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Strengths-based behavioral telehealth with sexual and gender diverse clients at Center on Halsted

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Abstract

The COVID-19 pandemic necessitated an immediate response and rapid transition from traditional face-to-face behavioral health services to behavioral telehealth at an organization serving sexual and gender diverse (SGD) individuals in Chicago. In this practice innovations article, we explore the unfolding public health crisis and the impact on service delivery for SGD individuals. Using a large multi-service organization as a case study, this paper describes how key members of the staff and leadership team shifted services online as a means of responding to isolation, loneliness, and disparities in access to healthcare for Chicago SGD communities. Lessons learned and practice recommendations are presented.

Key words: Sexual and gender diversity; lesbian, gay, bisexual, transgender, and queer+ (LGBTQ+) communities; telehealth; telemedicine; behavioral health; counseling

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Introduction

The COVID-19 pandemic is a crisis affecting the health and well-being of people across social, cultural, and linguistic identities (Díaz-Jiménez et al., 2020; World Health Organization, 2020), including sexual and gender diverse (SGD) communities (which include lesbian, gay, bisexual, transgender and queer [LGBTQ+] individuals). The National Association of Social Workers ([NASW], 2020) commented that COVID-19 is not only a health crisis, but also "...a crisis of social injustice, inequitably affecting vulnerable and marginalized populations that include, among others, individuals who earn low incomes, or are incarcerated, homeless, in foster care, over the age of 65 (especially those in long-term care), Black, Indigenous, and People of Color (BIPOC), or undocumented" (n.p.). Over the past several years, public health officials have promoted adopting telehealth to reduce barriers to healthcare for underserved populations (Centers for Disease Control and Prevention, 2016; Illinois Department of Public Health, 2020).

Telehealth typically refers to a broader scope of remote services to support health and mental health-related matters, health information dissemination, and education via phone or an online platform (e.g. Zoom). *Telemedicine* is often defined more narrowly as real-time, live online or phone interactive communication(s) between a client and medical provider that meets the standards for financial reimbursement (Chaet et al., 2017; Dombo et al., 2014; Zhou et al., 2020). While sometimes referred to as *telemental health* or *telebehavioral health*, we use *behavioral telehealth* to describe these online interactions. Behavioral telehealth can include behavioral health (BH) services via one-one or group interactions through videoconferencing, telephone, text messages, emails, forums, or smartphone apps (Zhou, et al., 2020).

In this practice innovations article, we explore the unfolding COVID-19 health crisis and the impact upon SGD communities using a case study stemming from the immediate and continued response by Center on Halsted (COH), a non-profit organization located in Chicago serving SGD communities. COH was able to quickly pivot many of its services online such as behavioral health due to the relaxing of Health Insurance Portability and Accounting Act (HIPAA) regulations (Wright & Caudill 2020). This allowed COH to effectively respond to meeting the needs of all SGD clients, as well as technical challenges experienced by older clients, and immediately address existing barriers to care (e.g., transportation and travel costs). We use a strengths-based, empowerment perspective to examine how this organization rapidly adapted to the new situation. We also show how COH continues to provide BH services to meet SGD people's needs while drawing upon existing support systems and enhancing a sense of community-based empathic care.

Background and Literature

Challenges related to isolation and loneliness for members of SGD communities across all age cohorts may stem from a myriad of oppressors arising from the individual and systemic promotion of homophobia, transphobia, cis-sexism, heteronormative ideology, and discrimination (Harper & Schneider, 2003; Perone et al., 2020). While experiences of rejection, internalized stressors, and prejudicial experiences, underscored by minority stress, may elevate challenges for SGD people, individual and group resilience can ameliorate these stressors (Meyer,

2015; Singh, 2017). Nonetheless, health and mental health stressors remain a problem for certain members of Chicago's SGD communities, particularly for people of color. The city remains incredibly segregated by race/ethnicity, socioeconomic status, sexual orientation, and gender identity/expression with many SGD people living within northside neighborhoods such as Edgewater, Lakeview, Rogers Park, and Uptown (Morten et al., 2019). Regardless of such challenges, the *Illinois Human Rights Act* (2006) and City of Chicago (2018) *Human Rights Ordinance*, note that Chicago and Illinois have some of the most progressive policies protecting LGBTQ+ people from discrimination (e.g., housing, healthcare, employment). However, findings from the 2019 *Chicago LGBTQ+ Community Needs Assessment* of over 2,000 respondents underscore many ongoing inequalities related to culturally responsive and comprehensive healthcare services, affordable housing, workforce development, social services, and violence prevention (Morten et al., 2019).

