



Vitality: A Health Sciences Journal

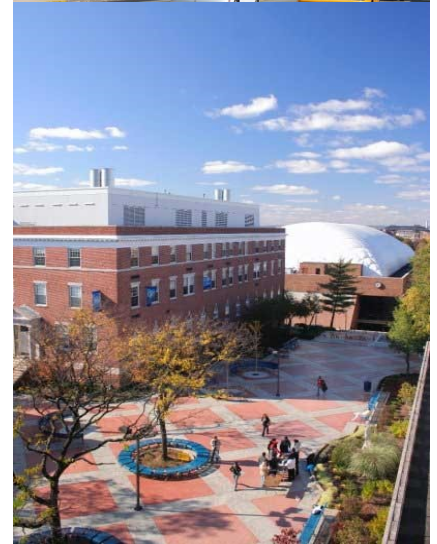
Immigrants and Health Vulnerability:

By Naiva Altenor 23'

Introduction Current data suggest that 40 percent of immigrants, defined as non-citizens, compared to 20 percent of United State born citizens, had no medical contact since migrating to the United States; this means, no in person visits at doctors, clinics, or other medical facilities (Fuentes et al.,2022). Immigrants are a vulnerable population, facing many challenges that can impact their health and well-being (Gallo, Penedo, Espinosa de los Monteros, & Arguelles, 2009). Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations. The high percentage of non-citizen immigrants without medical services, coupled with their vulnerable status, suggests a need to examine health disparities in this population—with a special focus on mental health. Furthermore, it is imperative to explore the additional challenges that children of immigrants may face as they endeavor to both assimilate to their new surroundings and support their caregivers' during the stressful, transitional journey to a new land.

Health Disparities in Immigrants Immigrants face a variety of challenges that can impact their health and well-being including language barriers, cultural differences, lack of access to healthcare, and discrimination. Studies have shown that immigrants are more likely to experience poor mental health outcomes than the general population (Murray et al., 2021); specifically, they are more likely to experience depression, anxiety, and post-traumatic stress disorder (PTSD) (Garcia et al., 2018). Disparities in mental health outcomes can be attributed to a variety of factors, including cultural differences, lack of access to healthcare, and discrimination.

Approximately 50 percent of American families receive health insurance through their employment (Rodriguez et al, 2009). One of the biggest barriers to healthcare for immigrants is the lack of health insurance—they are less likely to be insured and this compounds the difficulty in seeking help for mental health issues (Jani et al., 2019). Even when immigrants have health insurance, they may face language barriers or cultural barriers that prevent them from seeking care. In addition to the lack of health insurance, immigrants may also face other financial barriers to accessing healthcare, such as high deductibles or copays, resulting in unaffordable mental health care for some (Murray et al., 2021). Additionally, recent studies have shown that language barriers and cultural differences can lead to mistrust of healthcare providers and may prevent immigrants from seeking care, even when they have health insurance (Chen et al., 2018). Another factor that contributes to mental health disparities in immigrants, is discrimination that may present itself in a variety of ways. Discrimination can take many forms including racism, xenophobia, and prejudice; all of which may increase stress and anxiety compounding mental health issues (Garcia et al., 2018). **Childhood Mental Health in Immigrant Families** First- generation immigrant children may face additional challenges to optimal mental health and well-being. Children of immigrants may face language barriers, cultural differences, and discrimination, negatively impacting their mental health outcomes. Studies have shown that children of immigrant parents are more likely to experience anxiety and depression than children of non-immigrant parents (Zhang et al., 2020), with one of the biggest challenges they face being acculturation stress. Acculturation stress is the stress that comes from trying to adapt to a new culture (Mitra et al., 2018). (please see page 7 to continue)



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Children Living In Poverty and Health

By Kinlee Bruns 23'

Introduction In 2021, an estimated 37.9 million Americans lived in poverty, of which 16 percent were children (American Psychological Association [APA], 2022). There can be extensive challenges to health and well-being when children are living below the poverty line, including exposure to environmental toxins, living in dangerous settings, barriers to high-quality healthcare (Christie-Mizell, 2022), and increased risks of untreated conditions (Bloch et al., 2011). Low-income households experience economic insecurity, which influences educational opportunities and age-appropriate child development when compared with more economically secure households (Cottrell et al., 2014).

Environmental Impact Higher rates of crime, poverty, and unemployment in disadvantaged areas have an impact on children's mental and physical health (Christie-Mizell, 2022). Children who live in high poverty areas often have subpar housing and an increased exposure to stressful and traumatic situations, all of which are linked to poor health outcomes (Barrett et al., 2021). The leading cause of death among children currently in the U.S. is unintentional injury, with the highest incidents occurring in Black, American Indian, and Alaska Native children (Centers for Disease Control and Prevention [CDC], 2022). Barrett et al. (2021) investigated the relationship between poverty and rates of juvenile fatalities from firearms, revealing that fatalities were 4.6 times more common in the counties with the highest percentage of poverty compared to counties with the lowest concentration of poverty.

