Racial and Health Disparities: Identifying Mental & Behavioral Health History and Resources in Connecticut

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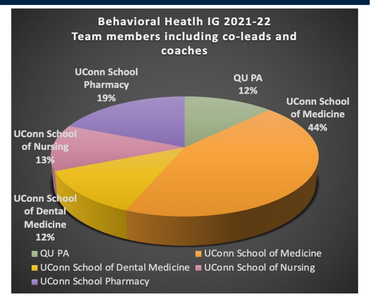
Abstract

CT AHEC's Urban Service Track/AHEC Scholars Program (UST/AS), is designed to engage students across various health disciplines in clinical, didactic, and community-based activities that draw attention to and build skill sets that can address the needs of Connecticut's urban underserved communities. Students from UST/AS were encouraged to supplement these efforts through student-led monthly interest group meetings for five months of the 2021-2022 academic year. Our Interest Group, Behavioral Health, used this time to research the history of behavioral and mental health for minority communities in Connecticut and how we may be able to take steps to reduce the disparities recognized in these underserved communities by increasing access to resources for providers, and therefore, their patients.

Background

The Behavioral Health IG was led by Urban Service Track/AHEC Scholars Megan Machnicz, P3, Shivam Patel, MS-2, and Emily Teetple, QU PA-S2. Our senior coaches were Anita Luxkaranayagam, MS-3 and Timofey Karginov, MS-3, MPH. The alumni partner was Lisa Vallee, MSW. Our team was comprised of 5 disciplines outlined in the chart.



Methods

The interest group met 5 times between November and March. Each meeting had a separate topic:

- November: Opioid Use Disorders/Opioid Epidemic
- December: Substance Use Disorder. Guest Speaker Sarah Warzecha, MSW
- January: Mental Health treatment in the US and Guest Speaker Dr. Rachael Kishton
- February: Provider Burnout
- March: Group Reflections

As a group, we conducted a retrospective cross-national analysis of behavioral and mental health epidemiology in minority communities with a focus on disparities in Connecticut. Data was gathered from public resources including the CDC, WHO surveillance database, and the Substance Abuse and Mental Health Services Administration.

Objectives

- Compare mental and behavioral health disorders and outcomes based on race, with a focus on minority communities
- Assess health disparities primarily in the state of Connecticut
- Create a behavioral and mental health resource list for providers to distribute to patients to increase access to care in Connecticut and narrow the gap in care
- Question addressed: Why are there higher rates of mental and behavioral health disorders in minority communities?

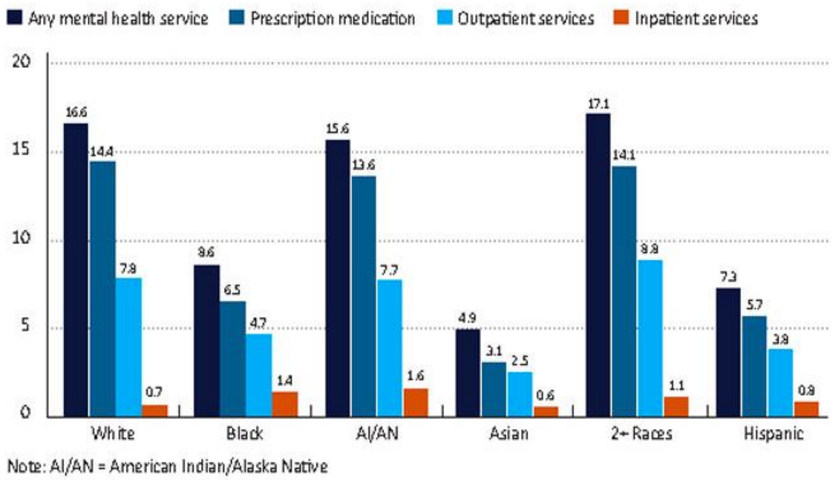
Results

Excerpt from question and answer from guest speaker Dr. Rachael Kishton (Psychiatry and Family Medicine)

- ***On an individual basis, what can we do to provide resources to patients with chronic mental health needs, and how can we enact change?***
  - "Unfortunately the funding piece of deinstitutionalized psychiatry did not come through, so resources are limited. One helpful thing is helping a patient find a case manager who can help coordinate care (medical, social services etc.). Try to get someone "plugged into a system" before their situation deteriorates. Early intervention in key." - Dr. Rachael Kishton

Figure 3. Use of mental health services is relatively low among blacks, Asians and Hispanics.

