CARING FOR TRANS/GENDER DIVERSE YOUTH IN RURAL SETTINGS

Lessons learned on the frontier of New Mexico
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OBJECTIVES

➤ What does rural look like?

➤ What are challenges specific to rural settings for transgender youth?

➤ What are strengths specific to rural settings for transgender youth?

➤ From clinical to systems-based, what are some creative ways to mitigate challenges and bolster strengths?

➤ What are some ethical conundrums found in rural mental health care?
WHAT IS RURAL/UNDERSERVED?

➤ Whatever is not urban (based on population density and development “footprint”)
➤ Over 97% of US territory is considered rural
➤ 20% of the US population lives in rural settings
➤ Vast differences based on
  ➤ Geographic region
  ➤ Culture
  ➤ Economics
  ➤ Legal protections
➤ Undeserved area versus
➤ Underserved population
FUNDAMENTAL RURAL BARRIERS

➤ Roads, physical distance, limited infrastructure
➤ Poverty, lack of jobs, lack of insurance coverage
➤ Lack of internet access, cell phone reception/service
➤ Low number of providers
➤ Higher age of provider - retirement, up-to-date practices
➤ High turnover of providers and staff
  ➤ “The loss of the champion”
➤ Slow diffusion of best practices
➤ Funding streams specific to counties/populations
➤ Language barriers

RURAL IMPACTS ON HEALTH

➤ Increased infant mortality
➤ Increased at-risk health behaviors
➤ Increased injury, accidents
➤ Increased suicide rates (men, children)
➤ Higher rates of obesity, diabetes, heart disease
➤ Decreased rate of preventative services
➤ Decreased health literacy
➤ Decreased trust of healthcare providers
DOES SIZE MATTER?

➤ Size
  ➤ Physical number of resources = less options
  ➤ Less people = less supports
  ➤ Privacy
  ➤ Infrastructure, jobs, economics

➤ Climate
  ➤ Local laws/protections
  ➤ Culture of local businesses, places of worship
  ➤ Medical and mental health care culture - what if the only gig in town is a religious organization with trans exclusions?
  ➤ Visibility and community
  ➤ Proximity to urban area
THE GREAT INTERSECTION

- Transgender youth are already underserved
  - Survey of small group of TGD youth/guardians in Seattle
    - Lack of providers who know what they are doing
    - Inconsistent protocols followed
    - Uncoordinated care
    - Delays in starting puberty blockers/hormones
    - Insurance exclusions
- Trans youth social and health disparities
- Higher rates of depression, anxiety, trauma, substance use
- More intersectional identities - more experiences of social/health disparities

Higher rates of

- Feeling unsafe
- Bullying/harassment
- Missed school days

Less

- Staff support from school
- Supportive peers
- LGBTQ student resources
- School harassment policies

INDIVIDUAL RURAL YOUTH CONCERNS

- Privacy and impacts on family system
- Poverty and lack of insurance
- Limited resources (community centers, support groups)
- Regional culture
- Lack of access to media/internet
- Distance and poor infrastructure
- Lack of visible LGBT-specific communities/Lower number of visible or out peers/adults; lack of mentorship
- Loss of school, home and community without alternative options
- Trauma history with no long-term providers
- Gatekeeping practices that limit care to “specialists”
ALL THE POSSIBLE INTERVENTIONS

➤ Individual

➤ Family of origin or choice support**

➤ Child protective services, legal system

➤ Healthcare system
  ➤ Care delivery system
  ➤ Care coverage
  ➤ Education of workforce

➤ Education system**
CLINICAL ISSUES IN PRACTICE

- Pros/Cons of “specialty” gender practice in rural care
  - Deferred responsibility of other providers onto you
  - Promotion of stigma and marginalization
  - Risk missing other mental health needs of the youth
  - Trusted/known in the community
  - People will reach out for consultation/training
  - Youth feeling safer with an experienced clinician