As a result of the urgency in addressing the immediate BH needs of all diverse communities during the COVID-19 pandemic, the use of behavioral telehealth became a pressing consideration. A rapid response was required with little preparation or training by most organizations (Kopelovich et al., 2020). State licensing standards and billing policies had not envisioned the need for a rapid rollout of behavioral telehealth (Pinals et al., 2020). Such services became a necessity for all those in need of home-based phone and online health and mental health care. As many minorities, including SGD individuals, are disproportionately impacted by physical and mental health risk factors (Atteberry-Ash et al., 2019; Bennett & Gates, 2019; Dentato et al., 2019; Fortuna et al., 2020; Lloyd et al., 2020; Lyons et al., 2020; Newcomb et al., 2020), the need for behavioral telehealth cannot be understated, especially amid a global pandemic. In fact, synchronous and asynchronous connections associated with behavioral telehealth must not be overlooked, especially for specific segments of SGD communities (e.g., youth, mature adults), to promote support while reducing isolation during COVID-19 (Fish et al., 2020). Previous research in this area reveals positive results stemming from access to telehealth advisor services associated with health literacy; the use of internet resources; better access to support and guidance; alleviating anxiety; and improving self-management and care provision

overall (Salisbury et al., 2016). Social workers in health care have a role in building guidelines for behavioral telehealth practice, as well as ongoing evaluation of its effectiveness in addressing positive behavioral change, improving access to healthcare, and addressing chronic health conditions (Alencar et al., 2019; Fitzner et al., 2014; Richter et al., 2015; Touger & Wood, 2019).

Telehealth technology has made a positive contribution and impact upon reducing health disparities (Tarlow et al., 2014). Ongoing research must continue to examine the importance of utilizing telehealth with diverse populations as there are mixed perceptions of its effectiveness, use, and impact upon African Americans and Latinx people (George et al., 2009, 2012), youth (Myers et al., 2008), and older adults (Cardozo & Steinberg, 2010). Relatedly, there remains a lack of research examining the impact of behavioral telehealth and its usage among SGD client populations, who may also be members of the above diverse groups.

Recent research in this area underscores the need for culturally affirming and responsive telehealth and telemedicine services, increased health workforce training, and expansion of care (Waad, 2019; Whaibeh et al., 2019). A feasibility study of twenty-five gender diverse women of color in Washington D.C. found that culturally responsive telehealth interventions help improve outcomes and increasing the utilization of services; it can also be a low-cost solution, addressing barriers to treatment for minority groups in need of such care (Magnus et al., 2018). Ultimately, there is a specific need for the critical and urgent expansion of research examining the potential reach and impact of telehealth and telemedicine use among transgender and gender diverse clients (Asaad, et al., 2020).

Center on Halsted

Since 2007, Center on Halsted (COH, 2020b) has been located on the north side of Chicago in a neighborhood known as ‘Boystown’ or East Lakeview, offering convenient services within a largely SGD residential area. The mission of COH is to *“advance community and secure the health and well-being of the LGBTQ+ people of Chicagoland*" with a vision to create “*a thriving [LGBTQ+] community, living powerfully in supportive inclusive environments*" (COH, 2020a, n.p.).

COH provides a wide array of BH programming provided by a team of diverse mental health therapists offering services. These services include in-person and online individual and

group therapy and providing letters of support for gender affirmation surgery and care. Current therapy groups focus on topics and populations including COVID-19; BIPOC; people living with HIV/AIDS; transgender, gender diverse and non-binary people; and queer women.

BH services are provided on a fee-based structure for individuals with insurance as well as for people with no insurance or via sliding scale. Grants also cover free services for youth, people who have experienced trauma, and individuals living with HIV from lower socioeconomic groups. The BH department also offers training for graduate and doctoral students across disciplines through the Sexual Orientation Gender Institute (SOGI) and co-hosts a biannual LGBTQ+ Health and Wellness Conference with Northwestern University's Institute of Sexual and Gender Minority Health and Wellbeing and Emory University's Prism Health Program (COH, n.d.).