A safe environment is not only needed to prevent unintentional death, it is essential for creating occasions for physical activity opportunities. Caregivers have a valid concern about allowing children to play outdoors in crime-ridden areas, resulting in fewer places to engage in safe play (Weir et al., 2006). Regular physical activity is associated with optimal development, strong bones, weight management, mental and emotional well-being, academic performance, and lowers overall risk of morbidity (CDC, 2022). One of the social determinants of health is neighborhood and built environment; the high incidence of unintentional injuries compounded by limited opportunity for movement can profoundly alter children's health outcomes (CDC, 2022).

Developmental Impact Ideally, a young child's life is ripe with opportunities to elevate early childhood development (ECD), which encompasses motor, intellectual, linguistic, and emotional development (Gil et al., 2020). Developmental delay, or failing to meet predicted age-appropriate milestones, is influenced by many variables, some of which are parental negligence, the absence of stimulation, food deficiency, and poverty (Gil et al.). Ongoing stress from living in poor and destitute surroundings, impacts a child's neurodevelopment and raises the risk of poor academic achievement (Garner et al., 2012). Enduring encounters with community poverty may lead to poor grades, lower test scores, and can result in lower educational attainment (Hair et al., 2015). Hair et al. (2015) investigated 389 individuals, ages 4 to 22, to establish that children residing in households below

the poverty line scored between 4 and 8 points less on achievement assessments. An inadequate childhood education with fewer resources, decreases the chance of optimal growth, can have a persistent impact into adulthood (Gil et al.) affecting health outcomes and the ability to access high-quality care.

Healthcare In the United States, child poverty continues to rise, having a broad impact on health outcomes and widening the gap in health disparities (Racine, 2016). Many low-income households cannot afford basic healthcare as they lack health insurance or experience coverage issues, which results in an increase in untreated conditions in children (DeVoe et al., 2008). Guendelman et al. (2005) conducted a study and found that working poor people had about four times the odds of being without insurance and 2.6 times the chance of experiencing coverage interruptions. Federal-state programs that provide health insurance for low-income children have been expanded to give this vulnerable group more access to healthcare, but issues still exist for those that are outside of the threshold (Racine). Children living in poverty experience inadequate and unreliable treatment plans that increase the dangers to their short-term health and well-being, affecting their long-term prospects at having a fruitful and disease-free life (DeVoe).

Conclusion Inequities have a substantial influence on the health and well-being of children living in poverty, compounding their inability to access health insurance—viable solutions are imperative (Spencer et al., 2018). The ideal situation would be for all children in the United States to have consistent access to high-quality care, with special attention given to children who are tremendously impacted by health disparities as a part of an underserved family and community (DeVoe et al., 2008). Given the tremendous impact it may have on a child's future, empowering and prioritizing daycares, schools, and the community networks may be a strategy to reach all children and increase their chances of developing optimally (Gil et al., 2020). Children's well-being can be enhanced by involving them in more physical activities during school hours or daycare, as home environments may present a greater risk for accidental harm or injury. The disparity in health and medical care experienced by American children living in poverty, along with the increased risk of untreated illnesses and exposure to dangerous environments, all impact a child's capacity to develop in ways that are age-appropriate—reform is imperative in order to achieve equality (Lee et al., 2020).



Homeless Mothers and Children By Avery Tan 23'

Introduction Families, primarily women with young children, make up between 30 and 40 percent of the estimated 3.5 to 4.5 million homeless people in the United States (Williams & Hall, 2009). Homelessness, defined as a situation in which a person or family sleeps outside or in a shelter offered by a homeless aid organization, is a significant sign of poverty and hardship (Radcliff et al., 2019). Challenges among the homeless are many, including lack of shelter, inadequate food, and poor access to support services (Radcliff et al., 2019). Homeless mothers are faced with additional problematic barriers associated with lower socioeconomic status, including difficulty securing childcare, unstable housing, and access to mental health support (Reilly et al., 2018). Major depressive illness appears to be more common among low-income homeless mothers; in addition, children who are raised by homeless mothers with depression, experience poorer medical, emotional, and educational outcomes (Bassuk & Beardslee, 2019). The data suggest that homelessness and poverty contribute to this increased incidence of depression among homeless mothers, having a significant short-term and long-term impact on the overall wellbeing of their children (Bassuk & Beardslee, 2019). To compound matters, mental illness can interfere with a mother's ability to secure safe housing and services, reducing further her opportunities to become self-sufficient (Bassuk & Beardslee, 2019).