- Confidentiality considerations
  - Where is the practice? Should you practice in or out of the community?
  - Are you known in the community for working only with TGD people?
  - Do staff/employees know each other or related to patients - clear confidentiality guidelines in your practice
CLINICAL ISSUES IN PRACTICE

➤ Transportation
  ➤ Flexible hour and/or creation of drop-in day to keep appointments flexible
  ➤ Phone sessions? Video sessions? Guardians via phone?
  ➤ Peers/families supporting each other for transportation
  ➤ Medical transport
  ➤ Make visits count

➤ Length of care/sustainability
  ➤ How long do you plan on serving this community?
  ➤ The longer you stay, the more people you know, the more networks you make, the more resources flow and connect
  ➤ If you’re planning on leaving, what’s the plan?
CLINICAL ISSUES IN PRACTICE

➤ Coordinating care
  ➤ Helps all clinicians stay on the same page
  ➤ Helps maintain consistency in care protocols followed for each youth

➤ BEST
  ➤ Working within primary care, pediatricians office
  ➤ PCMH model

➤ Care within the same system

➤ Care in different systems

➤ Benefits of rural
  ➤ Most people know you and have your number
  ➤ Quick interpersonal communications, care coordination and consultations
  ➤ Easy networking to find resources

➤ Meeting the care community
  ➤ Show up
  ➤ Listen
  ➤ Engage, then listen some more
CLINICAL ISSUES IN PRACTICE

➤ Burnout
  ➤ No one person can do it all
  ➤ Narcissism and sainthood and the pitfalls of both
  ➤ Don’t assume it’s all on you - don’t make clinical moves as a hero without thinking through it first (is it in the best interest of you or the patient?)
  ➤ What’s on you? What’s unmovable? What can be mitigated? What cannot?
  ➤ Delegate! Find your allies in other systems beyond your own
  ➤ Don’t duplicate services
  ➤ Before acting, always ask - how will this be sustainable?
  ➤ Try to not work alone - try to at least have case management, if not individual/family therapists
  ➤ Case management
  ➤ Case management
  ➤ Case management
MENTAL HEALTH ASSESSMENT IN RURAL SETTINGS

- Not enough clinicians to do them
  - MH clinicians disagree about the nature of the assessment
    - We have a MH collaborative to talk it out
    - The majority of the assessment is about what possible risks in the rural setting the youth may face and how to mitigate those
    - Other major issue in assessment is guardian approval/consent
  - Many youth started on hormone therapy without assessment
  - **Clinical intakes done by BH - serves as the “assessment”**
    - Triage for MH care as clinically indicated
    - Slow things down as clinically indicated
  - General protocol seen in New Mexico
    - Seen by pediatrician, endocrinologist, family practice
    - Screened for mental health
    - Referred as clinically indicated
      - Sometimes care held due to concerns
      - Sometimes care moved forward while also pending MH
  - If something goes awry, don’t panic, just start where the youth is at
ETHICAL ISSUES IN PRACTICE

➤ Should you connect youth you know to each other?
➤ Multiple roles/relationships (research story)
➤ Supporting transition even when it leads to bad social outcomes, worsening mental health issues
➤ Should you prescribe blockers, hormones?
➤ Harm reduction
➤ Being a member of the community
➤ Not being a member of the community
➤ Hearing about patients in other contexts (story)
➤ Boundaries (story of invite to Pueblo)
➤ Fertility services and lack thereof
INDIVIDUAL CLINICAL CONCERNS

➤ Coming out/confidentiality
   ➤ During social or physical transition
   ➤ During dating or sexual activity
   ➤ In different settings or contexts - home, school, etc
   ➤ Coming out about sexuality as well!

