Importance of Behavioral Health Integration for LGBTQ People

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Learning Objectives

1. Describe unique combined physical and behavioral health needs of LGBT populations;
2. Explain the overall importance of behavioral health integration for providing optimal primary care to LGBT people;
3. Identify specific behavioral health integration strategies for improving the care of LGBT patients in primary care.
CASE EXAMPLE: K

- 30 y.o. white, nonbinary person AFAB, using they/them pronouns, who is partnered with a cisgender woman
- History of depression & anxiety dating back to mid adolescence, some of which they in hindsight attribute to gender dysphoria (not feeling comfortable with assigned sex and underlying upset at being misperceived and misunderstood)
- Attended a women’s college and identified as lesbian until coming to understand their identity as nonbinary and queer halfway thru.
- History of being significantly overweight and still have an elevated BMI, suspected PCOS, dx with type 2 diabetes in mid-20’s and are now on multiple meds for diabetes as well as for mood sx
- Not interested in pursuing medical affirmation of their nonbinary identity, so are not seeking hormone or surgical interventions---but they are not sure if this might change in the future.
- Partner is supportive of their gender, but comes from a background that equates food with love, so is often making statements or actions which make it hard for K to attend to their own nutrition.
Behavioral Health Disparities among LGBT People
Disparities among Gay and Bisexual Men

• Compared with straight men, gay and bisexual men are more likely to meet criteria for:
  – major depressive disorder (x 3)
  – panic disorder (x 5)
  – at least 2 co-occurring disorders (x 4)
Disparities among Lesbian and Bisexual Women

• Compared with straight women, lesbian and bisexual women are more likely to meet criteria for:
  – generalized anxiety disorder (x 3)
  – at least 2 co-occurring disorders (x 3)
LGB Mental Health Service Utilization

• Compared with general population, LGB people are more likely to:
  – See mental health provider (x 2-3)
  – See PCP for mental health problem (x 1.5-3)
  – Attend support or therapy group (x 3-4)

• Compared with general population, gay and bisexual men more likely to take psychiatric medication (x 4)
Depression and Anxiety among Transgender Adults

• Prevalence of clinically significant depressive symptoms:
  – 51% of transgender women
  – 48% of transgender men

• Prevalence of clinically significant anxiety symptoms:
  – 40% of transgender women
  – 48% of transgender men
Factors Associated with Higher PTSD Severity in Transgender Adults

- Higher everyday discrimination
- Greater number of attributed reasons for discrimination
- Social gender transition
- High visual gender non-conformity

ADVANCING EXCELLENCE IN SEXUAL AND GENDER MINORITY HEALTH
Factors Associated with Lower PTSD Severity in Transgender Adults

• Younger age
• FTM spectrum gender identity
• Medical gender affirmation
Substance Use Disorders among Transgender Adults

• Among 452 transgender adults in MA, increased odds of SUD treatment history plus recent substance use were associated with:
  – intimate partner violence
  – PTSD
  – public accommodations discrimination
  – low income
  – unstable housing
  – sex work

• SUDs increasingly viewed as downstream effects of chronic gender minority stress
Suicidality among LGBT Adults

• Lifetime prevalence of suicide attempts in the United States:
  – General adult population: 4%
  – LGB adults: 11-20%
  – Transgender adults: 41%
Suicidality among LGBT Youth

• Compared with peers, LGBT youth are more likely to:
  – report suicidal ideation (x 3)
  – attempt suicide (x 4, with 30-40% prevalence)

• Questioning youth more likely to experience depression or suicidality than LGBT peers
Minority Stress Framework

External Stigma-Related Stressors

Internal Stigma-Related Stressors

General Psychological Processes

Behavioral Health Problems

Physical Health Problems
Minority Stress Treatment Principles for Behavioral Health Clinicians

- Normalize adverse impact of minority stress
- Facilitate emotional awareness, regulation, and acceptance
- Empower assertive communication
- Restructure minority stress cognitions
- Validate unique strengths of LGBTQ people
- Foster supportive relationships and community
- Affirm healthy, rewarding expressions of sexuality and gender
Gender Identity and Co-occurring Psychiatric Disorders

• often impede gender identity exploration and alleviation of distress
• Need to stabilize co-occurring psychiatric symptoms for facilitation of gender identity discovery and affirmation
• WPATH guidelines for reasonable control of co-occurring disorders
Role of Behavioral Health Clinician in Gender Affirmation Process

- Fostering gender identity discovery and adjustment
- Presenting appropriate non-medical and medical strategies for gender affirmation
- Assistance in making fully informed decisions regarding personalized gender affirmation process:
  - relevant options
  - risks/benefits
  - evaluate capacity for medical decision making/informed consent
  - arranging suitable referrals to care
Gender-affirming Behavioral Health Care