Barriers of Homeless Mothers Challenges for homeless mothers can lead to feelings of discouragement, disappointment, and hopelessness (Bassuk & Beardslee, 2019). The housing and resource struggle may exacerbate feelings of depression and despair (Bassuk & Beardslee, 2019). A mother's ability to become self-sufficient and fully support her children, is impacted by a lack of marketable skills, higher education, and consistent job history (Bassuk & Beardslee, 2019). Joblessness, homelessness, and depression can make it extremely hard for these mothers to raise their children effectively, and inadvertently may have a deleterious effect on their growth, development, and academic performance (Bassuk & Beardslee, 2019). Receiving assistance with long-term safe housing and food security, can minimize some of the concerns for homeless mothers (Bassuk & Beardslee, 2019). Research investigating people who experienced multiple traumas, found that homeless mothers experienced on average 12 potentially traumatic life events, which is more than twice the average of five trauma exposures among the general population (Williams & Hall, 2009). In association with the level of trauma, these women may experience being disregarded and misunderstood, with their trauma remaining undiagnosed—leaving them among the most vulnerable of populations (Bassuk & Beardslee, 2019).

Caring for Children Children of homeless mothers experience a higher frequency of emotional and behavioral disorders that impact their overall health, emotional wellbeing, and educational outcomes (Bassuk & Beardslee, 2019).

Some homeless mothers with depression are unaware that they lack adequate parenting skills (Bassuk & Beardslee, 2019). Research found homeless mothers were more inclined to be disengaged, lack predictable routines, and use harsher disciplinary strategies with their children (Bassuk & Beardslee, 2019). Furthermore, these mothers exhibited a lack of child development knowledge and provided little learning stimuli (Bassuk & Beardslee, 2019). Child Care assistance is a critical arm of resource support that can benefit both mother and child (Charkhchi et al, 2018). Unfortunately, homeless children under the age of two are reportedly more likely to require hospitalization, experience more frequent trips to urgent care, and have fewer well-baby visits (Bassuk & Beardslee, 2019). These children are also more likely to have emotional and behavioral disorders, attachment issues, cognitive vulnerabilities, difficulty in interpersonal connections, lack of school preparedness, and poor school performance (Bassuk & Beardslee, 2019). Data demonstrate higher rates of both internalizing and externalizing disorders among children of homeless mother's starting in preschool, while teenagers had 2 to 4 times higher rates of depression (Bassuk & Beardslee, 2019).

Housing and Food Insecurities Food insecurity is defined as "access by all people at all times to enough food for an active, healthy life" (Coleman-Jensen et al., 2011, p. 1). There are many items to address along the road to becoming self-sufficient for homeless moms and their children, and that includes the constant threat of food insecurities (Charkhchi et al., 2018). Food and housing insecurity result in poorer overall health, with increases in lifestyle related diseases such as obesity, hypertension, and diabetes (Charkhchi et al., 2018). Research shows that 12.7% of American households in 2015 experienced food insecurity, meaning that none of the members of the household had access to enough food to live an active, healthy existence (Charkhchi et al., 2018). Given there is a correlation between food insecurity and negative health outcomes, it is important to note that homeless mothers and children are at risk for many health problems that arise due to not having adequate, nutritious foods.

Discussion As a result of their difficult circumstances, many women who are facing homelessness feel defeated, despondent, and hopeless (Bassuk & Beardslee, 2019). The chances of locating and maintaining housing as well as achieving financial independence are limited by access to available support services (Bassuk & Beardslee, 2019). It is imperative that homeless mothers and their children receive housing and food security to decrease their burden, improve their short term and long term health outcomes, and ultimately achieve self-sufficiency (Charkhchi et al, 2018). Access to child care assistance, job security, and mental health support are reasonable aspirations, and will enable mothers to provide adequate support for their children and create an acceptable level of comfort and stability for herself and her family (Charkhchi et al., 2018).

Health Disparities Among Inmates

By Katherine Sciglimpaglia 23'

Introduction Every year that someone spends in prison cuts their life expectancy by two years (McCann, 2022). Five years in prison can increase the odds of death for a person by 78%; as a result, the overall life expectancy in the United States has decreased (Widra, 2017). Correctional healthcare is low-quality, difficult to access, and expensive (Prison Policy Initiative). Inmates have a higher burden of chronic diseases such as hypertension, diabetes, asthma, chronic liver disease, and HIV than non inmates (Kulkarni, Baldwin, Lightstone, Gelberg & Diamant, 2010). There are no conditions or diseases that are unique to prisons, but many are more prevalent due to prison conditions such as airborne infections, shared injecting equipment, anxiety, or depression (World Health Organization).

