

The Role of Integrated Healthcare Services in Meeting Somatic and Mental Health Needs of LGBTQ Individuals

Allen Thomas, University of Central Arkansas
and
Alexandros Maragakis, Eastern Michigan University

Abstract

The purpose of the present paper is to address significant health issues facing LGBTQ clients and the role of integrated care in minimizing these issues. LGBTQ individuals face significant health disparities compared to cisgender and heterosexual individuals, which are compounded by the reality that these individuals have reduced access to care or may be apprehensive about potentially biased clinicians. Integrated systems may be an arena within which these disparities can be minimized. Modification of these systems to better address the needs of LGBTQ clients may occur on varying levels. This paper also provides recommendations for modifying current integrated systems.

Keywords: integrated care, LGBTQ, health, sexual orientation, gender nonconforming

The Role of Integrated Healthcare Services in Meeting Somatic and Mental Health Needs of LGBTQ Individuals

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals face significant stressors and health disparities compared to their cisgender and heterosexual peers according to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014). These risks and disparities occur at rates many times that of the general population (Haas, Rodgers, & Herman, 2014). Bisexual and transgender individuals in particular report rates of distress even beyond that of gay men and lesbians (Jorm, Kurten, Rodgers, Jacomb, & Christensen, 2002; Silva, Chu, Monahan, & Joiner, 2015; Wadsworth & Hayes-Skelton, 2015). Acknowledging these disparities for LGBTQ people becomes important for enhancing their care and minimizing barriers to health.

A wealth of research currently exists regarding health risks and disparities experienced by LGBTQ people. Individuals within this population face increased rates of psychological distress. LGBTQ people are also more likely to report past suicide attempts or ideation (King et al., 2008; McKay, 2011; Smalley, Warren, & Barefoot, 2011). These risks and disparities compound to create a paradigm in which there are significant barriers to health and well-being for some LGBTQ people.

In comparison to heterosexual individuals, LGBTQ people report higher incidences of psychological distress, which includes anxiety and depression. Previous researchers have stated that there are higher rates of anxiety (Silva et al., 2015). Gay men in particular have been cited as experiencing higher rates of anxiety compared to heterosexual individuals. Silva et al. (2015) have pointed to higher rates of depression occurring in lesbians and gay men who are college aged.

In addition to higher incidences of psychological distress, suicidal thoughts and attempts have received much attention with regards to LGBTQ individuals. Across age groups, LGB individuals report more suicide attempts than their heterosexual peers. Previous research has cited that LGBTQ youth attempt suicide at rates 2-3.5 times the number of attempts for their heterosexual peers (Eisenberg & Resnick, 2006; SAMHSA, 2014). Previous research has highlighted an increased risk of suicide for non-heterosexual men compared to their heterosexual male peers and women regardless of sexual orientation (Bagley & Tremblay, 2000; King et al., 2008; Mathy, Cochran, Olsen, & Mays, 2011; Moreira, Halkitis, & Kapadia, 2015; Sandfort, de Graaf, Bijl, & Schnabel, 2001), while others have conversely indicated an increased risk for non-heterosexual women compared to heterosexual women and men of varying orientations (van Heeringen & Vincke, 2000; Wichstrom & Hegna, 2003). Stone and colleagues (2014) found evidence supporting higher rates for lesbian women, indicating that they were more likely to have attempted suicide compared to bisexual and heterosexual women. In addition to suicide attempts, LGBTQ people report higher rates of self-injurious behavior (SIB; King et al., 2008; McKay, 2011; Smalley et al., 2016).

Much of the extant research has focused on health disparities between heterosexuals and lesbians and gay men. However, there is a growing body of research which addresses concerns regarding health for bisexual and transgender people. For example, individuals who are bisexual, transgender or gender diverse may experience significant distress at higher rates compared to lesbians and gay men (Jorm et al., 2002; Silva et al., 2015; Tompkins et al., 2015).

Previous research has highlighted significant psychological health concerns for bisexual people. Bisexual individuals have been cited as experiencing higher rates of sexual assault (Ray-Sannerud, Bryan, Perry, & Bryan, 2015), depression and self-injurious behavior (Blosnich & Bossarte, 2012; Silva et al., 2015), and anxiety (Jorm et al., 2002; Wadsworth & Hayes-Skelton, 2015) compared to gay men, lesbians, and heterosexual people. Research by Stone and colleagues (2014) has indicated that bisexual men were more likely to have attempted suicide compared to gay and heterosexual men.

Similar to bisexual people, gender diverse people experience increased rates of pathology compared to the general population (Budge, Adelson, & Howard, 2013) but also cisgender sexual minorities. Transgender people are 25 times more likely than heterosexuals and 10 times more likely than gay men and lesbians to experience suicidal thoughts (SAMHSA, 2014). According to Haas et al. (2014), gender diverse individuals report past suicide attempts at 9-10 times the rate of heterosexual people.

