an¹. The nurse*
489 *then asserts that her culture and beliefs are protected by law, which means*
490 *she is exempt from working with people who she regards as offensive and*
491 *sinful. She says she is therefore entitled to pass the woman and her female*
492 *spouse onto another colleague whose faith does not prevent them from*
493 *working with a same-sex couple.*

494

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

¹ Direct practitioner quote from Somerville, 2015.

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

500 **Conclusion**

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

509 In general, it is important to remember that LGB people have a higher risk of
510 experiencing mental health problems but also have a higher risk of
511 experiencing discrimination in mainstream mental health services: ‘these
512 elevated levels of psychiatric problems in non-heterosexual people are very
513 worrying and call not only for a response by professionals in primary care and
514 mental health services but also efforts at prevention’ (Chakraborty et al,
515 2011). The culture of discrimination outlined in this paper is partly due to the
516 historical legacy of the pathologisation and treatment same-sex attraction in
517 psychiatric practice. Although same sex attraction is no longer classified as a
518 mental disorder per se, this does not prevent therapists from offering
519 ‘conversion therapy’ or mental health practitioners with particular religious
520 beliefs from discriminating against LGB people. The consensus statement on

521 conversion therapy commissioned by the UK Department of Health provides a
522 clear and internationally transferable message that it is unethical and wrong to
523 offer 'a treatment for which there is no illness' (UK Council for Psychotherapy,
524 2014).

525

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

543

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

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

550

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

556

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717
718 **Funding**

719

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

723

724

Final Version Accepted for Publication