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Providing essential gender-affirming telehealth services to transgender youth during COVID-19: A service review

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Abstract

The COVID-19 pandemic has had significant effects on service delivery for transgender and gender diverse youth. Many in-person services were suspended in response to the need to follow quarantine and social-distancing guidelines, at both the state and national levels. In response, our pediatric gender clinic adopted a rapid implementation of telehealth services to provide access to gender affirming care. However, there exists little guidance on how to provide gender-affirming care via these platforms. In this article, we provide a narrative review of the development of a full-scale model for delivering telehealth services to transgender and gender diverse youth and their families during the COVID-19 pandemic. We also discuss the benefits and drawbacks of telehealth services for transgender and gender-diverse youth and focus on the continued need for advocacy around systemic barriers to care.

Keywords

Telehealth, telemedicine, telecare, COVID-19, gender services, youth

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Introduction

The Gender Multispecialty Service (GeMS) at Boston Children's Hospital is the first pediatric institution in the US to provide multidisciplinary, gender-affirming care (GAC) to children, adolescents, and young adults. Many adaptations to our treatment delivery methods have been made to acclimate to the evolving needs of our clients and in response to the voices of the transgender and gender diverse (TGD) community. However, despite the proven benefits of telehealth services, the GeMS clinic did not offer these services prior to March of 2020. This changed with the emergence of the COVID-19 pandemic and in response; GeMS converted all in-person mental health (MH) services to telehealth over the course of one week. This adaptation was consistent with other subspecialty clinics across the country.[1,2]

Since the inception of telehealth services in GeMS, our MH team has completed over 3300 virtual visits. While some MH services have returned to an in-person model, telehealth services have proven to be very popular with patients and clinicians, a trend that appears to be supported in emerging literature.[1–3] In fact, we anticipate that at least 50% of MH visits in our clinic will remain virtual post-pandemic. In this article, we provide a narrative review of lessons learned when adapting our MH services to provide essential GAC to clients via telehealth, and how this process led to innovations in our clinical practice.

Telehealth and GAC

Telehealth services in general have only started to be examined for use with the TGD community. Thus far, it's been found that TGD individuals are interested in utilizing telehealth for medical-related care and counseling; additionally, clinicians are utilizing tele-consultation services for the provision of care.[4–8] Prior to COVID-19, one study with transgender youth found that those who participated in a virtual counseling session for HIV testing and prevention expressed high satisfaction levels and said they would recommend the service to others.[5] Often telehealth is presented as a modality to increase access to care and to

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reduce barriers (e.g. travel, finances, etc.).[2] However, there is currently limited evidence regarding the outcomes of telehealth services for the TGD community. Furthermore, many clinicians have received little-to-no telehealth training. Despite these concerns, telehealth appears to be a popular option with TGD people and many are open to the idea of care being conducted virtually.[6,8,9]

Pandemic considerations for TGD youth

COVID-19 has created many additional risk factors for LGBTQ youth as a whole.[10–19] Specifically, TGD youth were at increased risk for mental health concerns pre-pandemic due to myriad factors such as health disparities, emotional distress related to gender dysphoria, rejection from social supports like family, and societal discrimination. With the ongoing pandemic, many of these risk factors have become further exacerbated for LGBTQ youth,[20–22] especially as society began experiencing increased mental health stress due to COVID-19.[23] The need to socially distance and quarantine has led many individuals to be cut off from vital social supports in their community, such as chosen family and school support, and to possibly be at the mercy of non-affirming home environments.[11–15,19] With this in mind, it is very clear that GAC is an absolute, lifesaving necessity and needed to continue with as little interference as possible despite the ongoing pandemic.[12,16,17] Telehealth services offered this necessary continuity of care, as well as an opportunity to address increasing mental health distress.[23]

Clinic innovation

Within weeks of the pandemic hitting the US, GeMS suspended all in-person services to align with national guidance. This halt to services was both unexpected and jarring for TGD youth and their families as well as for the clinicians serving them. In an effort to preserve access to GAC, our clinic's MH team quickly created new protocols to adapt all in-person services to telehealth. This call to action was met within one week of the declared federal emergency from FEMA, allowing for both established and new clients to continue seeking GAC, as there was no disruption to services.

