Fall 2014

Mental Health Disparities among LGBT Populations

Aaron Nicholas
American Public University System

APUS Library Student Paper Submission Form

(This form not to be used for master's theses/capstone papers)

Student Name: Nicholas, Aaron

Course Number: (e.g. LSTD510): PBHE527 Paper Date: Fall 2007

Professor Name: Lori Dewald

Program Name: Public Health

This paper submitted by the student listed above under this title:

Mental Health Disparities among LGBT Populations

is recommended for publication on DigitalCommons@APUS by the following member(s) of the APUS academic leadership:

First recommender: Brian Freeland

Second recommender (optional): Samer Koutoubi

Please send this completed document and the student publication to DigitalCommons@APUS.edu.

Mental Health Disparities among LGBT Populations

PBHE527 D001 Fall 14

Aaron Nicholas

American Public University

Abstract

Health inequalities resulting from social pressure or stigma are defined as a health inequity (King, 2014). A number of studies show that social pressure has influenced health equalities of the United States LGBT population, leading to a health inequity (Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2014). Failure to address such disparities place LGBT populations at increased risk of health issues, including depression, a leading cause of suicide (Centers for Disease Control and Prevention (CDC), 2011a; Mao, et al., 2009). In fact the LGB population suffers from a 10 to 40 percent rate of attempted suicide, compared to the heterosexual population of 0.4 to 5.1 percent (O'Donnell, Meyer, & Schwartz, 2011). This paper analyzes and addresses the current situation of mental health among United States LGBTs through review of current literature and policy, specifically the Affordable Healthcare Act (ACA) and Defense of Marriage Act (DOMA), and present a potential health promotion program. Current application of ACA and DOMA was discovered to have a negative impact on the mental health of LGBT populations. However, through the use of policy changes and application of the presented health promotion program, it is possible to mitigate this health inequality.

Introduction

Social disadvantage has been noted as a determining factor in poor health, including mental health (Meads, Carmona, & Kelly, 2012). Such conclusions have been drawn conclusively on an international level (Meads, Carmona, & Kelly, 2012). Life expectancy is one health measure that has been noted fluctuates according to economic development and political organization (Meads, Carmona, & Kelly, 2012). Health disparities among a population are tied to a number of factors to include education, income, political legislation, social stigma, etc… (Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2014). However, health inequalities that are the result of social pressure or stigma are defined as a health inequity (King, 2014). A number of studies show that social pressure has influenced health equalities of the LGBT population, leading to a health inequity (Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2014). Locally, health disparities among homosexuals continue in the United States (Centers for Disease Control and Prevention (CDC), 2011b). The problem of analysis is compounded by gaps in data collection on state and federal level health reports (Centers for Disease Control and Prevention (CDC), 2011a). This is due in part by failures in state and federal research surveys to collection sexual orientation identification information (Centers for Disease Control and Prevention (CDC), 2011a). However, failure to address such disparities place LGBT populations at increased risk of health issues, including depression, a leading cause of suicide (Centers for Disease Control and Prevention (CDC), 2011a; Mao, et al., 2009). In fact the LGB population suffers from a 10 to 40 percent rate of attempted suicide, compared to the heterosexual population of 0.4 to 5.1 percent (O'Donnell, Meyer, & Schwartz, 2011). Additionally, a higher rate is seen in minority LGBT populations, paradoxical to the fact that whites generally suffer higher suicide rates than ethnic minorities (O'Donnell, Meyer, &

Schwartz, 2011). Social stigma, prejudice, and discrimination are continuously identified as reasons for such high levels (O'Donnell, Meyer, & Schwartz, 2011). Additionally, LBGT youth generally continue to be discriminated across religious lines (Gosselin, 2009). This includes religious education institutions (Gosselin, 2009). Furthermore, after a number of legal settlements and actions, companies have begun creating a system of separate but equal, such as eHarmony with the creation of Compatible Partners (Gosselin, 2009). The United States currently practices an environment of segregation where LGBT individuals are concerned, including within the health care field.

The intrapersonal level continues to be the most basic level in health, with theories focusing on factors such as attitudes, beliefs, motivation, knowledge, etc… (McKenzie, Neiger, & Thackeray, 2013). This level has been identified as useful when attempting to influence behavior (McKenzie, Neiger, & Thackeray, 2013). In order to combat suicide health disparities among the LGBT population the health belief model has been identified as the best predictor of human behavior and how to change current attitudes. This model has a number of key constructs and measurements, making it unique among the theories of human behavior. The Health Belief Model takes into account the susceptible nature of the population and lends to adaptability in the wide range of health disparities affecting LGBTs. Susceptibility and severity include the high rates of suicide and the financial burden following. Perceived benefits include the aversion of suicide. However, barriers include the financial cost of services and the belief that organizations may not understand LGBT ideals. Self-efficacy is of concern as social stigma and discrimination continue unabated. However, the population already has set into place a number of self-efficacy inducing ideals and programs.

Reduction of LBGT health disparities is essential in order to secure the health of all American citizens. In order to accomplish this task it is important to properly design a program that address the key issues identified. Included within this planning phase is the identification of target audiences. As has been noted, this includes a number of groups through the country, ranging from the individual to the federal level. Included within this planning phase is the identification of program goals and mission statement, two important components that aid in the identification of guiding values and provide purpose and direction to the overall program. Of course built within this design are a number of strengths and weakness inherent to all health programs. While it is ideal to have a limited number of weakness, identification may aid in the mitigation of damage from such areas.