➤ Rural specific
   ➤ Limited pool of social supports
   ➤ Most people familiar with each other
   ➤ Risk of being outed by dating/sexual partner
   ➤ Limited options for alternatives in housing, places of worship, education
   ➤ Guardians and siblings impacted a great deal as well
   ➤ Family members, friends working in the the youth’s healthcare, education, legal system
   ➤ Youth living as “stealth”
WAYS TO DEAL

➤ Plan before hand if possible
  ➤ What are the youth’s goals? Stealth? Out to some? Out to all?
  ➤ When, to whom, how?
  ➤ Try to find one youth ally in each environment; what are some alternative social pools?
  ➤ Identify strengths/supports and areas that need to be bolstered
  ➤ Rely on any “cultural” ally you can find to help breech religious or other cultural barriers
  ➤ Review confidentiality policies at local school, healthcare system with the youth
➤ Address sibling and guardian concerns
  ➤ Sibling’s impact at school, at home?
  ➤ Guardians’ impact at employment, place of worship, with extended family
  ➤ Have family sessions to problem solve
  ➤ Allies in the workforce, unanticipated religious allies
➤ Dating
  ➤ What dating pool will the youth access and what risks do each incur? (apps? online?)
  ➤ Plan before hand if possible
  ➤ Addressing sexual violence in small communities
INDIVIDUAL CLINICAL CONCERNS

➤ Risk assessment
   ➤ Immediate safety concerns, exposure to violence, sex trafficking
   ➤ Use of street-purchased hormones, sharing injections needles
   ➤ Substance use
   ➤ Sex exchange work
   ➤ Risk of being ousted from home, community, education system

➤ Strength assessment
   ➤ Hopes, dreams, goals, aspirations
      ➤ Motivational interviewing for health behaviors
      ➤ Use strengths towards these goals
   ➤ Any supports in any areas (home, school, etc) - get creative
   ➤ Don’t just try to link to trans community - link to other intersectional strengths and communities (diversify options; story)
   ➤ Intersectional identities and strengths/communities associated with these
   ➤ Youth-lead solutions to perceived barriers and risks
INDIVIDUAL CLINICAL CONCERNS

➤ Harm reduction plans
  ➤ Extended family supports or non-family of origin supports
  ➤ Safe injection/needle sharing practices
  ➤ Anticipated trauma flares and how to handle them
➤ Helping a youth think through the pros/cons of being an advocate or mentor in their community
  ➤ Story: sometimes a policy win for many can hurt the individual involved
➤ Education options
  ➤ Home-schooling
  ➤ GED
  ➤ Charter schools
BUILDING TRUST

➤ Low trust of medical systems, clinicians
  ➤ Gatekeeping
  ➤ Lack of knowledge
  ➤ High turnover
  ➤ Trauma history
➤ You don’t know what you don’t know
  ➤ Listen - don’t assume challenges; hear out the strengths as well
  ➤ Find the “elders” in the TGD community
  ➤ Liaison with youth community centers to help build trust
  ➤ If there is someone doling out hormones on the street, try to gain trust of this person and encourage into care - rest will follow
➤ Involve community voices in your care service
  ➤ Youth-lead patient advisory counsels
  ➤ Family-focussed community supports
PROVIDERS

➤ Not enough
  ➤ Rely on care partners (clinical pharmacists, NPs/PAs)
  ➤ Speciality to step-down care with open-end collaboration
  ➤ What do to when you have one medical provider in the whole State?
  ➤ Providers don’t advertise for fear of being overwhelmed or ostracized
  ➤ Use of mental health trainees

➤ High staffing tuner over
  ➤ Yearly required online and/or in-person cultural trainings

➤ Sustainability
  ➤ Do not have a specialty service rely on one champion
  ➤ Try not to practice without case management and/or peer support workers - clinicians cannot do it all

➤ Vet all referrals (urology story)
EDUCATING PROVIDERS

➤ LGBTQ mental health collaboratives
  ➤ Case consultations
  ➤ Article/research reviews
  ➤ Expert lectures
  ➤ Getting on the same page about care protocols
➤ Mentoring
  ➤ Fenway through ECHO
  ➤ 1:1 mentoring
  ➤ Consultation with national gender centers
➤ National experts can help assuage fears
➤ Provide standardized form letters for prior auths, referrals
➤ Grand rounds, CME/CEU education talks
➤ Target training sites for social work, master-level clinicians, psychology and psychiatry trainees
➤ Share your materials
PROJECT ECHO