Prisons are normally for people who have been convicted of a crime and they tend to be larger populations of inmates, while jails detain people awaiting trial or sentencing and are smaller than prisons (Nelson, 2022). Local law enforcement departments administer jails, and prisons are run by the state or the federal government. Individual states with their own prison system operate state prisons, compared to federal prisons which are run by the federal government (Nelson). There are also several types of federal prison facilities: prisons hold convicted criminals, penitentiaries are for long-term incarceration, and correctional institutions are focused on rehabilitation (Nelson). Because prisons and penitentiaries are for longer terms compared to jails, these facilities often house inmates that require more consistent care. The healthcare provided in prisons should be consistent with that in infirmaries, subacute-care hospitals, hospices, and nursing homes (Bick, 2007).

Health of United States Prisoners The health of and the health care for prisoners is generally worse than the general population and inmates are more likely to suffer from illnesses and diseases (Wilper et. al, 2009). Inmates are also at high risk for tuberculosis, with correctional inmates reportedly suffering from tuberculosis at rates as high as ten times that of the general population (MacNeil, Lobato & Moore, 2005). From 1993 through 2003, the percentage of tuberculosis cases among local jail inmates increased from 42.8% to 53.5%, whereas cases among federal inmates increased from 2.9% to 11.8%. Case rates for the 11 years studied were 29.4 per 100,000 for federal prisons and 24.2 for state prisons (MacNeil, Lobato & Moore).

Jail populations have repeated exposure to infectious diseases, difficulty of access to treatment for chronic health conditions, interruption in continuity of care for serious behavioral health conditions, and on-going issues for the prevention and treatment of substance abuse (Trotter et. al, 2018). Among inmates in federal prisons, state prisons, and local jails, 38.5%, 42.8%, and 38.7%, respectively, suffered from a chronic medical condition (Wilper et. al, 2009). **Access to Medical Services** The National Commission on Correctional Health Care sets standards and offers accreditation to jails and prisons for health care services, but many facilities do not choose to participate (McCann, 2022).

Among inmates with a persistent medical problem, 13.9% of federal inmates, 20.1% of state inmates, and 68.4% of local jail inmates had not received a medical examination since being incarcerated (Wilper et. al, 2009). The high percentage of inadequate care can be deadly to these populations as they are more prone to a wide range of chronic diseases (McCann). People held in prisons are required to pay copays of \$2 to \$5, but they are only making between \$0.14 to \$0.63 per hour from the paid employment they may secure while in prison (McCann, 2022). At that rate, it can be comparable to the general population making minimum wage and paying a couple hundred dollars for a copay. For example, in Massachusetts the copay for a prisoner is \$3 while their prison job minimum wage is \$0.14, so an inmate must work for approximately 21.43 hours to afford one copay (Sawyer, 2017). The equivalent copay at minimum wage for the general population would be \$235.71. Copays can jeopardize health for incarcerated people and cause them to hesitate before deciding to seek treatment (National Commission on Correctional Health Care).

Improvements There are many improvements that can be made for inmate health care such as making health care systems in prison nonprofit and autonomous from prison authorities; increasing communicable disease education, prevention and treatment; improving care for chronic conditions; increasing availability of addiction and mental health treatment; maintaining Medicaid eligibility for inmates; and improving the planning of inmates' discharge (Wilper et. al, 2009). Disease education and prevention are ways to improve the health of inmates while they are incarcerated and may impact their health behaviors post incarceration. Focusing on Medicaid eligibility while inmates are incarcerated can make the discharge process more efficient. Being prepared for inmates' discharge can be an effective way to improve health care access for inmates after they are released and impact recidivism.

Jails do not have policies in place for acute and chronic illnesses because federal policies do not allow for Medicaid to treat prisoners (Trotter et. al, 2018). Medicaid will not pay for inmates' medical care while they are in prison or jail, but if they enroll in Medicaid while being incarcerated, then they may be able to get health care more quickly after being released (HealthCare.gov). Applying for Medicaid while incarcerated will in turn improve the planning of inmates' discharge process. There are more than 600,000 ex-offenders released from state and federal prisons annually and approximately nine million from jails, and ex-offenders often have trouble accessing care due to a lack of health insurance and adequate discharge planning (Kulkarni, Baldwin, Lightstone, Gelberg & Diamant, 2010).

Conclusion Inmates are more susceptible to many chronic conditions due to close living proximity and living conditions. Jails have repeated exposures to many infectious diseases and a high percentage of inmates at prisons and jails have suffered from a chronic medical condition. The healthcare system should treat prisoners humanely, contributing to the possibility of returning them to society as functioning members.