As has been witnessed in the literature, there currently exist a number of policies that encourage mental health disparities among LGBT populations. Such policies include the Affordable Healthcare Act and the Defense of Marriage Act. Both federal level legislative pieces directly affect the way in which LGBTs access healthcare within the United Stated health care system. As such the targeting of both policies is important in the goal of reducing mental health disparities. Furthermore, the reduction of these policies may lead to proportionate reduction in social stigma witnessed against the LBGT population. This in effect, reduces perceived barriers to healthcare increasing the efficiency of the health belief model selected for this health promotion program. Policy development has been cited as a significant measure of public health system health (United Nations, 2013). This includes the existence of negative health policies, such as the Defense of Marriage Act which has been noted by the Indiana State Medical Association as a driver in health disparities among LGBT couples (Buffle, 2011). Legal benefits and financial benefits are associated with legal marriage status, bringing about a higher rate of

health care access (Buffle, 2011). The loss or denial of benefits is a flagrant violations of medical ethics principles including autonomy, nonmaleficence, procedural justice, and distributive justice (Summers, 2014). Such example highlight the need to rebalance state and federal policies in order to reduce LGBT health disparities. The purpose of this paper is to present a potential health promotion program in order to decrease the LGBT mental health inequity.

Problem Statement

Social disadvantage has been noted as a determining factor in poor health, including mental health (Meads, Carmona, & Kelly, 2012). Such conclusions have been drawn conclusively on international levels through various research articles (Meads, Carmona, & Kelly, 2012). However, health inequalities that are the result of social pressure or stigma are defined as a health inequity (King, 2014). Life expectancy, for example, is one health measure that has been noted that fluctuates according to economic development and political organization (Meads, Carmona, & Kelly, 2012). Health disparities among a population are tied to a number of factors to include education, income, political legislation, social stigma, etc… (Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2014). A number of studies show that social pressure has influenced health equalities of the LGBT population, leading to a health inequity (Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2014).

Locally, health disparities among homosexuals continue in the United States (CDC, 2011b). The problem of analysis is compounded by gaps in data collection on state and federal level health reports (CDC, 2011a). This is due in part by failures in state and federal research surveys to collection sexual orientation identification information (CDC, 2011a). However, failure to address such disparities place LGBT populations at increased risk of health issues, including depression, a leading cause of suicide (CDC, 2011a; Mao, et al., 2009). In fact the

LGB population suffers from a 10 to 40 percent rate of attempted suicide, compared to the heterosexual population of 0.4 to 5.1 percent (O'Donnell, Meyer, & Schwartz, 2011). Additionally, a higher rate is seen in minority LGBT populations, paradoxical to the fact that whites generally suffer higher suicide rates than ethnic minorities (O'Donnell, Meyer, & Schwartz, 2011). Social stigma, prejudice, and discrimination are continuously identified as reasons for such high levels (O'Donnell, Meyer, & Schwartz, 2011). Furthermore, LBGT youth generally continue to be discriminated across religious lines (Gosselin, 2009). This includes religious education institutions (Gosselin, 2009). Furthermore, after a number of legal settlements and actions, companies have begun creating a system of separate but equal, such as eHarmony with the creation of Compatible Partners (Gosselin, 2009). The United States currently practices an environment of segregation where LGBT individuals are concerned, including within the health care field.

The health inequity felt by LGBT individuals must be addressed and corrected as part of a broad health promotion program. Uncorrected, this health disparity leaves a significant population at a social disadvantage with relation to mental illness, and more specifically suicide. As such, the general public is left vulnerable to the costs, financially and emotionally, associated with attempted and successful suicides from LGBT individuals. This program must tackle a large complex issue that has deeply engrained social stigma. Therefore, program design will need to be equally complex in order to effectively address this psychosocial public health concern.

Models of Interest

The Health Belief Model

The health belief model is one of the most used models in health behavior application in health promotion programs (McKenzie, Neiger, & Thackeray, 2013). Failure of citizens to

participate in health prevention programs during the 1950s began the development of the model (Champion & Skinner, The Health Belief Model, 2008). The model is built on value-expectancy concepts (Champion & Skinner, The Health Belief Model, 2008). Six constructs exist within the model, perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Champion & Skinner, The Health Belief Model, 2008). The model hypothesizes that three classes of factors exist in health-related action, and all three must occur simultaneously (McKenzie, Neiger, & Thackeray, 2013). The three factors within the health belief model are the existence of sufficient motivation, the belief of vulnerability, and that there are perceived costs and benefits within the action (McKenzie, Neiger, & Thackeray, 2013). When a perceived threat and susceptibility have been established, a measurement of benefits against barriers dictates the change. Recently the addition of self-efficacy has come into the model, and as a strong player. This has been noted in programs that promotion healthy interventions (McKenzie, Neiger, & Thackeray, 2013). One key limitation within the model occurs when a population fails to recognize themselves as at risk (Champion & Skinner, The Health Belief Model, 2008).