Health risk behaviors occur at higher rates for LGBTQ people than their heterosexual and cisgender peers. These behaviors include substance use and sexual risk-taking. Previous research has cited increased rates of substance use, including smoking tobacco and drinking alcohol, in LGBTQ individuals compared to their cisgender and heterosexual counterparts (Halkitis et al., 2013; Moreira et al., 2015). In research conducted by Cochran and Cauce (2006), LGBTQ people entering substance abuse treatment indicated higher frequency of substance use compared to their heterosexual peers in treatment. Sexual health risk behaviors occur at higher rates within the LGBTQ population, including unprotected sex (Dutton, Koenig, & Fennie, 2008; Kenagy, 2005; Mayer et al., 2008; Newcomb & Mustanski, 2010). Men in particular have been reported to be more likely to engage in unprotected sex (Moreira et al., 2015).

Discrimination is one of the major obstacles to health and well-being for LGBTQ people (SAMHSA, 2014). Many health risks are tied to unaffirming or violent environments. For example, individuals who live in states that do not have protective policies regarding discrimination are at least five times more likely to be diagnosed with two or more mental illnesses compared to individuals in states with protective policies (SAMHSA, 2014). According to Moreira and colleagues (2015) suicidal ideation and attempts rise in geographic areas where people commit homophobic hate crimes. This relationship may also occur regarding individuals who are transgender or gender variant. Haas et al. (2014) posit that experiencing discrimination may contribute to the significant disparities in distress for LGBTQ people compared to their cisgender and heterosexual peers.

Intragroup discrimination may have a negative relationship to well-being for bisexual and transgender people within the LGBTQ population. Bisexual people can experience biphobia within the LGBTQ community but also from heterosexuals. Silva et al. (2015) stated that distress in bisexual people could partially come from experiences of discrimination from a dominant society and the LGBTQ community. Similar to bisexual people, transgender and gender diverse individuals face stressors from society and the LGBTQ community. These individuals face higher rates of discrimination in domains such as employment, housing, and education compared to cisgender people (Haas et al., 2014).

With regards to physical health, further gaps exist for this population compared to their cisgender heterosexual peers. LGBTQ individuals are more likely to face barriers in receiving treatment and less likely to have health insurance, factors which impede on their access to adequate care (Mayer et al., 2008; SAMHSA, 2014). Individuals within this population are also more likely to delay or not seek medical care, while being more likely to have emergency room visits (SAMHSA, 2014).

While many of the aforementioned risks and barriers are social and psychological in nature, they have significant bearing on physical health. Lack of resources reduces the capacity for LGBTQ to meet significant needs as simple as food and shelter.

Particularly for individuals who face the most risk (i.e. bisexual and transgender people, LGBTQ people with intersecting marginalized identities), these issues may have a severe impact on physical health.

Not only do LGBTQ individuals experience increased rates of distress and suicidal ideation, but these rates increase for individuals who are bisexual or transgender. Because of these significant health risks, it is important for behavioral health clinicians to find new ways to better meet LGBTQ clients' needs. As it stands, these disparities between LGBTQ people and their cisgender and heterosexual counterparts do not seem to be diminishing. Therefore, efforts need to increase to address health risks and disparities for LGBTQ people. This process can potentially be done through the use of integrated care practices that link primary care and behavioral health providers in one setting, making access to much needed somatic and psychological care more accessible for this population. As these integrated care practices are now becoming a focal point of training in behavioral health programs, it is vital that issues of care for LGBTQ people are discussed and the potential benefits of integrated care for this population are explicated.

Integrated Care

Overview

Integrated care (IC) systems, which involve embedding behavioral health providers (BHPs) in the primary care setting, have received much attention over recent years as a method to improve quality of care and reduce staggering healthcare costs (Robinson & Reiter, 2015). Given that 60-70% of primary care visits are complicated by behavioral health issues (Cummings, O'Donohue, & Cummings, 2011), and primary care providers (PCPs) typically spend two to three times the typical fifteen minutes allotted when a patient presents with behavioral health issue (Cummings, 2003), the colocation of BHPs presents an opportunity for patients to receive care from a behavioral health specialists while allowing PCPs to optimize their time and remain productive.

Beyond the cost saving benefits to the healthcare system, IC systems impact both quality of care and patient and provider satisfaction (Robinson & Reiter, 2015). Patient health outcomes are superior when seen in an IC setting in comparison to those in traditional settings. Patients also tend to report higher levels of satisfaction with their experience, particularly due to the fact that providers worked together and created joint care plans (Katon, et al., 1995). Providers report higher levels of satisfaction and higher amounts of productivity (Katon, et al., 1996). These improvements in health outcomes and satisfaction for both patients and providers have led to proliferation of IC systems.