(Inmates Continued) Correctional facilities have low quality health care that is difficult to access and expensive (Prison Policy Initiative). Almost 70% of jail inmates had not received a medical examination since being incarcerated (Wilper et. al, 2009). Prisoners are required to pay copays with the little money they are making while incarcerated which affects the likelihood of getting an appointment. Improvements that should be made regarding the health disparities of inmates include Medicaid eligibility and adequate planning for inmates' discharge (Wilper et. al, 2009). While this will improve the process after being released, inmates also deserve humane treatment while they are incarcerated. The healthcare system should treat prisoners humanely, contributing to the possibility of returning them to society as functioning members.

Foster Care Youth Face Challenges to Optimal Health By Nieyajaha Harris 23'

Introduction 391,000 youth in foster care are among some of the most vulnerable individuals impacted by health disparities (Key facts and Statistics,2023). Many of the children in foster care come from homes where they received maltreatment such as different forms of abuse, neglect, and parental substance abuse (Font,2020). Surveys show maltreatment increases the chance of suicidal thoughts by three times, and the chances of suicide attempt by three to fourteen times (Taussig,2014). As a result of these traumatic experiences, they may be more likely to experience physical and mental health issues (Taussig,2014). Once they enter the system, the youth have a better chance at receiving screening, health services, and treatments, because not only do they have access to healthcare, but they also have caregivers who are held accountable for their health (Fortin,2009). Once these youth leave the system, they no longer have accountability, and this may explain the decline in the utilization of care and services. Every year 29,500 foster care youth age out or are emancipated from foster care (Villagrana,2016). These emancipated youth often enter the world feeling unprepared and fall victim to circumstances such as homelessness and unemployment. Homelessness and unemployment are usually good indicators that they will stop using the necessary physical and mental health services. There are many physical and mental health disparities impacting foster care youth and the use of healthcare services. **Chronic Illness Disparities in Foster Care Youth** Researchers found that foster care youth have poorer health outcomes than the economically secure youth of the general population. The foster care youth often come from economically insecure backgrounds, and this may have limited their access to quality healthcare prior to entry (Ahrens,2014). Youth from economically insecure backgrounds are less likely to: (1) report health status, (2) have insurance, and (3) report their lack of insurance when compared to youth with economically secure backgrounds (Ahrens,2014).

It is evident that socioeconomic backgrounds may determine risk factors and may be helpful in assessing chronic illness. The socioeconomic backgrounds of those in foster care not only affect the care to which they have access, but also where they live,—this environmental factor is associated with chronic illnesses such as asthma. A study concluded that foster care youth are twice as likely to have asthma than youth not in foster care (Dunnigan,2017). In addition, a higher prevalence was seen in foster youth that lived in cities when compared to those in rural areas (Dunnigan,2017). Poor air quality in these environments as a result of pollution may explain these findings.

Mental Health Disparities The environment also impacts the foster youth's mental health by virtue of both their entry into the system, and the trauma they may have experienced prior to entry. Trauma may create abandonment issues and feeling burdensome. This translates to eighty percent of the youth in foster care needing mental health services. These youth utilize mental health services ten to twenty times more than youth in the general populations suffering from higher rates of PTSD and major depression (Villagrana,2016). Research conducted by Taussig (2014) concluded that in addition to PTSD and major depression, 26.4% of foster youth aged 9-11 are suicidal (Taussig,2014). Suicidal minors are getting younger, and this means intervention services are needed sooner and with more fervency. Further findings highlighted the lack of awareness that may exist in foster care guardians. When asked questions about the youth's possible suicide ideation, caregivers only reported 15.7% (Taussig,2014). These numbers reveal a dire need for training and support for caregivers, especially in preparing the youth for life after emancipation.

Utilization of Care and Services in Emancipated Foster Youth Low rates of healthcare service utilization are common among emancipated youth. After leaving they have less support, and less accountability, resulting in a decline in overall service utilization. Although a study conducted in Delaware shows the services utilization of foster care youth increases after 180 days (Knight,2016), data indicates a fifty-four percent decrease in utilization after emancipation (Villagran,2016). The decrease in utilization may further exacerbate the emotional, physical, social, and societal barriers that exist for this underserved population.



(Foster Care Youth Continued) The decrease in utilization may be attributed to homelessness, unemployment, and poverty creating less access to healthcare/quality healthcare, and may be compounded by the stigma related to mental health issues and needing professional help (Villagran,2016). The low rates of utilization further exacerbate the emotional, physical, social, and societal barriers that exist for this underserved population.

Conclusion Foster care youth face neglect, abuse, feelings of abandonment, and poor health outcomes including chronic illness and mental health issues. Additionally, their emancipation leads to low utilization of health services, homelessness, and other unfortunate circumstances. This continues the cycle of poor health and highlights the immediate need. To remedy what these youth face once entering the system, it is important to fully equip their caregivers.