Theory of Planned Behavior

The Theory of Planned Behavior began as a means to determine the relationship between attitudes, intentions, and behaviors (Montano & Kasprzyk, 2008). The Theory of Planned Behavior is successful in ‘purely volitional behavior’ (McKenzie, Neiger, & Thackeray, 2013). The theory is very similar to the Theory of Reasoned Action, with the exception that the Theory of Planed Behavior includes the perceived behavioral control (Montano & Kasprzyk, 2008). Perceived behavior control ‘refers to people’s perceptions of their ability to perform a given behavior’ (Ajzen, 2006). The constructs within the theory are intention, belief, attitude, and

behavior (McKenzie, Neiger, & Thackeray, 2013). Subjective norms also plays a large part in the theory, where actions or behaviors are more likely to occur if there is a perceived social norm to it (McKenzie, Neiger, & Thackeray, 2013). Furthermore, with regard to the added perceived behavior control, motivation for interventions is improved with an increase in perceived control (McKenzie, Neiger, & Thackeray, 2013). Failure to provide a sense of control will severely limit intentions which will decreases the chances of a change in behavior (McKenzie, Neiger, & Thackeray, 2013; Montano & Kasprzyk, 2008). This lack of perceived behavioral control is a severe limiting factor on this theory. One study conducted in Australia used the Theory of Planned Behavior (Dolnicar & Hurlimann, 2009). In this study the goal was to identify the attitudes of a community towards the use of alternate sources of water (Dolnicar & Hurlimann, 2009). More specifically this study analyzed why communities were choosing which alternate source, and example of volitional behavior (Dolnicar & Hurlimann, 2009; McKenzie, Neiger, & Thackeray, 2013)

LGBT Health Disparities Model

The complex nature of health disparities among LGBT individuals creates an equally complex task of selecting the most appropriate model. The Theory of Planned Behavior is the first model to be eliminated. The lynchpin within the model is the perceived image of behavioral control (McKenzie, Neiger, & Thackeray, 2013). A number of socioeconomical issues surround the issue of LGBT. Legislation against the population is one example to consider (Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2014). Another example, is the high prevalence of poverty within the LGB population (Albelda, Badgett, Schneebaum, & Gates, Poverty in the Lesbian, Gay, and Bisexual Community, 2009). These issues are far from the control of the population, thus decreasing the perceived behavioral control. Furthermore, the stigma against the

LGBT population creates issue as social norm plays a pivotal role in the Theory of Planned Behavior. The view that being a part of the LGBT community is against social norm may hinder efforts in using the Theory of Planned Behavior Model.

The health belief model appears to be the most relevant and potentially effective model to use in the health disparities among the LGBT community. The construct of susceptibility is vital within the Health Belief Model. As such, the failure of a high risk group to recognize itself as such, will severely hamper the Health Belief Model. This does not appear to be the case, as the increased risk factors being in the LGBT have been mentioned. Low rates of education will reduce perceived benefits, and may increase barriers. Data shows that LGBT couples have lowers education levels then their different-sex counterparts (Albelda, Badgett, Schneebaum, & Gates, Poverty in the Lesbian, Gay, and Bisexual Community, 2009). The identification of self-efficacy among the LGBT population lends aid in support for the use of the Health Belief Model. Furthermore, the Health Belief Model is a well-established model and can be used in a myriad of different situations (McKenzie, Neiger, & Thackeray, 2013). This lends itself well where LGBT issues extend into a wide array of areas including poverty, HIV infection, and are less insured (Centers for Disease Control and Prevention (CDC), 2014c; Albelda, Badgett, Schneebaum, & Gates, Poverty in the Lesbian, Gay, and Bisexual Community, 2009; Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2014).

Literature Review

Article 1 - Ryan, C., Russel, S., Hueber, D., Diaz, R., & Sanchez, J. (2010). Family Acceptance in Adolescence and the Health of LGBT Youth Adults. ***Journal of Child and Adolescent Psychiatric Nursing,*** **205-213.**

Family connections and relationships have been shown to aid in the prevention of major health risk behaviors. Studies have focused on the role in adolescent behavior and family relationships but little has been done to analyze these behavior with Lesbian, Gay, Bisexual, and Transgendered (LGBT) youth. This is further highlighted by the almost nonexistence of data available for transgendered youth. While negative development has been the focus on current and past studies little has been done to categorize the positive aspect parents have on the development of LGBT youth. This lack of data is in contrast to the common understanding the LGBT youth suffer from high risks of physical and emotional health disparities. This study analyzes the positive role that family acceptance plays in the development of LGBT adolescents across gender and racial lines.

The study found a number of relationships and correlations. One important relationship was families with low religiosity reported higher rates of acceptance than those with high religiosity. Additionally, higher occupational status with parents was found to be tied to a high rate of acceptance. Youths who lived with a higher accepting family scored higher in all three areas of health, including self-esteem, social support, and general health.

Article 2 - Chance, T. F. (2013). "Going to Pieces" Over LGBT Health Disparities: How an Amended Affordable Care Act Could Cure the Discrimination That Ails the LGBT Community. *Journal of Health Care Law & Policy,* 375-402.

Health disparities are common to minority groups, with particular affinity for those divided across racial and ethnic lines. As such the LGBT community suffer from high rates of uninsured persons coupled with numerous health care barriers. This is in correlation to the 45,000 Americans who died in 2010 without insurance. Such numbers have brought about the Patient Protection and Affordable Care Act (ACA). The two purposes of this enactment is to

increase access and improve quality of health care for all Americans. However, this act does little to no work against the discrimination to LGBT communities that have led to health care disparities. As such it is predicted that the ACA will have little impact on the increased health of the LGBT population.