While many may benefit from traditional IC systems, which are based in primary care settings, there are various populations that may not experience these benefits. For example, it has been proposed that PCPs be embedded in mental health settings that focus on providing care for those with serious mental illness (SMI), given that those with

SMI tend to have difficulties in the primary care setting (Maragakis, Siddharthan, RachBeisel, & Snipes, 2015). These “reverse” IC systems take advantage of the holistic approach to health provided in traditional IC systems, and moves them in to the setting which a patient is most likely to show up and benefit from the new system.

The LGBTQ community is unique in that it is not entirely clear if a traditional IC system would be beneficial, given that LGBTQ people are less likely to access or utilize primary care (SAMHSA, 2014). However, unlike those with SMI, there are not mental health clinics that specialize primarily in the treatment of LGBTQ people. Therefore, both traditional and reverse IC systems may have strengths and limitations in improving the health disparities that LGBTQ people face.

Traditional Integrated Care Systems

Traditional IC systems involve BHPs being collocated in the primary care setting. In these IC systems, PCPs or support staff screen for a wide range of behavioral health concerns (e.g., depression, anxiety, substance abuse). If, during treatment, a behavioral health concern is ascertained, a “warm hand-off” occurs. This process entails a PCP bringing in a BHP to consult with the patient while they are still in the clinic. These warm hand-offs allow for patients to receive immediate treatment for their behavioral health concerns, and eliminate the possibility of patients not following through with a behavioral health referral.

After the initial appointment with the BHP, both the BHP and PCP create a joint treatment plan designed to address both the somatic and behavioral concerns of the patient. Typically, behavioral interventions delivered in the traditional IC setting mimic the fast pace of the primary care setting, and are brief in both time and number of sessions (i.e. 15-20 minutes, for 2-4 sessions). If a patient requires more than 2-4 sessions for a behavioral health concern, then a referral is made to an outside provider who specializes in treatment for the concern (e.g., exposure for PTSD), and “bridging” services are provided by the IC BHP until the referral to the outside provider goes through.

Strengths. Traditional IC systems take advantage of the high volume of primary care settings, and allow for patients with behavioral health concerns quick and immediate access to BHPs. Also, this model can take advantage of the numerous health clinics that are specifically tailored for LGBTQ people, and supplement the services already being provided. Given the high prevalence of behavioral health concerns within the LGBTQ community, this would allow for individuals seeing their PCPs to access immediate behavioral health services. Furthermore, given the emphasis on multicultural and diversity training in behavioral health, BHPs may be better equipped than their PCP counter-parts at tailoring treatments to meet the unique needs of LGBTQ people. The use of IC may be particularly useful at reducing perceived stigma of LGBTQ people in the primary care setting.

Limitations. The major limitations with a traditional IC system is that LGBTQ people are less likely to access primary care and use emergency care services

(SAMHSA, 2014). Therefore, like those with SMI, LGBTQ people may not experience any of the improved services offered in an IC system simply by not accessing healthcare in the appropriate location. This reduced likelihood of attaining primary care could be due to a number of potential factors. First, LGBTQ individuals have less access to insurance due to financial and occupational issues, both of which can be created by discrimination. Second, LGBTQ individuals may hold a mistrust of medical personnel, similar to some people of color, due to a history of mistreatment and stigma from primary care personnel.

Another limitation to a traditional IC model is the brevity of behavioral health treatments. Many of the mental health issues experienced by LGBTQ people may require more intense interventions than what is allotted in the 15-20 minute sessions provided in IC settings (e.g., exposure for PTSD). Therefore, even though there may be some improvement in services with access to an IC system, many LGBTQ people may still require referral to outside mental health providers.

Reverse Integrated Care Systems

Reverse integrated care (RIC) systems involve PCPs being collocated in the mental health clinic. In these RIC systems, behavioral health clinicians screen for a range of somatic concerns and risks. If an individual is considered at risk, or has not seen a somatic provider recently, then a warm hand-off with the PCP is initiated. This allows for immediate access to a PCP, while being seen in the context of the mental health clinic.

Similar to the traditional IC system, a joint treatment plan is created by the BHP and the PCP to address both somatic and behavioral concerns. However, unlike the traditional IC model, the BHP is considered to be the “quarterback” of the patient’s care while being seen in a RIC system, given that the patient’s concerns are primarily behavioral.

Strengths. The primary strength of the RIC model for LGBTQ people is that it provides both somatic and behavioral health treatment in the setting which they are most likely to seek access, i.e., the mental health clinic. Also, by being seen in a mental health clinic, individuals experiencing more serious or persistent mental health concerns may have those concerns addressed within the mental health setting without having to be referred after a few sessions. This may allow for more continuity of care, without the need to refer out, particularly if an individual’s primary concerns are behavioral.

