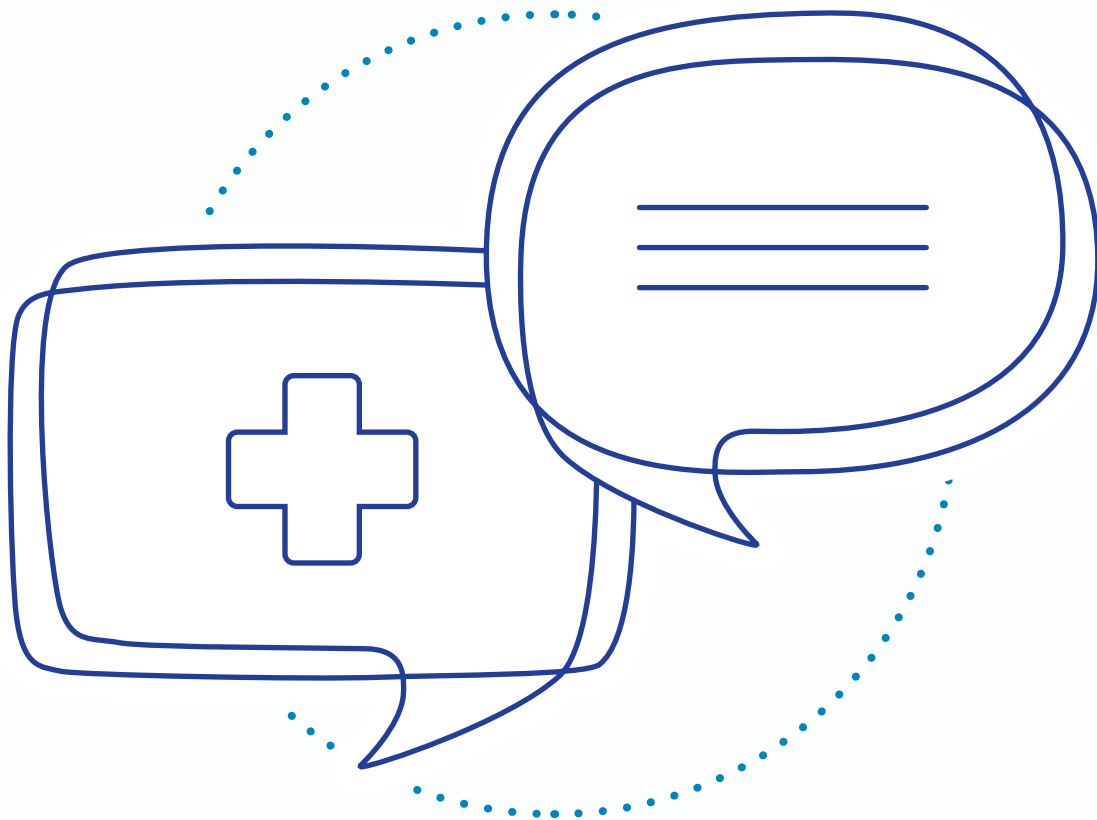


Integrated Behavioral Health Care for Transgender and Gender Diverse People

An Affirming, Harm Reduction, and
Trauma Responsive Approach

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NATIONAL LGBTQIA+ HEALTH
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THE CURRENT LANDSCAPE

Transgender and gender diverse (TGD) individuals are disproportionately affected by social determinants of health and have increased experiences of discrimination, delayed entry into health care, housing barriers, violence, psychological distress, likelihood of receiving mental health diagnoses, harassment, and fragmented health care.^{1,2} These disparities are heightened for people who embody multiple marginalized identities.^{3,4} Restrictions on insurance coverage and the lack of providers trained in gender-affirming care create additional barriers to positive health outcomes for TGD communities.^{5,6} Moreover, recent enacted and proposed state-level legislation to limit gender-affirming care will further silo provision of care and exacerbate inequities and disparities in TGD health outcomes.^{7,8}

Given the many barriers to accessing gender-affirming care, it is essential for health centers and other health care organizations across the nation to provide patient-centered, comprehensive, timely, and less stigmatizing and siloed models of care for TGD people. In this publication, we discuss how integrated behavioral health care delivered within affirming and trauma-responsive spaces is a promising solution for improving health care access, utilization, and outcomes for the TGD people in our communities.

¹ Kachen A, Pharr JR. Health care access and utilization by transgender populations: A United States transgender survey study. *Transgender Health*. 2020;5(3):141-148. doi: 10.1089/trgh.2020.0017.