This article finds that current policy suggestions are not and will not meet the needs of LGBT communities in addressing the health care disparity. Cultural competency training is recommended as a solution in LGBT health care discrimination. Furthermore, the authors mention that providers require specialized training in order to meet the unique needs of the LGBT population.

Article 3 - Burkhalter, J., Warren, B., Shuk, E., Primavera, L., & Ostroff, J. (2009). Intention to quit smoking among lesbian, gay, bisexual, and transgender smokers. *Nicotine & Tobacco Research,* 1312-1320.

High rates of smoking continue to persist in LGBT persons compared to average similar gendered groups in the United States. In facts rates in gay in bisexual men are 27 to 71 percent higher and 70 to 350 percent higher for lesbian and bisexual women. Additionally high rates of depression, substance abuse, social discrimination and employment discrimination are observed. In order to provide medical invention the barriers of smoking cessation need to be understood. This study aims to apply the theory of planned behavior (TPB) in order to explain variance in intention to quit smoking over a 6 month time period. While cessation variables are understood in the general population, the unique challenges of the LGBT community warrant investigation.

This study found that the study population suffers from high levels of stress and depression. Furthermore, the study found that no LGBT specific variables were observed outside of the TPB with relation to quitting intention. Positive attitudes and the belief that quitting would lead to health and longevity created the greatest intention to quit. Perceived partner approval to quit was deemed marginally significant.

Article 4 - Russell, R., Ryan, C., Toomey, R., Diaz, R., & Sanchez, J. (2011). Adolescent School Victimization: Implications for Young Adult Health and Adjustment. *Journal of School Health*, 223-230.

Victimization in the form of every day communication, harassment and physical violence are commonplace to LGBT youth in middle and high school. National surveys indicate the 90 percent of United States LGBT youths report hearing the word ‘gay’ in a derogatory way, 44 percent were verbally harassed, and 44 percent were physical harassed. Secondary school victimization has been linked with compromised adolescent health and adjustment. This includes academic achievement, absenteeism, aggressive behavior, compromised emotional health, and suicidal ideation. LBGT youth continue to have high levels of health risk behavior during adolescents. This study aims to analyze the effect of victimization on long term health of adolescents with relation to adult depression, suicidal ideations, life satisfaction, self-esteem, and social integration, a little studied relationship.

The study found that there exists a strong relationship between school victimization and young adult mental health and risk for STDs and HIV. However no link was found that ties victimization with substance abuse. Depression and suicidal ideation were significantly higher in LGBT males. The decrease of victimization will lead to an increase in emotional and health welfare.

Behavior Model Selection

The Health Belief Model

The health belief model is one of the most used models in health behavior application in health promotion programs (McKenzie, Neiger, & Thackeray, 2013). Failure of citizens to participate in health prevention programs during the 1950s began the development of the model (Champion & Skinner, The Health Belief Model, 2008). The model is built on value-expectancy concepts (Champion & Skinner, The Health Belief Model, 2008). Six constructs exist within the model, perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Champion & Skinner, The Health Belief Model, 2008). The model hypothesizes that three classes of factors exist in health-related action, and all three must occur simultaneously (McKenzie, Neiger, & Thackeray, 2013). The three factors within the health belief model are the existence of sufficient motivation, the belief of vulnerability, and that there are perceived costs and benefits within the action (McKenzie, Neiger, & Thackeray, 2013). When a perceived threat and susceptibility have been established, a measurement of benefits against barriers dictates the change. Recently the addition of self-efficacy has come into the model, and as a strong player. This has been noted in programs that promote healthy interventions (McKenzie, Neiger, & Thackeray, 2013). One key limitation within the model occurs when a population fails to recognize themselves as at risk (Champion & Skinner, The Health Belief Model, 2008).

The Health Belief Model and LGBTs

The complex nature of health disparities among LGBT individuals creates an equally complex task of selecting the most appropriate model. The health belief model appears to be the

most relevant and potentially effective model to use in the health disparities among the LGBT community. Within the model there exists four constructs, perceived susceptibility, perceived severity, perceived benefits, and perceived barriers (Champion & Skinner, The Health Belief Model, 2008). Self-efficacy, or the idea that one can achieve the outcome, also plays an important part in the health belief model (Champion & Skinner, The Health Belief Model, 2008). The Health Belief Model is a well-established model and can be used in a myriad of different situations (McKenzie, Neiger, & Thackeray, 2013). This lends itself well where LGBT issues extend into a wide array of areas including poverty, HIV infection, and are less insured (Centers for Disease Control and Prevention (CDC), 2014c; Albelda, Badgett, Schneebaum, & Gates, Poverty in the Lesbian, Gay, and Bisexual Community, 2009; Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2014).

Perceived Susceptibility and Severity

The construct of susceptibility is vital within the Health Belief Model. As such, the failure of a high risk group to recognize itself as such, will severely hamper the Health Belief Model. Suicide is the 10th leading cause of death among those from ages 10 to 24 (Stone, et al., 2014). As previously mention LGBTs suffer significantly higher rates of suicide. This fact has been observed for over 25 years (McAndrew & Warne, 2010). Furthermore, this population is four time less likely to report a suicide attempt, making intervention methods all the more difficult (McAndrew & Warne, 2010). Suicide remains the most permanent solution to short term problems. Besides death, suicides place a heavy burden both financially and emotionally of family members, friends, and health care facilities.