With the BHP as the focal point of transitioning care to a PCP, LGBTQ people may be more likely to trust the PCP and comply with care. The nature of behavioral health often implies longstanding therapeutic relationships partially based on trust compared to PCP visits. Thus, a warm hand-off between the BHP and PCP may reduce the mistrust many LGBTQ people feel regarding primary care.

Limitations. RIC clinics have been proposed for individuals with SMI, given that these individuals have a particularly hard time handling the primary care setting, and

that antipsychotic medications are associated with somatic health problems (i.e. diabetes). Also, mental health clinics tend to specialize in providing treatment and services for individuals with SMI, making it reasonable to expect a large group of people to benefit from a PCP being in the clinic. However, there may not be a wealth of LGBTQ clients for PCPs to see within RIC settings. Having a large group of individuals who could keep the PCP consistently productive is crucial to the success of a RIC clinic, especially given the equipment and costs associated with creating the clinic. Given that mental health clinics do not tend to specialize in LGBTQ concerns, it would be difficult to ensure that a PCP would have enough work to remain consistently productive.

Recommendations for Enhancing Care of LGBTQ Individuals in Integrated Care

As BHPs, clinicians can take further steps to enhance care for LGBTQ people in integrated care systems. Given the significant health concerns of this population compared to cisgender and heterosexual peers, as well as barriers to healthcare, BHPs may hold expertise suited to better meeting the needs of LGBTQ clients. The following recommendations outline the utility of behavioral health within integrated care systems and how these systems can better meet the needs of individuals within this population.

Create a culture of sensitive and inclusive care. By conducting care that is attentive to the needs and culture of LGBTQ clients, BHPs can help to reduce barriers within integrated care systems for these individuals. BHPs often gain multicultural training that helps create practice that is reflexive and cognizant of cultural issues, including those regarding gender and sexual orientation. Having knowledge regarding this population helps to reduce miscommunication between practitioners and clients, leading to increased satisfaction. Previous research has cited that, within behavioral health systems, LGBTQ clients indicate dissatisfaction often due to lack of provider competence (Avery, Hellman, & Sudderth, 2001; Lyons, Bieschke, Dendy, Worthington, & Georgemiller, 2010). When combining this issue with that of a cultural mistrust of professionals, due to fear or experiences of negative bias such as homophobia or transphobia, it is important for BHPs to utilize their knowledge of LGBTQ issues to further enhance care. Such a process may take the form of modifying language to be inclusive, such as using gender neutral forms or adopting words that are not heteronormative.

Taken further, sensitive care can also address the multiple identities many LGBTQ individuals hold. For instance, treating a White gay man within integrated care may not take the same form as treating a Black transgender woman, due to their difference in issues, societal treatment, and often their amount of resources. BHPs can then use their knowledge of racial, gender, and sexual orientation issues to better communicate with PCPs and other clinical staff, potentially aiding in retention of clients who are at the intersection of a LGBTQ identity and other marginalized identities.

BHPs as educators in integrated care settings. Reducing negative bias from other professionals within integrated care may take the form of BHPs using their expertise to enhance clinical staff training. LGBTQ individuals often receive care that may be assumptive or pathologizing (Dean, Victor, & Guidry-Grimes, 2016). BHPs

receive training in challenging their beliefs about clients in order to ensure quality of care. This information can then be used in a variety of ways, such as training programs which help other practitioners increase their multicultural knowledge and awareness of personal biases. Thus BHPs take the role of educators within integrated settings for the purpose of teaching new skills to other practitioners.

While PCPs are a likely and suitable target for education on LGBTQ clients, other clinical staff need this training as well. Clients within integrated care come across a myriad of professionals, from front desk staff to nurses. Expanding training to encompass the totality of an integrated staff reduces the likelihood of LGBTQ clients experiencing negative bias. For instance, training front desk or clerical staff on appropriate language minimizes the chance of these clients experiencing dismissive actions such as misgendering (Gay and Lesbian Medical Association, 2006). Creating a staff that is fully aware and sensitive to the needs of LGBTQ clients is paramount to maintaining their care, as a negative incident with staff may increase mistrust of the clinical setting. The Gay and Lesbian Medical Association (GLMA, 2006) recommends checking in with staff to ensure they are following policies and procedures related to LGBTQ clients within clinics.

Hughes, Damin, and Heiden-Rootes (2017) also recommend training facilitated by professionals accustomed to working with the LGBTQ population. BHPs constitute part of this group of professionals, though others with expertise in families, developmental concerns, and specifically LGBTQ issues could provide training to enhance the nature and knowledge base of care for LGBTQ individuals in integrated settings.

Adopt nondiscrimination policies. LGBTQ clients face barriers in health care for many reasons, including those attributed to practitioners and the clinical setting (citations needed). Creating policies that set modes of accountability for discrimination lend to better care for LGBTQ people. As mentioned above, there are not many settings that explicitly focus on LGBTQ issues. While some primary care clinics may devote more effort to addressing concerns for this population, behavioral health clinics may have less resources to do so. Thus, it is integral to the well-being of LGBTQ clients that clinics which serve them have policies in place that prevent harassment and discrimination.