Caregivers should have ongoing training that allows them to better serve their youth. Similar to how home health aides, and medical personnel participate in in-service classes or continuing education, the foster caregivers should also be trained in relevant topics such as suicide awareness and how to properly prepare the youth for life after emancipation. Another solution that could help these youth, is providing them with workshops to improve their quality of life including elements like job preparedness, health and wellness, and financial literacy. By equipping the caregivers and the youth, we can improve the expected health outcomes for this vulnerable and valuable people group.



Autism Spectrum Disorder: Pursuing Health Equity By Isabel Torres 23'

Introduction As of 2016 it was estimated that 1 in every 40 children ages 3 to 17 years, are diagnosed with autism spectrum disorder (*New Studies Estimate Autism Prevalence at 1 in 40 | OAR*). Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder that results in a range of difficulties including, but not limited to, in social interactions, communication skills, and performing repetitive behaviors (Nguyen et al. 2016). The Center for Disease Control reports that Caucasian children are 1.1 times more likely to be diagnosed with ASD than Black children and Black children are 1.1 more likely than Hispanic children ([CDC], 2019). There is a subset of children diagnosed with ASD who face additional barriers stemming from intersecting issues such as race, ethnicity, socioeconomic status, and sexuality. The combination of having ASD and experiencing the effects of social determinants of health, increases morbidity and mortality in this population (Bishop-Fitzpatrick and Kind, 2017).

Racial/Ethnic Disparities Caregivers of children with ASD have reported less access to primary physicians and nurses, with African American and Latino parents describing inaccessibility to their children's providers via phone, and lack of access to expeditious care. (Bishop-Fitzpatrick and Kind, 2017) Additionally, providers were reportedly not parent-inclusive and were culturally insensitive among African American and Latino families (Magaña et al. 2015). Autistic children experience obstacles that includes poor physician preparedness for diagnosing and treating ASD resulting in delayed adequate care (Magaña et al. 2015). In a review of Medicaid claims from the years of 1993 and 1999, Black children were improperly diagnosed with conduct disorders or adjustment disorders instead of ASD.

These reported misdiagnoses lead to a greater delay in proper diagnosis and care when compared to those of Caucasian children (Mandell et al. 2009). Communication with healthcare providers is a crucial component of accessing quality care for children diagnosed with ASD. Language barriers found in non-English speakers resulted in receiving less hours of individual services when compared to English speaking people (Nguyen et al. 2016).

Socioeconomic Status/ Poverty Disparities Families of lower socioeconomic strata, report less continuous care and reduced early intervention for ASD children (Bishop-Fitzpatrick and Kind, 2017). Low-income families struggle to prioritize time and transportation for the needed therapies to assist children with managing their ASD (Nguyen et al. 2016). Those in the Hispanic community who are also among the lower socioeconomic strata, have experienced an increase in ASD diagnoses; between 2002 to 2010, the prevalence of children in this people group who were diagnosed with ASD increased from 3.9 per 1000 to 8.0 per 1000 (Durkin et al. 2017). Family and housing also have a major effect on the age of diagnosis for ASD; those living in single-parent and stepfamily arrangements are most likely to be diagnosed later on (Jo et al. 2015). Along with family and housing, the educational attainment within the household correlates with early ASD diagnosis. Those within a household of lower educational attainment, have a lower prevalence of early and accurate diagnosis, while those who have higher education attainment have a higher prevalence of early and accurate diagnosis (Durkin et al. 2017).

Sexuality Disparities The LGBTQ+ community is a subpopulation that is understudied in areas of healthcare access and health equity. The health data show that the LGBTQ+ community who have disabilities, have poorer health status than the general population. Interviews directed and data collected among adults who identified within the LGBTQ+ community and diagnosed with ASD, showed that this population struggles with mental illness and post-traumatic stress disorder at higher rates than the general population (Hall et al. 2020). The LGBTQ+ community diagnosed with ASD struggles with reaching out for medical assistance, this is in part due to previous poor experiences with health care providers. There may be many reasons providers have not supported human sexuality education; for example, there is a perception that the ASD population may lack understanding about their sexuality. The evidence suggests that more education and training is needed to assist healthcare providers in adequately caring for ASD adults within the LGBTQ+ community (Hall et al. 2020).

Discussion More research is necessary to investigate the intersection of ASD management and the effects of social determinants of health and health disparities (Parikh et al. 2018). The recent and growing concern is that the ASD population is not gaining proper access to behavioral health services—one study found that 9 out of 10 children were unable to efficiently utilize behavioral health services (Nguyen et al. 2016). It is imperative that education is available for healthcare workers and parents to ensure early diagnosis and intervention, as these lead to better health outcomes (Jo et al. 2015). Programing that involves inclusively addressing sexual preference, adequate screening, appropriate referrals, and science-based education, can begin to elevate the care provided for all people (Mandell et al. 2009). Additional attention should be focused on ASD education in medical schools, policymakers, and public health.