Perceived Benefits

The need to recognize benefits of changing a behavior is pivotal to the health belief model (Champion & Skinner, The Health Belief Model, 2008). With this in mind the perceived benefit of suicide prevention are the least challenging to convey. Example of such programs already exist, such as the Gay Hotline, a service geared towards assisting LGBT individuals as a stress coping mechanism. However, perceived benefits should be reinforced through information relating to the financial impart post suicide. This includes costs of medical care and intervention along with mortuary affairs. Such costs can be astronomical and may circumvent life insurance policies. This information is important in order to buff up perceived benefits.

Perceived Barriers and Self-efficacy

Data shows that LGBT couples have lowers education levels then their different-sex counterparts (Albelda, Badgett, Schneebaum, & Gates, Poverty in the Lesbian, Gay, and Bisexual Community, 2009). Low rates of education will reduce perceived benefits, and may increase barriers. Barriers include the continued social stigma against LGBT populations, including religious organizations. Barriers resulting from these stigmas is very real and practical. Failure of organizations to understand LGBT concerns and view point is one such instance. As an example, health care providers have been criticized as having little to no training in caring for LGBT individuals, increasing health disparities (Chance, 2013). Furthermore, it has been recognized that LGBT populations suffer from higher rates of poverty (Albelda, Badgett, Schneebaum, & Gates, Poverty in the Lesbian, Gay, and Bisexual Community, 2009). As such, there can be expected a number of perceived financial barriers to reaching out for care. This may also include fear of employment status for those who support families via one income. The identification of self-efficacy among the LGBT population lends aid in support for the use of the Health Belief Model. Such self-efficiency needs to come in the form of individual

empowerment, helping to offset social stigma and discrimination. Pride parades are one example where the LGBT community pushes towards self-efficacy, recognizing that the population suffers from high instances of discrimination.

Program Design

Primary Goals

The first discussion on program goals to have is the definition of goals as it pertains to planning a health promotion program. Goals area broad set out guidelines that outline the direction in which the program would like to move (McKenzie, Neiger, & Thackeray, 2013). Furthermore, goals are “simple and concise” (McKenzie, Neiger, & Thackeray, 2013). As such a full sentence is not required for goals (McKenzie, Neiger, & Thackeray, 2013). The Millennium Development program is one such example (Karim, et al., 2013). The goals established by the Millennium Development Goal Four has pushed the country of Ethiopia to reduce the incidents of fatalities for children under five years of age (Karim, et al., 2013). This goal provides direction for varying programs such as the Health Extension Program (Karim, et al., 2013). Furthermore, this goal help identify that reduction in mortality rates for children one to 59 months would not suffice alone to meet program goals (Karim, et al., 2013). As for the goals of the LGBT Mental Health Program, goals set out to reduce incidents of depression and suicide among LGBT individuals:

1. Reduce the number of LGBT suicides in the United States

2. Engage governmental leaders in tackling the issue of high rates of mental illness among LGBT populations

3. Develop a locally self-sustaining attitude and behavior towards LGBT individuals

4. Secure public funding towards prevention programs and mental health assistance

5. Educate government and community leaders in the importance of depression and suicide from social stigma

Mission Statement

An important part of proper program planning is the development of a mission statement, program goals, and objectives (McKenzie, Neiger, & Thackeray, 2013).Mission statements state the current focus and philosophy of a program (McKenzie, Neiger, & Thackeray, 2013). Mission statements are very common place in many health programs and organization such as the National Environmental Health Association and the *Journal of Global Health* (Balsamo, 2005; Journal of Global Health, 2011). Similarly, this statement if ever changing to include new roles and responsibilities that an organization may take on. This is evident in the changing of the mission state of the American Society of Pediatric Neurosurgeons, whose president reviews and updates the mission statement as needed (Rekate, 2002). The development of the mission statement for this program should include the fact that the program is community based and aims to help LGBT individuals both directly and through active legislation on their behalf. As such the mission statement for the program is as such:

> "The mission of the LGBT Mental Health Promotion Program is to provide a variety of educational and lobbying activities geared towards federal, state, and local government officials in an effort to reduce the mental health disparity among the LGBT population"

Target Audience

As part of the PATCH Model, identifying target groups is important in the preplanning phase of health programs (McKenzie, Neiger, & Thackeray, 2013). Utilization of this model is important as it identifies community mobilization. LGBT mental health disparities range across a number of social levels. As such, the target audience will mirror such a range. In this program, three main groups have been identified as the target audience, LGBT individuals, healthcare providers, and governmental policy makers.

LGBT Individuals

LGBT individuals are the first group as they are the primary focus of the program. This group continues to suffer from high rates of mental illness including depression and attempted suicide. As mentioned before, much of this rate comes from a number of social stigmas aimed against the LGBT population as a hole. This includes the construction of discriminatory legislation and perceived lack of support from social entities and organizations. Additionally, religious organizations have gained notary as being less then accepting of LGBT individuals. Data collection will be required in order to establish appropriate needs of this group. This is due to the seemingly lack of data from governmental agencies, specifically with regard to transgendered individuals (Stone, et al., 2014; Centers for Disease Control and Prevention (CDC), 2011a).