Participants in research conducted by Romanelli and Hudson (2017) pointed out the importance of nondiscriminatory care and how individuals often do not feel as though they have protections in healthcare environments. To mitigate this experience, policy is a more concrete manner of enforcing inclusive standards with regards to LGBTQ care. Establishing firm guidelines regarding violations and resultant consequences may be more likely to hold providers accountable in providing nondiscriminatory care. These guidelines, which can serve as helpful templates for integrated care settings, could potentially come from mandates regarding standards of care or ethical issues established by professional organizations such as the American Counseling Association, as well as varying levels of government. However, appropriate

attention and caution must be paid, as policy will need to be regularly and routinely evaluated regarding its appropriateness for LGBTQ clients seeking care (Romanelli & Hudson, 2017).

Update paperwork. Many forms related to healthcare may be unaffirming of LGBTQ identities. For instance, many forms only indicate two choices for gender (“male” or “female”) and are heteronormative when asking about sexual behavior or relationships (assumes different gender partner, fewer options relating to cohabitation). Updating these forms are important for gathering specific information regarding LGBTQ individuals.

Organizations such as the Fenway Institute (2012a) and the GLMA (2006) have proposed the use of forms that are not assumptive regarding sexual behavior and identity. Gender neutral forms, which provide a blank space for individuals to write their gender or multiple options beyond male and female, help to provide a more affirmative healthcare environment and give detailed information regarding clients. In a similar fashion, creating open-ended or multiple options regarding partnerships helps to reduce stigma regarding same-sex relationships. Paperwork must be updated to match current terminologies and understanding of sexual orientation and gender in order to ensure that care is meeting LGBTQ clients’ specific needs.

Paperwork also helps the treatment team better deliver care to individuals. As pointed out by the Fenway Institute (2012b) gathering information helps clinicians to address specific issues and disparities affecting LGBTQ people. For example, knowing that a client is transgender helps clinicians to provide specific services. Dutton and colleagues (2008) purport that transgender men often do not receive routine gynecologic procedures such as mammograms and pap smears, thus negatively impacting their physical health. Having this information is vital in tailoring care to clients’ identities and bodies. PCPs will be alerted as to what questions to ask regarding physical health and BHPs can assist clients in managing emotional and behavioral concerns regarding transitioning. The treatment team as a whole can then work together to ensure that each client is cared for in a holistic manner that is affirming of their gender and/or sexual orientation.

Update language and protocols. Similar to paperwork, the everyday language used with LGBTQ clients should reflect updated knowledge, terms, and understanding. There are many terms regarding gender and sexual orientation that may not be covered in multicultural classes. For instance, terms such as agender, genderqueer, demigender, pansexual, and asexual are becoming more prominent in psychological literature though are still not prominent in training. Understanding these terms and using them with clients helps to ensure practitioners gain pertinent information to clients.

Refining these terms helps to further specify services and care. Being able to access behavioral and physical health services helps LGBTQ individuals gain holistic care that addresses all of their needs. Updated terms help to ensure that they are receiving appropriate services and procedures. PCPs are then able to assess clients for

services rather than only using services that pertain to their birth-designated gender. BHPs become involved by tailoring behavioral strategies to a client's body and needs. For instance, a genderqueer client who was designated male at birth may need particular care in terms of physical assessments, but also specialized behavioral strategies tailored to their sexual activity and relationships.

Address specific client needs. The LGBTQ population is widely varied, thus making it important for practitioners to provide treatment tailored to individuals on a case to case basis. Having PCPs and BHPs present helps to minimize both physical and behavioral health issues for these clients. Based on gender, race, sexual orientation, age, and other factors, individuals need different types of care. Consider that many Black individuals may need cardiovascular care to address their increased risk for cardiovascular disease compared to their White peers (Carnethon et al., 2017). Adding physical and behavioral interventions to address these issues is important for maintaining the health of Black LGBTQ individuals, especially those who are aging. Integrated care settings provide unique opportunities to address health concerns for LGBTQ clients beyond their gender or sexual identity in ways that may not be addressed in purely behavioral or physical health settings.

LGBTQ individuals, particularly those who are transgender, face barriers to their healthcare for numerous reasons. For one, PCPs often are not willing to provide physical services that do not match clients' gender (e.g., practitioners not providing pap smears for transgender men). Second, LGBTQ clients are often pathologized or given care they do not consent to or do not need. For these purposes, it is important to address the primary concerns of LGBTQ individuals in integrated care based on presentation without the presence of bias. LGBTQ clients having access to important and routine physical and behavioral health creates increased potential for positive health outcomes and minimizes issues with obtaining care such as potential financial concerns and needing to travel between multiple practitioners (Romanelli & Hudson, 2017).