In addition to BH programming, COH provides services for SGD youth, women, gender diverse communities, HIV/AIDS testing and care, senior services including housing in partnership with Heartland Alliance, cultural events, a cyber center, legal, and anti-violence programming as well as ongoing LGBTQ+ community events. Due to the aforementioned available resources and programming, COH quickly adjusted with a rapid expansion of behavioral telehealth services. At the start of the COVID-19 pandemic, these services helped meet the needs of the widely diverse LGBTQ+ community across all neighborhoods, especially those most in need on the far south and west sides of the city.

Strengths Perspective and Empowerment-Based Care

In response to societal discrimination, SGD people in North America developed the first advocacy groups to advance their rights during the early 20th century (e.g., Homophile Movement, Daughters of Bilitis, Gay Liberation Front, Street Transvestite Action Revolutionaries). These groups laid the vital groundwork for developing SGD-focused community centers that emerged in the 1970s and early 1980s and thrived in the absence of an adequate federal response to HIV/AIDS (Martos et al., 2017). Center on Halsted and other such community centers have been essential to developing, implementing, and supporting strengths and empowerment-based practices at the individual, family, and community levels. A strengths-based approach is consistent with a care-based ethics which values relationship and caring for people (Ross, 2020;

Ross et al., 2021).

As Saleebey (2012) noted, the strengths perspective recognizes the value of individuals, their communities, and the environments in which they live. It prioritizes empowerment-based practice by placing clients' strengths and holistic well-being at the center of client-worker-agency relationships. While strengths and empowerment-based practice has a long history in social work (Kelly & Gates, 2016), practice with SGD communities has historically lacked an empowerment perspective (Gates & Kelly, 2013, 2017).

Center on Halsted (2020c) is grounded in this tradition of strengths and empowerment-based, grassroots, community-focused services for Chicagoland LGBTQ+ communities. A review of the programming at COH highlights a holistic approach, including LGBTQ+ focused BH services, vocational training, and outreach programming for historically oppressed LGBTQ+ groups (e.g., BIPOC, young people experiencing homelessness, older adults), anti-violence training, and legal support. BH services at COH provide space for developing interpersonal skills, discussing relevant challenges, and fostering a sense of community and pride.

A sense of community has been described in the literature as the extent to which individuals feel as though they can be invested, safe, secure, and influential among a group of people or in a geographical space (Gates & Lillie, 2020; McMillan & Chavis, 1986). SGD people who have a sense of community tend to feel a sense of belonging, shared identity, and psychological closeness, which is associated with community resilience and well-being (Frost & Meyer, 2012; Lin & Israel, 2012). During the initial outbreak of COVID-19, clients at COH, many of whom relied upon the relationships formed through groups, needed social contact more than ever. Existing groups all transitioned into an online format hosted on Zoom which was difficult for some clients, particularly older adults, necessitating telephonic case management.

Services that could not be easily transitioned online continue to be offered in the office. For example, HIV testing continues to occur in larger conference rooms using plastic barriers and personal protective equipment. When social isolation became necessary, COH considered dispensing Pre-Exposure Prophylaxis (PrEP) via home-based delivery to people not HIV positive but at higher risk for contracting the virus. These personal visits provided important social

contact for people who otherwise may have few social connections during COVID-19. Additional strengths, challenges and innovations led by COH staff members in consultation with their SGD client populations are further described below.

Strengths, Challenges, and Innovations: Behavioral Health and COVID-19

Strengths and Innovations

Staff Flexibility

Staff flexibility was crucial as the gravity and reality of the COVID-19 crisis quickly took hold in Chicago during March 2020. COH's leadership team, in consultation with members of the BH department and other outward-facing direct service teams (e.g., HIV services), worked quickly to make decisions with an empowerment and strengths-based perspective, shaping how the organization would respond to the crisis and serve community members. For example, BH therapies were moved to behavioral telehealth with the easing of HIPAA regulations and resultant procedures to bill services to insurance companies and Medicaid.

BH staff members and clients initially experienced technical issues, and some clients missed and longed for in-person connections. Nevertheless, anecdotal reports from COH clinical social workers and other BH staff indicated clients attended nearly 98% of all scheduled behavioral telehealth appointments. Notably, there has been a historical assumption within BH that in-person services offer more significant benefits than telehealth models when the opposite is often quite true for many clients (Powell et al., 2017; Pruitt et al., 2014). Additionally, COH staff members worked quickly to address financial barriers related to the costs and access to adequate equipment (e.g., laptop and desktop computers). For some clients this involved using telephone contact or assisting clients with installing the Zoom app on their phones for case management services, counseling sessions, and tech support.