² Tebbe EA, Budge SL. Factors that drive mental health disparities and promote well-being in transgender and nonbinary people. *Nat Rev Psychol*. 2022;1(12):694-707. doi: 10.1038/s44159-022-00109-0.

³ Garcia-Perez, J. Lesbian, gay, bisexual, transgender, and queer + Latinx youth mental health disparities: A systematic review. *J Gay Lesbian Soc Serv*. 2020;32(4):440-478. doi: 10.1080/10538720.2020.1764896.

⁴ Robertson L, Akre ER, Gonzales G. Mental Health Disparities at the Intersections of Gender Identity, Race, and Ethnicity. *LGBT Health*. 2021 Nov;8(8):526-535. doi: 10.1089/lgbt.2020.0429.

⁵ Learmonth C, Vilorio R, Lambert C, Goldhammer H, Keuroghlian AS. Barriers to insurance coverage for transgender patients. *Am J Obstet Gynecol*. 2018;219(3):272.e1-272.e4. doi: 10.1016/j.ajog.2018.04.046.

⁶ Turban JL, King D, Carswell JM, Keuroghlian AS. Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*. 2020;145(2):e20191725. doi: 10.1542/peds.2019-1725. Erratum in: *Pediatrics*. 2021;147(4):

⁷ Van der Miesen AIR, Steensma TD, de Vries ALC, Bos H, Popma A. Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers. *J Adolesc Health*. 2020;66(6):699-704. doi: 10.1016/j.jadohealth.2019.12.018.

⁸ Redfield E, Conron K.J (co-first authors), Tentindo W, Browning E. Prohibiting gender affirming medical care for youth. The Williams Institute, UCLA, Los Angeles, CA; 2023. Available from: <https://williamsinstitute.law.ucla.edu/publications/bans-trans-youth-health-care/>. Accessed June 30, 2023.

INTEGRATED BEHAVIORAL HEALTH CARE AS HARM REDUCTION

Behavioral health care that is thoughtfully integrated within primary care has been shown to provide timely entry into the health care system, address multiple presenting concerns, provide comprehensive whole person care, and reduce stigma associated with engaging in behavioral health services.^{9,10} Moreover, integrated behavioral health care has demonstrated reductions in health care costs as well as improvements in behavioral health access, quality measures, patient health outcomes, and provider satisfaction.^{9,10}

These benefits, taken together with the public health need to reduce suicidal ideation and attempts among TGD people,¹¹ lead us to conceptualize integrated behavioral health care as a form of low-barrier harm reduction—a model of care designed to meet patient needs at the point of care where they show up. As one of the most highly adopted definitions of integrated behavioral health care suggests,¹⁰ integrated care is characterized by patient-centered, team-based approaches that consider cultural, linguistic, and trauma-related factors when addressing patients' health care needs. Even in the absence of gender-affirming medical treatment, integrated care represents a central entry point into a plethora of health care services for patients including those who are TGD.



What is Integrated Behavioral Health Care?

Integrated behavioral health care is a systematic, team-based approach to providing patient-centered care. Primary (or specialty) care clinicians team up with behavioral health clinicians to address the whole person, including physical health, mental health, substance use, life stressors, and health behaviors. Integrated care teams also consider cultural, linguistic, and trauma-related factors when addressing patients' health care needs.

⁹ National Academies of Sciences, Engineering, and Medicine. Implementing high-quality primary care: Rebuilding the foundation of health care. Washington, DC: The National Academies Press; 2021. doi:10.17226/25983.

¹⁰ Peek CJ, the National Integration Academy Council. Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality; 2013.

¹¹ Dickey LM, Budge SL. Suicide and the transgender experience: A public health crisis. *Am Psychol.* 2020;75(3):380-390. doi: 10.1037/amp0000619.

FUNCTIONS OF INTEGRATED BEHAVIORAL HEALTH CARE

Integrated behavioral health care is traditionally implemented within the primary care setting, and as such, a well-implemented integrated care model fulfills the central functions of primary care.¹² The following functions originally outlined the role of primary care providers; however, they can be applied to anyone who works within this setting: continuity, comprehensiveness, coordination, contact-first, competence, cost-effectiveness, communication, collaboration, compliance, and competing demands. These functions support the idea of integrated care as a form of low-barrier harm reduction for TGD people. A case example illustrates this concept below.

Austin, an 18-year-old Black, queer-identified person, presented to a health center for a routine physical. This was Austin's first time receiving care at this health center. While completing the physical exam, the primary care provider noticed Austin's discomfort with discussing body parts. With further questioning, Austin shared frustration with being assigned female at birth, and discussed the realization of having a masculine gender identity. Austin stated that several health care providers refused to provide testosterone or a referral to a surgeon despite Austin's willingness to pay cash instead of using the health insurance provided under Austin's parents. Austin also reported symptoms of depression and anxiety, as well as feelings of shame.