Future Directions

In order to enhance care for LGBTQ clients in integrated care settings, changes are necessary at various levels. From training and education to clinical practice, different individuals need suitable knowledge in order to properly care for LGBTQ clients in integrated settings. While these changes will be similar across multiple settings, integrated systems necessitate fine-tuned application of skills and knowledge for many reasons, including time spent with clients and model of care.

Future clinicians should be adequately trained with multicultural issues, especially for implementation in integrated systems. While many BHPs are more likely to gain knowledge and training in multicultural issues, there has been a noted lack of training, particularly regarding LGBTQ individuals (Johnson & Federman, 2014). Without specialized training, clinicians are coming into integrated settings with less knowledge, thus creating a potentially dire paradigm for the treatment of LGBTQ clients.

This in turn exacerbates the aforementioned health disparities for this population and worsens health outcomes.

Training and education can take many forms. Both BHPs and PCPs could have courses specifically tailored to treating LGBTQ clients. Clinicians can also attend workshops or conferences geared toward helping people within this population, creating a larger awareness about their specific issues. Such training and education should also be applied to integrated settings, considering that practice takes a different iteration and is often more brief. Thus, behavioral and physical health providers better ensure the delivery of adequate care.

After becoming professionals, it is also important for clinicians to maintain education regarding LGBTQ clients. Current clinicians should remain up to date on terminology and changes in health fields to better address the needs of LGBTQ clients. Many of these terms have changed or expanded to capture an improved glimpse of individuals who are gender or sexual minorities. Knowledge of terminology has a positive impact on clients, indicating that their clinicians are knowledgeable and affirming. However, as time passes, clinicians must also be flexible in learning from clients regarding specific terminology.

Research must also be conducted to assess the concerns that LGBTQ clients bring to integrated settings (Hughes et al., 2017). There is a growing, but still sparse, body of research regarding therapy effectiveness and challenges for this population, but this research is often not broadly applied. It is important to address the specific elements of treatment which work for individuals within this population, but also what facets of treatment must be adjusted in order to enhance health outcomes.

Conclusion

There are a significant number of health risks facing LGBTQ clients that modified systems of healthcare could potentially remedy. Taking advantage of integrated systems may be an effective method of minimizing health disparities for LGBTQ people. These settings are uniquely equipped to manage emotional and behavioral issues related to a minority sexual or gender identity, but also helps to create enhanced resources for a population that faces economic barriers. To fully operate within integrated care for the welfare of LGBTQ clients, many changes may need to happen, including education of staff and changes in policy. By combining the skills and attributes of physical and behavioral health, it is possible to create significant change in the lives of people within this group. As the fields of behavioral and physical health progress, it may behoove clinicians to investigate ways they may be able to enhance the care of LGBTQ individuals within integrated settings.

References

- Avery, A. M., Hellman, R. E., & Sudderth, L. K. (2001). Satisfaction with mental health services among sexual minorities with major mental illness. *American Journal of Public Health, 91*, 990-991.
- Bagley, C., & Tremblay, P. (2000). Elevated rates of suicidal behavior in gay, lesbian, and bisexual youth. *The Journal of Crisis Intervention and Suicide Prevention, 21*, 111-117. <http://dx.doi.org/10.1027//0227-5910.21.3.111>
- Blosnich, J., & Bossarte, R. (2012). Drivers of disparity: Differences in socially base risk factors of self-injurious and suicidal behaviors among sexual minority college students. *Journal of American College Health, 60*, 141-149. <http://dx.doi.org/10.1080/07448481.2011.623332>
- Budge, S. L., Adelson, J. L., & Howard, K. A. S. (2013). Anxiety and depression in transgender individuals: The roles of transition status, loss, social support, and coping. *Journal of Consulting and Clinical Psychology, 81*, 545-557. <http://dx.doi.org/10.1037/a0031774>
- Carnethon, M. R., Pu, J., Howard, G., Albert, M. A., Anderson, C. A. M., Bertoni, A. G., Mujahid, M. S., Palaniappan, L., Taylor, H. A. Jr., Willis, M., & Yancy, C. W. (2017). Cardiovascular health in African Americans: A scientific statement from the American Heart Association. Retrieved from <http://circ.ahajournals.org/content/early/2017/10/20/CIR.0000000000000534>
- Cochran, B. N., & Cauce, A. M. (2006). Characteristics of lesbian, gay, bisexual, and transgender individuals entering substance abuse treatment. *Journal of Substance Abuse Treatment, 30*, 135-146. <http://dx.doi.org/10.1016/j.jsat.2005.11.009>
- Cummings, N. A. (2003). Advantages and limitations of disease management- A practical guide. In N. A. Cummings, O. W. T., & K. E. Ferguson (Eds.), *Behavioral health as primary care: Beyond efficacy to effectiveness* (pp. 31-44). Reno: Context Press.
- Cummings, N. A., O'Donohue, W. T., & Cummings, J. L. (2011). The Financial dimension of integrated behavioral/primary care. In N. A. Cummings, & W. T. O'Donohue (Eds.), *Understanding the behavioral healthcare crisis: The promise of integrated care and diagnostic reform* (pp. 33-54). New York: Routledge.
- Dean, M. A., Victor, E., & Guidry-Grimes, L. (2016). Inhospitable healthcare spaces: Why diversity training on LGBTQIA issues is not enough. *Journal of Bioethical Inquiry, 13*, 557-570.
- Dutton, L., Koenig, K., & Fennie, K. (2008). Gynecologic care of the female-to-male transgender man. *Journal of Midwifery and Women's Health, 53*, 331-337. <http://dx.doi.org/10.1016/j.jmwh.2008.02.003>
- Eisenberg, M. E., & Resnick, M. D. (2006). Suicidality among gay, lesbian and bisexual youth: The role of protective factors. *Journal of Adolescent Health, 39*, 662-668.