Reduced Social Barriers

The COVID-19 public health crisis provided a unique testing ground for the assumption that service delivery changes would result in increased client access to programming at COH. Anecdotally it appears that there are some clients who more strongly adhere to telehealth appointments for BH than in-person appointments. While formal research is needed to determine

which factors might influence greater adherence to behavioral telehealth appointments, some initial ideas emerging from social worker-client interactions include the removal of barriers for clients, including transportation (e.g., missing buses or trains, reducing travel costs), scheduling and disorganization due to medical and BH issues (e.g., substance use issues, chronic fatigue, and dementia), and unstable housing or residential location far from COH.

With some of these barriers removed (i.e., transportation), other restrictions become less of an obstacle (i.e., scheduling, disorganization, unstable housing or location) to accessing services via behavioral telehealth. In fact, some clients might appreciate the physical barrier provided via behavioral telehealth through a phone or laptop screen. It is possible for some clients that the intimacy offered via in-person services may be too much and the barrier of a screen provides an additional level of safety. See Table 1 below for an overview of strengths, challenges, and innovations.

***** INSERT TABLE 1 HERE *****

Engagement with Geographically Diverse Communities in Chicago

Additionally, several other community-based services were moved to a behavioral telehealth model in response to COVID-19. One of the more striking examples is Teen Hang, which is a social group for LGBTQ+ identifying youth aged 13 to 18. While it may seem challenging to engage young people socially, let alone through remote devices, the program has seen success in engaging LGBTQ+ youth and providing them with a non-judgmental space to connect and explore their gender identity, gender expression, and sexual identities in an affirming way.

Non-judgmental space is significant for LGBTQ+ youth experiencing homophobia, transphobia, heterosexism, and the resulting isolation (Garcia et al., 2020; Kattari et al., 2016; Kelly & Ratliff, 2017), which may be compounded by COVID-19 social distancing requirements. With behavioral telehealth moved online, it is possible to envision an ongoing future scenario where COH, located on Chicago's northside, can provide more extensive services to SGD people living on the far south and west sides of the city. Given Chicago's historical segregation (Rosenberg, 2017) and the real-time challenges of traveling to the northside to receive services (e.g., time, distance, cost, safety), behavioral telehealth could be of benefit to more isolated SGD

communities. Additionally, COH could also provide safe and affirming spaces for young, trans, and queer people in more remote regions across North America. Much of this will depend upon how behavioral telehealth services are supported by relaxed HIPAA laws and the ability to bill for services.

Challenges

Familiarity with Technology

Despite promising developments in behavioral telehealth during COVID-19, several lessons were learned and opportunities were discovered in COH's rapid move to behavioral telehealth services. Technology barriers were initially a challenge for several clinical social workers and other BH staff and clients. As there was no initial training for staff or clients in using Zoom, many learned to engage in these services "on the fly." BH staff who were not familiar with using Zoom were able to use online training videos to teach themselves to use Zoom and search for standards of best practice. Several staff members completed continuing education training on telehealth and the ethical challenges of providing services online. Yet, several clients, particularly mature adults, had trouble adapting to the online space and shared some embarrassment due to a lack of knowledge about using such online formats. In addition to many being first-time Zoom users, some clients at COH had additional challenges with operating cameras, access to functioning computers, adequate internet speed, remembering passwords, and clicking the correct links.

Confidentiality and Safety

Confidentiality has also been a potential issue for several clients. Though clinical social workers and other BH staff have been required to set up a private and quiet workspace, having privacy has not always been possible for several clients. Some clients expressed concerns related to confidentiality with using technology and certain formats (e.g., Zoom). Other clients residing in shared housing with family members or roommates may have faced challenges with confidentiality when others are present. For clients with caregiving responsibilities, carving out time to be alone for BH services has been challenging. Clients experiencing intimate partner violence may have had to limit contact or conceal their conversations to keep themselves safe.

Interpersonal Contact

Additionally, missing social contact with one another at Center on Halsted's office has been challenging for several clinical social workers, BH staff members, volunteers, and clients alike. Many of COH's clients are yearning to return to the office, as they enjoy the process of getting ready for their appointments, preparing mentally for their session, socializing in the lobby, and interacting with others. For many clients, COH serves as an important source of social contact with their friends and being out in a safe and affirming environment. Staff equally miss the routine of working in the office. While several BH staff understandably have shared concerns about returning, as they do not wish to place their loved ones at risk, they are eager to return to the daily routine and business at COH. Staff want to show solidarity with the community by being present at COH and look forward to ensuring that safety precautions remain in place to make their presence a reality.