Emergency and safety protocols

To promote our goal of providing safe and effective GAC, the identification of self-harm risk and general safety has been at the forefront of our work. Although important for every population, TGD individuals are at greater risk for non-suicidal self-injury (NSSI) and self-harm.[24] It is also well-established that TGD individuals experience higher rates of suicidal ideation and depression compared to cisgender counterparts.[10,13,25] They are also at greater risk for victimization and child abuse.[10,15,26] With this myriad of safety concerns in mind, it is crucial for clinicians to center on the safety and overall wellbeing of TGD people. Safety and wellbeing have become even more paramount during COVID-19 as a variety of clinical concerns have been exacerbated, particularly for LGBTQ youth.[10–22]

To address some of the unique challenges of telehealth, our MH team developed a safety and emergency protocol specifically for virtual visits. One innovation to our practice is to now ask for and record the current physical address and phone number of the client and the guardian/caregiver at the outset of every appointment. This information is absolutely crucial when working through a crisis so that it can be provided to emergency response teams. Our MH team also continued to use an internal on-call system for clinicians so that support may be offered during crises.

In the interest of adhering to evidence-based practices, our MH team also implemented routine screening for depression and safety risk by using the Patient Health Questionnaire-9 (PHQ-9)[27,28] and the Colombia Suicide Severity Rating Scale (C-SSRS)[29] with appropriate ages. During a telehealth visit, when youth are identified to be at risk for harm by screener results or clinician assessment, the MH clinician works to maintain the therapeutic rapport, discusses treatment options to promote safety and security, and collaborates with in-person support as appropriate. If an MH clinician assesses that an in-person crisis/emergency evaluation is warranted, such as for the suicidality of youth, they remain in the telehealth visit with the client until the emergency team is visible or until a trusted adult is able to transport the youth to the hospital.

Confidentiality and privacy

In tandem with safety concerns during telehealth visits are issues of confidentiality and privacy. Data has demonstrated that LGBTQ youth, especially TGD youth, are at greater risk for family rejection and hostility.[11–15,19] With this in mind, confidentiality, and privacy are of the utmost importance, as youth are often in their homes with family located in close proximity.[15] Our MH clinicians directly discuss confidentiality/privacy with youth and their families, typically at the beginning of appointments, to set appropriate expectations and boundaries.

As we embarked on telehealth, our clinicians quickly discovered and implemented many practical strategies for safeguarding confidentiality and privacy. A frequent recommendation is for youth to use headphones and/or the chat function embedded in the virtual software. Additionally, we (1) explicitly ask who is present with the youth, both on-and-off screen, (2) set clear expectations for when youth and adults will be together versus separate, and (3) confirm that adults and other family members have left the room when appropriate. Further, when independent interviewing with a TGD youth is needed and caregivers

are using a separate device, we have caregivers fully leave the virtual meeting rather than just muting microphones and turning off cameras. By having caregivers leave the telehealth visit, it ensures that they are not listening to the youth when speaking with a clinician. We believe these strategies help to ensure confidentiality and privacy.

It is important to note, that some TGD youth may not be comfortable utilizing telehealth because of their own worries about confidentiality and privacy, and therefore may feel that they cannot speak openly, particularly if they are in a non-affirming environment. In such cases, it may be best to recommend that the youth receive in-person services in order to maintain their confidentiality and privacy; this option has become increasingly available to youth as some in-person services have returned.

Virtual assessment

The GeMS MH team views assessment as a clinical intervention that serves several purposes: (a) to provide better context to and diagnostic information about gender dysphoria; (b) to facilitate family discussions about gender identity, affirmation of a youth's gender, mental health, medical transition, etc.; (c) to inform treatment recommendations; and (d) to identify goals that would facilitate readiness for the gender-affirming medical transition when indicated. Transitioning to telehealth presented unique challenges for the GeMS assessment process, notably around safety, privacy, and assessment validity. Given the importance and sensitivity of assessment data, which is often utilized in medical-decision making processes with youth and families, it was vital to ensure a safe and confidential process.