Healthcare Providers

The importance of healthcare providers in the LGBT population can be witnessed in the new Affordable Healthcare Act (Chance, 2013). In his analysis Chance, states that healthcare providers lack education and training on providing care to LGBT individuals. As such, this population does not receive care that takes their sexual orientation into account. This may lead to less than adequate care, and a potential player in high rates of depression and suicide. In order to

rectify this problem, healthcare providers must become active players in the battle against LGBT mental illness.

Government Policy Makers

As previously mentioned legislation has played an important role on the health of LGBT individuals, such as the Affordable Healthcare Act (Chance, 2013). Legislation has been noted as having a detrimental effect of LGBT population health disparities, tying into the knowledge that legislation is a cause of some health disparities not associated with the LGBT population (Mustanski, Birkett, Greene, Hatzenbuehler, & Newcomb, 2014). This may be tied furthermore to the religious nature of the United States, due to the fact that religion has been cited as a negative factor of LGBT health (Gosselin, 2009). Regards as to the reason, political leaders are responsible for the development and reduction of legislation that positively or negatively effects the health of a population group. As such, it is important to include this group in the target audience of the LGBT Mental Health Promotion Program.

Program Design

Designed around the Health Belief Model, the program implementation will rely heavily of a self-sustained program that educates leaders and healthcare providers on the health disparities of LGBTs while simultaneously providing direct access to care for the target population. The primary role of the program is to aid in the development of local, state, and federal legislation to open mental health clinics designed to treat the LGBT population. Furthermore, the program review current legislation that has proven detrimental to the population and attempts to amend such laws and policies in order to mitigate damage. The program is based on the health belief model, and as such, relies heavily on perceived susceptibility, severity, and benefits. In order to account for these constructs education of the

susceptibility of population is vital in initiated behavioral change. The use of current research studies is useful in support the agreement that the LGBT population needs both inside and outside intervention. The rates of suicide, which remain astronomically high aid in the discussion of mental illness and suicide. Furthermore, the cost of suicide is common knowledge among the general public, leaving little extra need to expound on the subject. However, political leaders may not understand that financial burden suicide and attempted suicide may have on the government. This includes stress on already stressed mental health infrastructure and staff. Healthcare providers also need to be made aware of their susceptibility of prescribing incorrect or misdirected health advice. In order to drive these facts, data collection from the program is important in order to close any informational holes, and to supplement current theories and knowledge on the intricate understanding of mental health, the LGBT population, and discrimination. The final design within the program includes an in-depth evaluation design that analyses the changes of legislation on the LGBT population and also the effect the program has on passing LGBT friendly legislation.

Strengths and Weaknesses

The major weakness of the LGBT Mental Health Promotion Program is the fact that the LGBT population consistently remains a minority group. Unlike many other groups where reproduction aids in population size increases, LGBT populations remain low, without the capacity to expand. This makes this group highly susceptible to the will of the general public. Such instances where this has led to a negative health impact includes the initial AIDS epidemic in the 1980s where the majority of the population did not give credit to a minority problem (Scutchfield & Keck, 2009). This system is heavily tied to utilitarianism, a common ethical basis in today's healthcare (Scutchfield & Keck, 2009). However, in order to implement this program,

ethics outside of utilitarianism must be used. Using social connects to build a network may help in establishing that the LGBT population effects the general public as a whole, and that public support aids the majority. The strengths of the program include the ability to target key political figures in order to pass legislation. Unlike programs such as water access where work is geared towards large swaths of regions and population, the LGBT health program is able to work directly out of centralized political hubs. This allows for the easy access to the target population and to direct legislation that forces compliance, especially with healthcare providers.

Policy Management and Modification

Affordable Healthcare Act

Previous to the ACA, incidents of discriminatory practices were apparent such as refusal of treatment, refusals to touch the patient, use of excessive precautions, harsh language from providers, and physical abuse (Chance, 2013). While these are examples of conscious discrimination, there also exists an unintentional set of practices from providers (Chance, 2013). Regardless to the intent, current medical practices have left many LGBT individuals with limited access to proper healthcare. The original intent of the Affordable Healthcare Act (ACA) was to increase access to health care for the general population while targeting quality of care through market pressure (Chance, 2013). Some have argued that the ACA will aid the LGBT population, as it close coverage gaps for the general public including LGBT individuals. However, the ACA continues to propagate the issue of substandard access to health care for the LGBT population (Chance, 2013). This is in part to the fact that the ACA increases access to care to LGBT individuals without regard to quality of care for this minority group. Furthermore, the ACA is subject to federal law, where no discriminatory policy has been set that address sexual orientation (Chance, 2013). This creates a location specific policy as these laws change from

state to state (Chance, 2013). It is common for LGBT individuals to wait as long as possible before receiving health care due to projected discrimination from health care providers (Chance, 2013). This highlights the perceived barriers of the health belief model upon which this program is based. The ACA does not address this issue and as such falls short of decreasing the health inequity among LGBTs.

One policy change needed within the context of the ACA is the incorporation of 'LGBT-specific cultural competency' (Chance, 2013). It has already been noted that current practitioners lack training in caring got LGBT patients. Training should be mandated as a part of current medical and nursing school curriculums. Incorporation of this training will help in preparing future health care physicians and nurses in dealing with specific LGBT issues within the medical field. While this addresses issues of future practitioners, it does little to current care issues. As such, ethics committees, who are tasked with ethics training, should be slotted to include LGBT healthcare issues into annual training events (West & Morrison, 2014). This aids in closing the gap of current and future generations of healthcare personnel. A second policy change that needs to be built within the ACA is the inclusion of a federal level anti-discriminatory clause. This change builds upon capitalism marketing theories in refusing coverage under the ACA for insurers who do not have anti-discriminatory policies in place. Denial of acceptance into the ACA umbrella forces companies to comply with federal level laws, despite lack of legislation on the state level.