- Fenway Institute. (2012a). *Improving the health care of lesbian, gay, bisexual and transgender people: Understanding and eliminating health disparities*. Retrieved from http://www.lgbthealtheducation.org/wp-content/uploads/12054_LGBTHealtharticle_v3_07-09-12.pdf
- Fenway Institute. (2012b). *Policy focus: Why gather data on sexual orientation and gender identity in clinical settings*. Retrieved from http://fenwayhealth.org/documents/the-fenway-institute/policy-briefs/Policy_Brief_WhyGather..._v6_01.09.12.pdf
- Gay and Lesbian Medical Association (GLMA). (2006). *Guidelines for care of lesbian, gay, bisexual, and transgender patients*. Retrieved from http://www.glma.org/_data/n_0001/resources/live/GLMA%20guidelines%20200%20FINAL.pdf
- Haas, A. P., Rodgers, P. L., & Herman, J. L. (2014). *Suicide attempts among transgender and gender non-conforming adults: Findings of the National Transgender Discrimination Survey*. Retrieved from <http://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-SuicideReport-Final.pdf>
- Halkitis, P. N., Kapadia, F., Siconolfi, D. E., Moeller, R. W., Figueroa, R. P., Barton, S. C., & Blachman-Forshay, J. (2013). Individual, psychosocial, and social correlates of unprotected anal intercourse in a new generation of young men who have sex with men in New York City. *American Journal of Public Health, 103*, 889-895. <http://dx.doi.org/10.2105/AJPH.2012.300963>
- Hughes, R. L., Damin, C., & Heiden-Rootes, K. (2017). Where's the LGBT in integrated care research? A systematic review. *Families, Systems, & Health, 35*, 308-319.
- Johnson, L., & Federman, E. J. (2014). Training, experience, and attitudes of VA psychologists regarding LGBT issues: Relation to practice and competence. *Psychology of Sexual Orientation and Gender Diversity, 1*, 10-18. <http://dx.doi.org/10.1037/sgd0000019>
- Jorm, A. F., Kurten, A. E., Rodgers, B., Jacomb, P. A., & Christensen, H. (2002). Sexual orientation and mental health: Results from a community survey of young and middle-aged adults. *The British Journal of Psychiatry, 180*, 423-427. <http://dx.doi.org/10.1192/bjp.180.5.423>
- Katon, W., Robinson, P., Von Kroff, M., Lin, E., Bush, T., Ludman, E., . . . Walker, E. (1996). A multifaceted intervention to improve treatment of depression in primary care. *Archives of General Psychiatry, 53*, 924-932.
- Katon, W., von Korff, M., Lin, E., Walker, E., Simon, G., Bush, T., . . . Russo, J. (1995). Collaborative management to achieve treatment guidelines: Impact of depression in primary care. *JAMA, 273*, 1026-1031.
- Kenagy, G. P. (2005). Transgender health: Findings from two needs assessment studies in Philadelphia. *Health and Social Work, 30*, 19-26. <http://dx.doi.org/10.1093/hsw/30.1.19>