• Gender identity, expression, and role
• Reducing internalized transphobia
• Improving body image
• Adjustment through affirmation process (physical, psychological, social, sexual, reproductive, economic, and legal challenges)
Addressing K’s needs using BH Integration model

- Screening in primary care setting
- Warm hand-off to embedded BH specialist
- Further assessment
- Brief intervention
- Continuation of or referral to longer term treatment
Combined Behavioral and Physical Health Needs of LGBTQ People

• Two examples:
  – Gender-affirming care
  – Substance use
Case Example - Dan

- 49 year old Caucasian gay male, not currently in a relationship
- History of depression, worse during the winter months, but takes anti-depressant medication which is currently managed by PCP
- No history of behavioral health treatment
- Makes appt with PCP following ending of a long-term dating relationship and reports difficulty with concentration/focus, motivation, and is having difficulty performing at work.
- Screens positive on SBIRT and upon further discussion disclosed increase in alcohol use after break-up as main source of coping
Addressing Dan’s needs using BH Integration model

- Warm hand-off to embedded BH specialist
- Further assessment (detox?)
- Brief intervention (psychoeducation, skill building)
- Continuation of or referral to multiple treatment options (inpatient, partial, outpatient)
Behavioral Health Integration (BHI)
What are the Types of BHI?

Spectrum:
- Coordinated
- Co-Located
- Integrated

(Heath, 2013)
Coordinated

• Separate systems and facilities, issue driven
• Level 1
  • Minimal Collaboration
• Level 2
  • Basic Collaboration at a Distance
Co-Located

- Level 3
  - Basic collaboration on-site
  - Same facility, separate system
- Level 4
  - Close collaboration on-site with some system integration
  - Same facility, some shared systems
  - Driven by complex patients, regular face-to-face interactions, basic understanding of culture
Integrated

• Level 5
  • Close collaboration approaching an integrated practice
  • Same facility, some shared space, toward same team

• Level 6
  • Full collaboration in a transformed/merged integrated practice
  • Sharing all the same space within same facility
  • One integrated system of team care, roles and cultures blended
Fenway Health’s Spectrum of BHI: “open access”

1. 1340 Boylston St (Co-located): 4 primary care floors, 2 BH Specialists on coverage from 9a-5pm, use of pager system

2. Fenway: South End (Integrated): 1 primary care floor, 1 BH Specialist on coverage from 9am-5pm, no pager
Benefits

• 1340 Boylston (Co-Located): short coverage shifts, ability to move around in health center with pager, multiple BHS’s to provide back-up coverage when needed

• Fenway: South End (integrated): immediately available for consultation, strong connection with medical floor/teams
Challenges

• 1340 Boylston (Co-located): relationship building

• Fenway: South End (Integrated): long coverage days, lack of back-up coverage

• Both locations: productivity expectations
Models of Treatment

• Primary Care Appointments (1-4 sessions)
• Short-term therapy (1-12 sessions)
• Non-traditional Approach (phone, email, warm hand-off)
• Episodic Care (3-6 months with treatment plan review)
System Wide Benefits of BHI

• Immediate access to BH support/triage
• Improve provider confidence and competency to manage complex clients
• Reinforce team approach for care
• Reduce stigma/barriers to care
• “strike while the iron is hot”
Why Implement BH Integration?

• Improved Patient Experience
• Improved Population Management
• Potential Cost Savings
Patient Experience

1. Improving the patient experience
   • Reducing stigma (including dual stigma of mental illness and LGBT minority status)
   • Mind-body holistic approach to health

2. Improving access to care
   • Primary care clinics are more accessible
   • Reducing operational inefficiencies
   • Reducing cultural barriers among medical and behavioral health providers
   • “Striking when the iron is hot”
Population Management

- Universal screening
- Prevention and early intervention
- Managing co-occurring disorders
- Outcome-driven with performance measures
- A long-term goal of sexual orientation and gender identity data collection
Cost

• BHI expected to lead to cost savings
• Important since behavioral health care is poorly reimbursed in a fee-for-service model
Summary

• LGBTQ people have disproportionate prevalence of depression, anxiety, substance use disorders, suicide attempts and trauma.

• LGBTQ people often have unique combined physical and behavioral health needs, including gender affirmation or living with HIV/AIDS.

• Advancing behavioral health integration in primary care can improve access, engagement, value, and health outcomes for LGBTQ people.
PAIRS DISCUSSION: in your own practice settings

- How are you already implementing BH integration?
- What are your successes?
- What are your challenges?
- If not already doing, how might you begin?
- Intersection of LGBTQ affirming care and BH integration?
THANK YOU
References


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