The Defense of Marriage Act

According to the most recent census, 8.8 percent of American residents identify as gay or bisexual (Buffle, 2011). This indicates an underserved population of approximately 26.5 million Americans. Studies have shown a correlation of psychological health issues and the banning of

gay marriage laws (Buffle, 2011). After the 2004 and 2005 sweep of state laws banning gay marriage, the study conducted by Hatzenbuehler et al. (2010) showed a 36 percent increase in mood disorders, 248 percent increase in generalized anxiety disorders, 42 percent increase in alcohol abuse, and 36 percent for psychiatric comorbidity, all considered significant increases (Buffle, 2011). Additionally, respondents from states where such legislation was not passed report no significant increase in such psychological health issues (Buffle, 2011). This study supports the theory that the Defense of Marriage Act (DOMA) has a direct negative contribution on the mental health of LGBT individuals. Furthermore, as has already been mentioned, DOMA also has an indirect contribution the health inequity through the denial of legal and financial benefits associated with legal marriage. Highlighting this is the study by Ponce et al. (2010) where partnered gay men had a 42 percent and partnered lesbian a 28 percent reduction of partner sponsored dependent healthcare coverage (Buffle, 2011). The concept of healthcare coverage directly tied to an increase in health is common knowledge among healthcare specialists and professionals. As such, the converse also holds true, further supporting the negative impact of DOMA on the mental health disparity among LGBT populations.

Policy changes for DOMA are universally geared towards the complete rejection of this discriminatory bill. The nullification will result in the direct access to health care for partnered LGBTs through dependent sponsored coverage options and the opening of legal and financial benefits. Currently, the fate of law will be decided in the year 2015, as the United States Supreme Court has agreed to hear arguments on the constitutionality of the bill (BBC, 2015). However, pressure for the striking down of DOMA must be maintained in the event the law is upheld in court. This should include the lobbying to reject similar state laws that prohibit same-sex marriage.

Conclusion

In conclusion, health inequalities that lend to social pressure are classified as health disparities or inequities. Currently, there exist a health disparity for the LGBT community. Social pressure has placed the population at higher risk for a number of health problems including higher rates of suicides. In order to tackle this problem identification of appropriate health models is necessary. The Health Belief Model takes into account the susceptible nature of the population and lends to adaptability in the wide range of health disparities affecting LGBTs. Susceptibility and severity include the high rates of suicide and the financial burden following. Perceived benefits include the aversion of suicide. However, barriers include the financial cost of services and the belief that organizations may not understand LGBT ideals. Self-efficacy is of concern as social stigma and discrimination continue unabated. However, the population already has set into place a number of self-efficacy inducing ideals and programs.

The mission statement and primary goals of the programs help to maintain a consistent direction for the program. The target audience is composed on the LGBT individuals, healthcare providers, and governmental policy makers. The program design is centered on a health belief model approach. As such perceived susceptibility, severity, and benefits are important to implementing this plan. The use of education and program funding is essential in a successful mission. Weakness includes the fact that the LGBT population will consistently remain a minority group, and will be subject to the will of the majority. Strengths include that centralized physical location of two groups of the target audience.

In order to decrease continuing negative policies that hamper LGBT access to health care, a review of the ACA and DOMA was needed. Both are federal level laws that restrict and decrease access to healthcare for LGBT individuals. This has led directly to an increase in the

incidents of mental health disparities. In order to rectify this problem the incorporation of LGBT medical issues must be incorporated into healthcare training for upcoming and current healthcare practitioners. This can be accomplished through included mandatory training requirements built into the ACA. Furthermore, the ACA must begin to look at the quality of care for LGBT. This should include the exclusion of insurers who do not provide anti-discriminatory policies. The policy change for DOMA remains the complete striking of the federal law. This will open direct access to partner sponsored benefits. Through the use of policy change the mental health disparity can be reduced for LGBT individuals.

References

Ajzen, I. (2006, October). *TPB.* Retrieved from Theory of Planned Behavior: http://people.umass.edu/aizen/tpb.html

Albelda, R., Badgett, M. L., Schneebaum, A., & Gates, G. (2009). *Poverty in the Lesbian, Gay, and Bisexual Community.* Los Angeles, CA: The Williams Institute.

Albelda, R., Badgett, M. L., Schneebaum, A., & Gates, G. (2009). *Poverty in the Lesbian, Gay, and Bisexual Community.* Los Angeles: The Williams Institute.

Balsamo, J. (2005). Mission Impossible. *Journal of Environmental Health*, 4-69.

BBC. (2015, January 16). *US Supreme Court to rule on gay marriage*. Retrieved from News: US & Canada: http://www.bbc.com/news/world-us-canada-30855786

Buffle, W. C. (2011). Public Health Implications of Same-Sex Marriage. *American Journal of Public Health* , 986-991.

CDC. (2011a). *CDC Health Disparities and Inequalities Report — United States, 2011.* Atlanta, GA: Centers for Disease Control and Prevention.

CDC. (2011b). *Fact Sheet - CDC Health Disparities and Inequities Report - U.S., 2011.* Atlanta: Center for Disease Control and Prevention.