After completing the physical exam, the primary care provider suggested that Austin meet with a behavioral health provider who was located within the health center to address depression and anxiety. Austin agreed, and the primary care provider facilitated a warm hand off between Austin and the behavioral health provider.

¹² Kroenke K. The many C's of primary care. *J Gen Intern Med.* 2004;19(6):708-709. doi: 10.1111/j.1525-1497.2004.40401.x.

During the visit with the behavioral health provider, which occurred on the same day as Austin's medical visit, Austin provided additional details regarding discrimination from other medical providers, bullying in school, feelings of isolation and rejection, and a strong desire to begin the medical transition to align with his masculine identity. Austin also shared suicidal thoughts that had been increasing within the last year.

When Austin shared his pronouns (he/him), the behavioral health provider changed them immediately in the electronic medical record. Austin expressed his relief and stated that no one had allowed him to "just be" in a medical visit before. After offering validation and affirmation regarding Austin's reported distress and providing brief behavioral health interventions, including psychoeducation and the introduction of anxiety management strategies, the behavioral health provider collaborated with the primary care provider to provide a menu of options that could be implemented as early as that same day. Austin expressed joy with being "seen as a real person".

On that same day, Austin met with the primary care team nurse, who educated him on the risks, benefits, and safe administration of intramuscular testosterone. Austin left his visit with a prescription for testosterone, a follow-up visit with both the primary care and behavioral health provider— and more importantly, a smile and hope for the future.

Primary care provided the access point into care that would ultimately reduce Austin's distress, increase his self-esteem, decrease his feelings of rejection and loneliness, and decrease his suicidal thoughts. The primary care provider recognized that Austin's response to his secondary sex organs appeared to reflect distress and, after sharing her concern with Austin (*communication*), facilitated a warm hand off to a behavioral health provider (*contact-first, collaboration*). This warm hand off decreased the need for a referral to a specialty provider (*cost-effectiveness*) and removed the barriers that additional wait time could pose to meeting Austin's psychological needs. After meeting with the behavioral health provider, Austin was able to collaborate with the integrated care team and initiate life-saving medicine on the same day that he shared his distress (*continuity*).

The primary care provider demonstrated comfort and willingness to initiate testosterone (*comprehensiveness*) even while managing the demands of completing the routine physical (*competing demands*). She also understood the importance of providing affirming, trauma-responsive care to individuals who have been harmed in the past (e.g., previous providers declining to initiate testosterone) and who hold multiple marginalized identities (i.e., Black and queer; *competence*). Austin also benefited from reduced barriers associated with refusal to be treated “as a real person” and the need for an endocrinology referral. In acknowledging Austin’s inherent worth as a person and in meeting his needs in a timely manner, the integrated care team reduced harm associated with delayed access to care, the consequences of psychological distress (e.g., suicidal ideation/attempts, increased depressive, and anxious symptoms), and health care discrimination.

Declining to meet Austin’s needs on that day, or submitting referrals that would take weeks to fulfill, or requiring a psychological evaluation, would have undermined Austin’s autonomy and lived experience and gone against the recommended informed consent model of initiating gender-affirming care.^{13,14} The health care team was aware of this (*comprehensiveness, competence*) and acted in line with Austin’s values and preferences and recommended evidence (*compliance*).

As demonstrated by this case example, integrated behavioral health care not only has the power to reduce harm and remove barriers but can also facilitate improved health outcomes, reduce health inequities, and minimize fragmentation that is often inherent within the health care system.

CONCLUSION

Integrated behavioral health care cannot eliminate all barriers and health inequities experienced by TGD people. It can, however, serve as a bridge to overall wellness, and can fulfill functions associated with primary care, and in doing so, can represent a low-barrier, harm reduction method of meeting patients’ needs. It can provide a setting to address mental health concerns that may arise from the process of negotiating one’s identity as a TGD person, being denied certain forms of health care, or navigating spaces where one’s value is diminished. Integrated behavioral health care can also help to facilitate the initiation and management of gender-affirming hormone therapy, thereby reducing the need for referrals to specialty providers, eliminating wait times, and enhancing patient and provider satisfaction.

¹³ Schulz SL. The informed consent model of transgender care: An alternative to the diagnosis of gender dysphoria. *J Humanist Psychol.* 2021;58(1):72-92. doi:10.1177/0022167817745217.