(Immigrants and health continued from first page)

Children of immigrant parents may feel like they don't fit in with their peers, or they may feel pressure to assimilate into American culture, while also trying to assist their parents or caregivers with the same assimilation challenges. This stress can lead to anxiety, depression, and other mental health problems. More than half of the 17.8 million children in the United States who have at least one immigrant parent are raised in environments where the parents' English is inadequate (Orthy, 2022). Children of immigrant parents may also face language barriers that can impact their mental health, experiencing difficulties communicating with their peers and teachers, leading to social isolation and increased stress (Zhang et al., 2020). Finally, these children may face discrimination and prejudice from a variety of sources; for example, peers, teachers, or other adults in their lives creating feelings of disgrace and experiences of bias that can make them feel trapped in a cycle of poor mental health (Mitra et al., 2018).

Ramifications The ramifications of health disparities in immigrants and their children are significant. Poor mental health outcomes can lead to a range of negative consequences, including decreased quality of life, decreased productivity, and increased healthcare costs. These children experience mental health problems impacting their performance academically and assimilation socially, in the end impacting their future opportunities for success in the U.S. Studies have also found that mental health problems in immigrants can have intergenerational effects, with the children of immigrants being at greater risk for mental health problems (Derose et al., 2019). To compound matters, the stigma surrounding mental health issues in some immigrant communities can lead to underreporting and undertreatment of mental health problems (Leong & Lau, 2019). This highlights the importance of culturally sensitive and linguistically appropriate mental health services, to address the unique needs of immigrant populations. Providing accessible and equitable mental health services can not only improve the well-being of individuals and families, but can also have a broader positive impact on society as a whole—such as reducing healthcare costs and increasing productivity. Essentially, untreated mental health problems can lead to more severe conditions and even suicide. Addressing health disparities in immigrants and their children are not only a matter of social justice but also an important public health issue with far-reaching consequences. By providing appropriate care and support to this vulnerable population, we can improve the health outcomes and well-being of immigrants and their families, leading to a stronger and more equitable society.



Elderly Care By Samantha Kraszyk 24'

The Centers for Disease Control and Prevention (CDC) estimate that 16% of United States adults were aged 65 or older in 2019. According to the CDC, nearly 25% of the population will be over 65 by 2040. The United Nations (UN) states that with the ageing process there is an increased likelihood over time of developing health issues, and this may be compounded by the accumulated effects of health disparities experienced throughout a lifetime. The UN expresses these disadvantages may stem from a broad range of factors, including socioeconomic status, physical environment, previous occupation, and public health policies (Health inequalities exist in access to health care as well as health outcomes, 2018). Some of the health disparities experienced by the elderly involve increasing insurance costs, rising drug prices, mental health issues, and elderly physical abuse. Lack of adequate insurance coverage among the elderly community is attributed to an increased risk of severe health issues and premature death (McWilliams, et al., 2004). Many older individuals lack health literacy, this can lead to insurance scams, limited knowledge of available resources and services, and even failure to report elder abuse—which is on the rise (Aylaz, et al., 2020).

Lack of adequate insurance coverage It is a difficult task to select a health care plan that is affordable and does not become a financial burden. The elderly population may not get proper advice on choosing health insurance, and oftentimes ends up with subpar coverage (McWilliams, 2009). For example, when choosing prescription drug coverage, they may want to include health benefit coverage to supplement that which Medicare does not cover. Medicare only provides Part A, hospital, and Part B, medical, but does not include Part D, pharmacy benefits (Chakravarty, 2020). When choosing a plan or plans the elderly may need assistance, as the options are many and the stakes are high. Research found that five percent of elderly Medicare beneficiaries spent \$368 more annually even when selecting the cheapest plan, one fifth of those spent over \$500 more annually (Zhou & Zhang, 2012). Older adults can make mistakes when they select Medicare plans, and these errors can be costly (Kina, 2021). A study conducted by McWilliams, et al., found major differences in mortality rates, with Black and Hispanic elderly and lower income individuals having much higher mortality rates when compared to Caucasian elderly and those with higher incomes. The uninsured elderly had significantly higher mortality rates than their insured counterparts. **Mental Health** Many among the elderly population suffer from depression, anxiety, and loneliness due to health problems, which can increase the burden of disease on their families and society. Depression can manifest itself as sadness, fatigue, sleep disturbances, and loss of appetite and concentration (Dziedzic, et al., 2021). Using the Geriatric Depression Scale (GDS) to assess mental health, researchers identified depression in 39.38% of elderly participants. The variables associated with an increased incidents of depression were, an inability to function daily while living alone, having a physical illness, or experiencing a major life event in the prior six months. Conversely, having good social support was considered a protective factor (Li, 2023). Among the elderly population, five factors increase health inequity: 1) an expanding riskscape, 2) a reduction in social ties, 3) uncertainty about the future, 4) loss of trust in institutions, and 5) less ability to cope with new knowledge (Lee, 2021).