Centers for Disease Control and Prevention (CDC). (2011a). *CDC Health Disparities and Inequalities Report — United States, 2011.* Atlanta, GA: Centers for Disease Control and Prevention.

Centers for Disease Control and Prevention (CDC). (2011b). *Fact Sheet - CDC Health Disparities and Inequities Report - U.S., 2011.* Atlanta: Center for Disease Control and Prevention.

Centers for Disease Control and Prevention (CDC). (2014c, 10 December). *HIV Among Gay and Bisexual Men*. Retrieved from HIV/AIDS: http://www.cdc.gov/hiv/risk/gender/msm/facts/

Centers for Disease Control and Prevention (CDC). (2014c, 10 December). *HIV Among Gay and Bisexual Men*. Retrieved from HIV/AIDS: http://www.cdc.gov/hiv/risk/gender/msm/facts/

Champion, V., & Skinner, C. (2008). The Health Belief Model. In K. Glanz, B. Rimer, & K. Viswanath, *Health Behavior and Health Education* (pp. 45-66). San Francisco, CA: John Wiley and Son's.

Champion, V., & Skinner, C. (2008). The Health Belief Model. In K. Glanz, B. Rimer, & K. Viswanath, *Health Behavior and Health Education* (pp. 45-66). San Francisco: John Wiley and Son's.

Chance, T. F. (2013). "Going to Pieces" Over LGBT Health Disparities: How an Amended Affordable Care Act Could Cure the Discrimination That Ails the LGBT Community. *Journal of Health Care Law & Policy*, 375-402.

Dolnicar, S., & Hurlimann, A. (2009). Drinking water from alternative water sources: differences in beliefs, social norms and factors of perceived behavioural control across eight Australian locations. *Water Science and Technology*, 1433-1445.

Gosselin, G. (2009, May 11). Beliefs versus rights? Opponents of gay relationships complain religious values being threatened. *Michigan Lawyers Weekly*.

Journal of Global Health. (2011). Mission Statement. *Journal of Global Health*, 1.

Karim, A., Admassu, K., Schellenberg, J., Alemu, H., Getachew, N., Ameha, A., . . . Betemariam, W. (2013). Effect of Ethiopia's Health Extension Program on Maternal and Newborn Health Care Practices in 101 Rural Districts: A Dose-Response Study. *PLoS ONE*, 1-15.

King, N. B. (2014). Health Inequalities and Health Inequities. In E. E. Morrison, & B. Furlong, *Health Care Ethics: Critical Issues for the 21st Century Third Edition* (pp. 301-316). Burlingotn, MA: Jones and Bartlett Learning.

Mao, L., Kidd, M., Rogers, G., Andrews, G., Newman, C., Booth, A., . . . Kippax, S. (2009). Social factors associated with Major Depressive Disorder in homosexually active, gay men attending general practices in urban Australia. *Australian & New Zealand Journal of Public Health*, 83-86.

McAndrew, S., & Warne, T. (2010). Coming out to talk about suicide: Gay men and suicidality. *International Journal of Mental Health Nursing*, 92-101.

McKenzie, J., Neiger, B., & Thackeray, R. (2013). *Health Promotion Programs: A Primer; Sixth Edition.* Pearson Education Inc.

Meads, C., Carmona, C., & Kelly, M. (2012). Lesbian, gay and bisexual people's health in the UK: a theoretical critique and systematic review. *Diversity and Equality in Health and Care*, 19-32.

Montano, D., & Kasprzyk, D. (2008). Theory of Reasoned Action, Theory of Planned Behavior, and the Integrated Behavioral Model. In K. Glanz, B. Rimer, & K. Viswanath, *Health Behavior and Health Education* (pp. 67-96). San Francisco: John Wiley and Son's.

Mustanski, B., Birkett, M., Greene, G., Hatzenbuehler, M., & Newcomb, M. (2014). Envisioning an America Without Sexual Orientation Inequities in Adolescent Health. *American Journal of Public Health*, 218-225.

O'Donnell, S., Meyer, I., & Schwartz, S. (2011). Increased Risk of Suicide Attepts Amoung Black and Latino lesbians, Gay Men , and Bisexuals. *American Journal of Public Health*, 1055-1060.

Rekate, H. (2002). A Mission and Vision Statement for the American Society of Pediatric Neurosurgeons. *Pediatric Neurosurgery*, 1-7.

Scutchfield, F. D., & Keck, C. W. (2009). *Principles of Public Health.* Clifton Park, MA: Delmar Cengage Learning.

Stone, D., Luo, F., Ouyanf, L., Lippy, C., Hertz, M., & Crosby, A. (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*, 262-272.

Summers, J. (2014). Principles of Heathcare Ethics. In E. Morrison, & B. Furlong, *Health Care Ethics: Critical Issues for the 21st Century Third Edition* (pp. 47-64). Burlington, MA: Jones and Bartlett Learning.

United Nations. (2013). *Millennium Develpment Goals and Beyong 2015 : Goal 7 Ensure Environmental Sustainability.* New York: United Nations.

West, M., & Morrison, E. (2014). Hospital Ethics Committees: Roles, Memberships, Strusture, and Difficulties. In E. Morrison, & B. Furlong, *Health Care Ethics: Third Edition* (pp. 227-242). Burlington: Jones and Nartlett Learning.