In order to address the assessment concerns, the MH team opted to create a separate evaluation session for telehealth clients that were dedicated to the administration and completion of the assessment measures. The assessment measures have been adapted from paper format to a mixture of standard PDF files and interactive, secure internet links. The guardian assessment forms are sent to guardians during this proctoring session and they are asked to complete them within one week. The youth complete all of their assessment forms during the virtual evaluation session with a trained professional who is available for support and who can ensure the youth's confidentiality and privacy. Continuing to provide an assessment to TGD youth and their families has been indispensable—allowing for continuity of care to persist throughout the pandemic.

Virtual psychotherapy groups

Members of our MH team created innovative and completely new virtual psychotherapy groups with the goals of creating access to therapy, and increasing community during a time of unprecedented lack of connection. Group workers intentionally create virtual, therapeutic spaces for TGD members to feel authentically seen, heard, and supported. This is accomplished pragmatically by: (a) members signing group contracts prior to joining; (b) ensuring confidentiality by members wearing headphones, making sure that no one can see members' screens other than the youth, and using password-protected links; (c) choosing a platform that allows members agency to change their name and pronouns; and (d) applying group theory to develop a culture of safety.

From March 2020 through January 2022, our GeMS MH clinicians provided 215 psychotherapy group sessions via telehealth; serving a total of 67 TGD clients. Feedback from TGD youth and families about the virtual psychotherapy groups has been positive, centering on increased access to care and the unique experience of being connected to other TGD youth with shared lived experiences. Our MH team plans to offer virtual psychotherapy groups beyond the pandemic.

Benefits and drawbacks of telehealth services

For the GeMS MH team during the pandemic, telehealth services have been the fundamental delivery method of life-saving clinical services. In many ways, telehealth capability has allowed our clinic to increase access to care and provide clinical services despite social distancing and quarantine realities. However, this is not to say that telehealth has been without its challenges. Therefore, we have laid out both the benefits and the drawbacks of our current telehealth model for working with TGD youth and their families.

Benefits

Telehealth has primarily helped with access to services. The majority of our clients come from the New England region of the US. This often requires clients to travel up to several hours multiple times a year to obtain services. This understandably leads to financial and travel burdens, and can sometimes discourage clients from fully utilizing MH services. Telehealth appointments have allowed clients to be seen at home, where they are often most comfortable, especially in a time of quarantine. Several clients have also felt more comfortable emotionally in their home environment and have greater access to a variety of coping skills, with pets being one of the greatest examples. Many TGD youth and their families have openly expressed their appreciation for the ease of access and continuity of care that has been offered via telehealth. Even as the COVID-19 quarantine and social distancing guidelines have been relaxed, families have continued to request that all of our MH services (e.g. intakes, evaluations, etc.) remain virtual;

therefore, our clinicians have continued to provide telehealth appointments. Additionally, clinicians are able to be more flexible with availability in a telehealth model as there are no physical limitations, such as needing a clinic room in a hospital or office. It has also been the general experience of our MH team that there are substantially fewer no-shows/cancellations.

Drawbacks

One of the primary hurdles that our MH clinicians have experienced with telehealth are technology difficulties. Due to the rapid adoption of telehealth services, several computer programming issues existed. Internet services have also been overloaded for both clinicians and clients, especially when more people were attending school remotely and working from home. While many clients had appropriate devices, there remain several access issues related to a family's ability to have a device and pay for the internet/cell data to support a streaming video service. At times and when appropriate, offering phone visits in lieu of video visits is necessary due to such financial and technology access issues for youth. Further, due to the sudden need for telecommuting, many families might need to use multiple devices at one time based on family members' school or work needs, all of which can negatively impact internet and technology bandwidth within a household. However, we must highlight how youth and their families have been extremely collaborative in working through technology and access issues in order to utilize telehealth.