➤ Project ECHO (Extension for Community Healthcare Outcomes) – community education, mentoring, formation of long-term education and integrated teams

➤ Endocrine and HIV ECHO

➤ Serving New Mexico clinicians for consultation on TGD youth cases

➤ HIV ECHO

➤ Fenway is using UNM’s ECHO model for longitudinal training
HEALTH SYSTEM

➤ Maxed out systems already!
  ➤ Think before starting services about the who/what/when/why
  ➤ White Paper to help show structural direction of services, appropriate funding streams

➤ Time/staffing limitations for training
  ➤ Send key person in each health system area for yearly training
  ➤ Key person can dissipate up-to-date knowledge to entire team

➤ Mobile services

➤ Care collaboratives
  ➤ All on the same page with care protocols
  ➤ All know each other, can do quick consults
HEALTH SYSTEMS

➤ Insurance coverage
  ➤ Network
  ➤ Prior auth person can save clinicians from burnout
  ➤ Establish a paper trail of individual cases to build case for coverages for all
  ➤ Get insurances up-to-date on standards of care - don’t be afraid to call, call again, call again some more
  ➤ “Domino effect”

➤ Funding
  ➤ Collaborate on grant streams - don’t compete
  ➤ Ensure what populations/geographical areas the grant covers
  ➤ What after grand funding ends??
EDUCATION SYSTEM

- 1:1 advocacy or collaboration with individual person at a school
  - Remember: champions are good for as long as they are around
  - Find sustainable options and ensure your champion is mentoring others
  - LGBTQ adults in rural education face their own battles too (story about my error)
  - Safe Zone training

- **Health educators to run GSAs, perform HIV and Hep C, sex and health ed**

- Advocate for youth to change school districts and resources to do so, as indicated

- Intervention with individual school’s policy, administration

- Advocacy or intervention with the school board or district policies
  - Districts often copy each other - find one district to set up a model policy and often the others will follow

- Find state GLSEN chapter to help review and or support State-based student protections

- Work with national-based organizations to help promote State-based policy changes for TGD students
  - Title IX can help support systems to change
TGD YOUTH EMPOWER

- Transgender Resource Center of New Mexico
  - Family and youth support groups, education
  - Needle exchange
  - Safe lockers to store goods during the daytime
  - Links to clinicians in the area
  - Rapid HIV, hep C testing
  - Coordination of care with Truman, DOH
  - Limited on-site medical services
  - On-site therapy services
- Teen NMPower
  - Youth support group
  - HIV prevention for LGBTQ youth
  - Lavender Prom
- Santa Fe Mountain Center
  - Intersectional identity empowerment for Native Youth
  - Day camp for transgender youth
  - Harm reduction
  - Training for MH providers
- Community based participatory research
- Peer support workers

Queer Youth United

A FREE, overnight event for LGBTQ+ Youth and Allies ages 13-24

Network with peers from across the state

Participate in workshops from community organizations & connect with nature!

June 10-12

Contact chris@santafemc.org for more information, or
RSVP at tinyurl.com/QueerYouthUnited
TAKE AWAY POINTS

➤ Be part of the community - doesn’t have to be LGBTQ-related, but you need to know your community, key players, systemic-issues with infrastructure and medical delivery

➤ Sometimes, it is who you know

➤ Listen

➤ See what’s already being done - can you augment, support, change, grow, add?

➤ Change can happen in small or big ways - any effort for change is enough

➤ Don’t work alone, in spirit or clinical practice

➤ Think before acting and consider sustainability in all you do

➤ Empower youth by including them in the questions and answers

➤ Rely on a youth’s and rural area’s intersectional cultural strengths
QUESTIONS?