¹⁴ Wu CA, Keuroghlian AS. Moving beyond psychiatric gatekeeping for gender-affirming surgery. *JAMA Surg.* 2023;158(3):231-232. doi: 10.1001/jamasurg.2022.5828.

RESOURCES

Resources From The National LGBTQIA+ Health Education Center

Webinars

[Culturally and Trauma-Responsive Integrated Behavioral Health Care for LGBTQIA+ Communities](#)

[Trauma Informed Care for Transgender and Gender Diverse Patients](#)

[Mental Health Care for Transgender and Gender Diverse Communities](#)

[Health care Experiences of TGD People of Color](#)

[Addressing Opioid Use Disorders among LGBTQIA+ People through Trauma-informed Care and Behavioral Health Integration](#)

Learning Modules

[Behavioral Health Care for LGBTQIA+ People](#)

[Affirming Care for Transgender and Gender Diverse Children and Adolescents](#)

Publications

[Addressing Social Determinants of Health for Black LGBTQIA+ People](#)

[Addressing Opioid Use Disorder Among LGBTQIA+ Populations](#)

Additional Resources

Toolkit

Agency for Healthcare Research and Quality

[Integrating Behavioral Health and Primary Care Playbook](#)

Fact Sheet

American Psychological Association

[Behavioral Health Integration Fact Sheet](#)

Websites

Innovations Institute at University of Connecticut School of Social Work

[Center of Excellence on LGBTQ+ Behavioral Health Equity](#)

HRSA Health Center Program

[Behavioral Health and Primary Care Integration](#)

Press Release

US Department of Health and Human Services

[HHS Roadmap for Behavioral Health Integration](#)

REFERENCES

- American College of Physicians. (2023). Attacks on gender-affirming and transgender health care. Retrieved from <https://www.acponline.org/advocacy/state-health-policy/attacks-on-gender-affirming-and-transgender-health-care>
- Connors, J., Caseras, M. C., Honigberg, M. C., & Davis, J. A. (2019). LGBTQ health disparities. In Lehman, J., Diaz, K., Ng, H., Petty, E., Thatikunta, M., Eckstrand, K. (eds.) *The Equal Curriculum* (pp. 13-31). Springer, Cham.
- Dickey, I. M., & Budge, S. L. (2020). Suicide and the transgender experience: A public health crisis. *American Psychologist*, 75(3), 380-390.
- Garcia-Perez, J. (2020). Lesbian, gay, bisexual, transgender, and queer + Latinx youth mental health disparities: A systematic review. *Journal of Lesbian and Gay Social Services*, 32(4), 440-478.
- Kachen, A., & Pharr, J. R. (2020). Health care access and utilization by transgender populations: A United States transgender survey study. *Transgender Health*, 5(3), 141-148.
- Kroenke, K. (2004). The many Cs of primary care. *Journal of General Internal Medicine*, 19(6), 708-709.
- National Academies of Sciences, Engineering, and Medicine. (2021). *Implementing high-quality primary care: Rebuilding the foundation of health care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.
- Peek, C. J., & The National Integration Academy Council. (2013). *Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus*. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality.
- Redfield, E., Conroe, K. J., Tentindo, W., & Browning, E. (2023). *Prohibiting gender-affirming medical care for youth*. The Williams Institute, UCLA, Los Angeles.
- Reisner, S. L., Vettters, R., Leclerc, M., Zaslowsky, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental health of transgender youth in care at an adolescent urban community health center: A matched retrospective cohort study. *Journal of Adolescent Health*, 56(3), 274-279.
- Robertson, L., Akre, E-R., & Gonzales, G. (2021). Mental health disparities at the intersection of gender identity, race, and ethnicity. *LGBT Health*, 8(8), 526-535.
- Schulz, S. L. (2021). The informed consent model of transgender care: An alternative to the diagnosis of gender dysphoria. *Journal of Humanistic Psychology*, 58(1), 72-92.
- Tebbe, E. A., & Budge, S. L. (2022). Factors that drive mental health disparities and promote well-being in transgender and nonbinary people. *Nature Reviews Psychology*, 1, 694-707.
- Tordoff, D.M., Wanta, J. W., & Collin, A. (2022). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *Pediatrics*, 5(2), e220978.
- Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, 145(2), e20191725.
- van deur Meissen, A. I. R., Steensma, T. D., de Vries, A. L. C., Bos, H., & Popma, A. (2020). Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health*, 66(6), 699-704.
- Wu, C. A., & Keuroghlian, A. S. (2023). Moving beyond psychiatric gatekeeping for gender-affirming surgery. *JAMA Surgery*, 158(3), 231-232.

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