- King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay, and bisexual people. *BMC Psychiatry, 8*, 70. <http://dx.doi.org/10.1186/1471-244X-8-70>
- Lyons, H. Z., Bieschke, K. J., Dendy, A. K., Worthington, R. L., & Georgemiller, R. (2010). Psychologists' competence to treat lesbian, gay and bisexual clients: State of the field and strategies for improvement. *Professional Psychology: Research and Practice, 41*, 424-434. <http://dx.doi.org/10.1037/a0021121>
- Maragakis, A., Siddharthan, R., RachBeisel, J., & Snipes, C. (2015). Creating a 'reverse' integrated primary and mental healthcare clinic for those with serious mental illness. *Primary Health Care Research and Development*, Volume? 1-7.
- Mathy, R. M., Cochran, S. D., Olsen, J., & Mays, V. M. (2011). The association between relationship markers of sexual orientation and suicide: Denmark, 1990-2001. *Social Psychiatry and Psychiatric Epidemiology, 46*, 111-117. <http://dx.doi.org/10.1007/s00127-009-0177-3>
- Mayer, K. H., Bradford, J. B., Makadon, H. J., Stall, R., Goldhammer, H., & Landers, L. (2008). Sexual and gender minority health: What we know and what needs to be done. *American Journal of Public Health, 98*, 989-995. <http://dx.doi.org/10.2105/AJPH.2007.127811>
- McKay, B. (2011). Lesbian, gay, bisexual, and transgender health issues, disparities, and information resources. *Medical Reference Services Quarterly, 30*, 393-401. <http://dx.doi.org/10.1080/02763869.2011.608971>
- Moreira, A. D., Halkitis, P. N., & Kapadia, F. (2015). Sexual identity development of a new generation of emerging adult men: The P18 cohort study. *Psychology of Sexual Orientation and Gender Diversity, 2*, 159-167. <http://dx.doi.org/10.1037/sgd0000099>
- Newcomb, M. E., & Mustanski, B. (2010). Internalized homophobia and internalizing mental health problems: A meta-analytic review. *Clinical Psychology Review, 30*, 1019-1029. <http://dx.doi.org/10.1016/j.cpr.2010.07.003>
- Ray-Sannerud, B. N., Bryan, C. J., Perry, Nicholas, N. S. & Bryan, A. O. (2015). High levels of emotional distress, trauma exposure, and self-injurious thoughts and behaviors among military personnel and veterans with a history of same sex behavior. *Psychology of Sexual Orientation and Gender Diversity, 2*, 130-137. <http://dx.doi.org/10.1037/sgd0000096>
- Robinson, P., & Reiter, J. (2015). *Behavioral consultation and primary care: A guide to integrating services*. New York: Springer.
- Romanelli, M., & Hudson, K. D., (2017). Individual and systemic barriers to health care: Perspectives of lesbian, gay, bisexual, and transgender adults. *American Journal of Orthopsychiatry, 87*, 714-728.
- Sandfort, T. G., de Graaf, R., Bijl, R. V., & Schnabel, P. (2001). Same-sex sexual behavior and psychiatric disorders: Findings from the Netherlands Mental Health

- Survey and Incidence Study (NEMESIS). *Archives of General Psychiatry*, 58, 85-91.
- Silva, C., Chu, C., Monahan, K. R., & Joiner, T. E. (2015). Suicide risk among sexual minority college students: A mediated moderation model of sex and perceived burdensomeness. *Psychology of Sexual Orientation and Gender Diversity*, 2, 22-33. <http://dx.doi.org/10.1037/sgd0000086>
- Smalley, K. B., Warren, J. C., & Barefoot, K. N. (2016) Differences in health risk behaviors across understudied LGBT subgroups. *Health Psychology*, 35, 103-114.
- Stone, D. M., Luo, F., Ouyang, L., Lippy, C., Hertz, M. F., & Crosby, A. E. (2014). Sexual orientation and suicide ideation, plans, attempts, and medically serious attempts: Evidence from local Youth Risk Behavior Surveys, 2001-2009. *American Journal of Public Health*, 104, 262-271. <http://dx.doi.org/10.2105/AJPH.2013.301383>
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *Resources for culturally appropriate integrated services for LGBT individuals*. [PowerPoint slides]. Retrieved from *http://www.integration.samhsa.gov/about-us/LGBT_Webinar_PPT_-_FINAL.pdf.
- Tompkins, T. L., Shields, C. N., Hillman, K. M., & White, K. (2015). Reducing stigma toward the transgender community: An evaluation of a humanizing and perspective taking intervention. *Psychology of Sexual Orientation and Gender Diversity*, 2, 34-42. <http://dx.doi.org/10.1037/sgd0000088>
- van Heeringen, C., & Vincke, J. (2000). Suicidal acts and ideation in homosexual and bisexual young people: A study of prevalence and risk factors. *Social Psychiatry and Psychiatric Epidemiology*, 35, 494-499. <http://dx.doi.org/10.1007/s001270050270>
- Wadsworth, L. P., & Hayes-Skelton, S. A. (2015). Differences among lesbian, gay, bisexual, and heterosexual individuals and those who reported an other identity on an open-ended response on levels of social anxiety. *Psychology of Sexual Orientation and Gender Diversity*, 2, 181-187. <http://dx.doi.org/10.1037/sgd0000092>
- Wichstrom, L., & Hegna, K. (2003). Sexual orientation and suicide attempt: A longitudinal study of the general Norwegian adolescent population. *Journal of Abnormal Psychology*, 112, 144-151. <http://dx.doi.org/10.1037/0021-843X.112.1.144>