All these factors affect the mental health of the elderly, but social isolation and loneliness are primary risk factors for mental health issues. One factor that would improve mental health, is consistent and positive social interactions for older adults living in nursing homes and care facilities (Lee, 2021).

The Coronavirus pandemic (COVID-19) exacerbated health disparities among elderly populations due to changes in living conditions like strict social isolation guidelines, with quarantining having a significant deleterious effect on mental health (Lee, 2021). Dziedzic and colleagues assessed the well-being of elderly participants during the pandemic and found among that population the depression rate was 26.25, the anxiety rate was 34.85%, and the irritability rate 38.91%. Based on the modified Hospital Anxiety Depression Scale (HADS-M), widows and widowers and those living alone scored higher on the depression scale than those in relationships or living with a partner or family. Those living alone suffered from increased deterioration of physical and mental health, including depression, anxiety, and irritability.

Elderly Physical Abuse As you grow older, you experience many health and functional changes including increased dependency and accident risks, a decline in cognitive ability and financial success, and increasing social problems. Research shows that the depression score is significantly higher for individuals who had been abused or neglected (Aylaz, et al., 2020). Elderly physical abuse is considered intentionally hitting or hurting and may also include knowingly ignoring their medical and personal needs. Neglect refers to unknowingly denying the needs/care of elderly individuals and/or causing emotional or physical suffering. It is estimated that elder abuse comprises 2.2% to 18.4% of emergency department patients (Altintop & Tatli, 2019). The data suggest that approximately 103,129 elderly patients presented in the ED resulting from trauma, and 16,337 or 63% were identified as forensic physical trauma like being punched, attacked by a gun, struck by an object, kicked, or strangled (Altintop & Tatli, 2019).

How Can We Help?: A health insurance/prescription coverage intervention is needed to ensure the elderly population gets health insurance and prescription drug coverage at an affordable cost. Health programming should provide targeted assistance to help choose health plans, so the elderly population gets the most cost-effective plan based on their medication needs. Family members, health care providers, and caregivers need more education on the effects of isolation, declining physical health, and loss of independence, in order to combat mental health issues among the elderly. Nursing homes and assisted living facilities should have a psychologist on staff to help elderly individuals through the effects of COVID-19 and the prolonged separation, loneliness, and loss of friends and family. Doctors, physician assistants, and nurses should get enhanced training on how to handle elderly physical abuse cases and automatically include a psychologist in assessments and treatments. We need to elevate our care of seniors in the United States, respectfully acknowledging each individual's worth.

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Graduate Students Volunteer and Enjoy the Benefits both Personally and Professionally

- ◇ I learned more about many new things about myself, firstly, my faith in God, has grown entirely after this experience. The trust that was put into the minds of these people really shows that God always has a path for everyone and to let God direct the next steps as it will always be positive at the end. Despite the hardships I have gone through in the past I understand that I will never be in the same situation forever. Many people tend to let go of their faith because of temporary issues and after this experience I see that if there is a will there will be a way. ~N. A.~
- ◇ I've done volunteer work in the past, as I've already indicated, but this experience has made me realize that I don't do it nearly enough. I intend to devote more of my free weekends to volunteering, especially for the Happy Helpers program, and I also intend to give canned goods to the program as they need contributions to buy food. I discovered how much I am willing to give to others and how I thrive in this kind of setting, which sparked an interest in potential jobs or volunteer work with underprivileged people. Volunteering immediately helps underprivileged groups while boosting one's self-esteem and motivating one to contribute more. ~K. B.~
- ◇ I also learned that service is what has been missing in my life and it brings the most fulfillment. I am very observant and nurturing and the same way I would make sure the homeless are seen, felt and heard, I also treat those who I am volunteering with.~N.H.~
- ◇ I learned that I enjoy giving back to those in the community and those in need. It makes me feel good to do an act of kindness for people and even though I am helping other people, I also feel good about myself. ~K. S~
- ◇ In regard to implementing service in my life and in the lives of others, which includes my family, it's important to realize that in order to see the change in the world we must be that change. I also believe that allowing myself to serve within these different communities and spaces builds on my humanity to strive for a greater change and vision of what I hope the future to be. ~A. T.~
- ◇ Being a part of this made me feel wholesome and joyful. After volunteering for a few weeks, I felt at peace with my past. I have come to peace with what happened to me two years ago and accepted that life has other plans for me. ~I.T.~
- ◇ Volunteering my time to better my community helped me realize how much I miss volunteering. My mom started working with Court Appointed Special Advocates and they will be having plenty of opportunities to volunteer, I plan to offer my time to help out at their events to help children in the foster care system. ~S.K.~