Another drawback of telehealth is that a virtual platform is not the best, or most clinically appropriate, fit for everyone. For instance, some clients felt more uncomfortable talking to clinicians virtually and found it difficult to socially connect this way. Some TGD clients also found it difficult to look at themselves during virtual sessions as it exacerbated gender dysphoria; understandably, they find it uncomfortable being visible on screen.[6] However, there are coping strategies for this, including minimizing the video screen or covering up/minimizing their image on the screen to address this concern. These methods allow for the clinician to still see the youth, which is important for clinical work, while also offering a strategy to reduce dysphoria and associated distress. With these coping strategies, most of our patients continue to use, and even prefer telehealth visits.

Another important consideration, and possible drawback, is that telehealth software may display a person's legal name, which can also be a source of dysphoria and distress for TGD youth. However, using software that allows clients the agency to change their names on the screen to their affirmed names is a way to mitigate this drawback, and we encourage clinicians working with TGD youth to invite them to do this. Such drawbacks of telehealth offer opportunities for clinician support and advocacy.

Advocacy—future directions

Advocacy for and with the TGD community is a pillar of the GeMS MH team. The vulnerabilities of this population, including the fact that many are under 18, necessitate that clinicians engage in local, regional, and national advocacy efforts. While delivering telehealth services during COVID-19, we ran into several barriers that reaffirmed our commitment to advocating for greater access to GAC for TGD youth.

Licensure

GeMS is located in Boston, MA and clinicians see clients who travel from all over the US, with many clients concentrated in New England. Typically, with in-person services, licensure poses no concerns, as clients are seen in MA where all clinicians are licensed. However, with the onset of the pandemic and the switch to telehealth, systemic issues with licensure were exposed. Due to the rapid nature of our program's adaptation to a new telehealth model, clinicians had to sort through a significant amount of conflicting information and advice about licensure. To complicate matters, all states have different laws, rules, and processes for seeing clients via telehealth.

Our MH team is committed to providing care and felt it unethical to deny care to an already vulnerable population during a pandemic. Clinicians obtained temporary licenses, when possible, in nearby states, or counseled clients that they would need to be physically located in MA during their virtual appointment. However, this ongoing complication exposes major limitations of the current US licensure model. MH clinicians throughout the country currently do not have easy licensure reciprocity across state lines, which makes providing essential, telehealth services during a pandemic unnecessarily difficult. Additionally, GAC is often not easy to obtain, and there may be some geographical areas that are more limited than others. To deny GAC due to a geographical location is highly unethical and dangerous, especially as the rights of TGD youth continue to come under unprecedented legislative attack in the US. One way to mitigate this is by offering telehealth services, yet the complications of licensure for MH clinicians will continue to be a barrier, even after the pandemic. It is essential that there be continued efforts to advocate at a state, national, and international level for better access to GAC, such as through ease of licensure reciprocity.

Insurance

The pandemic has also highlighted the ongoing issue of insurance coverage for many clinicians in healthcare.

Prior to COVID-19, insurance coverage for MH-related telehealth services was inconsistent. However, during the pandemic, insurance coverage has been almost universal for these services. It has also been flexible, with MH clinicians being able to use multiple technology-enabled options (e.g. video software like Zoom, phone calls, etc.). This has been crucial while problem-solving for the many technical and access-related issues that clinicians encounter with telehealth, especially when working with an already marginalized population. With these considerations in mind, we implore that services should continue to be covered post-pandemic for several reasons including increased access to GAC, reduction of financial and travel burden, ease of having multiple caregivers present, the flexibility of scheduling, and freeing-up limited clinic space in hospital/office settings.

Conclusion

The COVID-19 pandemic created a need for clinics across the US to adapt their services to quarantine standards. While many clinics were forced to stop seeing clients early on in the pandemic, the GeMS MH team switched all of its services to a full telehealth model in one week. The development of our telehealth services has been invaluable by increasing access, reducing financial stress/travel burden, and allowing for connection in a time of extreme isolation and stress for TGD youth and their families. In sum, telehealth services in the GEMS clinic have truly been lifesaving and have significantly changed our model of care for the better. While there is still much unknown about the post-pandemic landscape, it is clear that telehealth services for TGD youth should be offered as part of the standard of care.

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