In sum, all of these changes and innovations outlined above and addressed by COH staff are premised in and enabled by an empowerment and strength's based approach to practice. Promoting self-determination and focusing on everyone's strengths and abilities in the face of adversity (e.g., a global health pandemic), COH was able to place the needs of their client's voices first, listen to their concerns, and innovatively address challenges in service delivery.

Discussion and Future Directions

COVID-19 has disrupted services for SGD people and other potentially at-risk communities in Chicagoland, prompting service providers to use telehealth interventions to keep SGD communities engaged in care and services. BH services at COH, including individual and group therapy for people living with HIV/AIDS, survivors of violence, SGD, BIPOC, and youth have been delivered via behavioral telehealth. While the shift to behavioral telehealth has presented new challenges and opportunities, including overcoming technology barriers, clients and staff remain actively engaged, showing one another care during these challenging times.

Several important lessons have been learned from COH's rapid uptake of telehealth technology. Whereas COH once operated under the assumption that traditional BH services offered in a face-to-face format best served clients of the organization, they discovered that

telehealth provided an equally successful form of engagement. Success was noted particularly for clients who experience multiple psychosocial issues, chronic scheduling and disorganization issues, and difficulty with transportation. Appointment attendance, even when factoring in technical difficulties, improved during COVID-19. While clients may have better attendance because their lives have become less complicated (there was less rearranging of appointments that complicated their schedules) behavioral telehealth is a viable form of service for SGD people. COH expects that some clients may want to continue via telehealth after COVID-19.

Organizations considering a transition to behavioral telehealth services should be competent with and aware of technology access issues. While internet access has become more ubiquitous, some clients may be unfamiliar with technology platforms such as Zoom and Google Meet. Furthermore, they may not have the financial means to purchase a smartphone, tablet, or laptop capable of running the required software or have unlimited internet access. Organizations must also consider the impact of intersectional diversity factors, including race and ethnicity, gender identity, age, and sexual orientation, related to the likelihood of BH engagement. Engagement in traditional, face-to-face BH such as counseling may not be the norm in every community or across every demographic. Engaging in behavioral telehealth may feel like an even more significant leap for some individuals. Reliability issues, such as dropped video sessions, might complicate engagement in services. Health care organizations should have protocols for responding to such technical challenges. In some instances, if the individual is having trouble with telehealth services, it may be necessary to reschedule, move the conversation to a telephone call, or consider a socially distanced face-to-face meeting. Organizations must respond to these challenges by developing policies and comprehensive behavioral telehealth training and education for clinical social workers and other BH staff providing telehealth services. Staff will also benefit from training on risk assessment using behavioral telehealth including but not limited to, how to respond to suicidality, risk of harming others, or family violence.

Future research in social work in health care should systematically evaluate the effectiveness of behavioral telehealth interventions with SGD people. While the experiences outlined at COH suggest that the shift to behavioral telehealth may have been an effective stopgap

measure during COVID-19, future research should evaluate the risks and benefits associated with a change to behavioral telehealth. This research should include an examination of intersectional and social factors that facilitate or hinder engagement. Not all individuals are equally able to engage in telehealth, and future projects should examine who is best served using such technologies short-term and long-term alike.

Table 1.

Strengths	• Well-trained, flexible, and cohesive administration and staff at COH within all departments (e.g., BH, HIV) • Rapid response with services developed and implemented via an empowerment, strengths-based, and client-centered approach and framework • Easing of HIPAA regulations and focus on reducing other barriers (e.g., transportation, financial)
Challenges	• Technical issues (e.g., using Zoom, operating cameras, access to computers, adequate internet speed, remembering passwords, etc.) • Financial barriers related to the cost of equipment due to low or fixed incomes • Clients missing social and personal connections • Client embarrassment related to lack of technical knowledge, the ability to navigate such challenges on their own, or with telephone assistance • Lack of trust with technology and confidentiality • Additional privacy and confidentiality concerns associated with online services due to clients living in shared spaces, not being out to parents, IPV, etc.
Innovations	• HIV testing with plastic barriers • Home delivery of PrEP • Case management, counseling, and tech support all flexibly provided via phone • Transportation and travel costs eliminated with online services • More flexibility with scheduling appointments • Engaging clients from remote locations across the city increased connectivity and reduced isolationism

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