Annual average percent use by adults of mental health services, by race/ethnicity and service type, 2008-2012



Note: AI/AN = American Indian/Alaska Native

Source: Substance Abuse and Mental Health Services Administration, 2015.

Discussion about opioid-use disorders and the opioid epidemic

- ***What gaps in care did you notice?***
  - Not a lot of rehab centers that fit for someone who does not have a OUD but needs to be detoxed
  - Providers did not follow up with the patients for long term planning
- **Where did things go wrong?**
  - Systematic problem
  - There were many checkpoints where the intervention could have taken place
  - Resources are not readily accessible
  - No tapering plan
- **What are some solutions?**
  - More guidelines in place for people who are using and being prescribed opioids
  - Long term effects
  - How to taper
  - Informed consent: fully informed
  - Patient pain agreements
  - PCP have to have special training to provide MAT in some cases = barrier that could be eliminated
- **What gaps in care did you notice?**
  - Not a lot of rehab centers that fit for someone who does not have a OUD but needs to be detoxed
  - Providers did not follow up with the patients for long term planning

Health Equity Strategies

- **Substance Abuse Services**
  - Hartford Behavioral Health
  - CT Narcotics Anonymous
  - Connecticut Community for Addiction Recovery
  - Department of Mental Health and Addiction Services
- **Mental Health Hotlines**
  - 211 of Connecticut
  - Disaster Distress Helpline
- **Organizations for Immigrants, Refugees, and People of Color**
  - CT BIPOC Mental Health and Wellness Initiative
  - CT Institute for Refugees and Immigrants
  - Therapy for Black Girls
- **Access to Therapy**
  - Open Path Collective
  - Psychology Today
  - Postpartum Support International
- **Other Great Mental Health Resources**
  - Root Center for Advanced Recovery
  - Healthy Lives CT
  - Haven
  - Wheeler Clinic, Institute of Living

Figure 1: QR Code for Links to Health Equity Strategies

Conclusions

- Further studies are warranted to assess how outpatient clinics, behavioral/mental health hotlines, recovery programs, therapy providers, and support organizations may reduce incidence of unaddressed and poorly resourced mental and behavioral health needs.
- Addressing disparities in mental and behavioral health through education and increasing availability of local mental and behavioral health resources.
- A diverse workforce that represents the population is key to the delivery of mental and behavioral health services.

Discussion and Future Directions

During our last meeting, we took the time to reflect on our journey and what we would suggest for the Behavioral IG next year.

What we liked most about our time together:

- Hearing from different speakers was good for broadening perspectives
- Was a nice check in for mental health
- We created a good "trauma informed environment"
- Everyone was very engaged – both the students and the speakers
- The burnout session was particularly popular

What we would suggest for the future direction of the IG:

- Spend some time at the beginning of meetings to talk about mental health, this was a good support group
- Discuss healthcare coping strategies
- Try to get more involved in the community! (i.e. in real practice!)
- Crisis management training would be a great interactive group activity
- Capture storytellin- Interview community members to share their behavioral health stories – incorporate narrative medicine. Perhaps collab with Anastomoses/ Bioethics and Medical Humanities IG.
- Adverse childhood experiences – explore this important topic more

References

CT AHEC Program at UConn Health Center Urban Service Track/AHEC Scholars Program h.uconn.edu/UST

Acknowledgements

Acknowledgements given UST/AHEC program assistant Dariene DuBois-Plante and to guest speakers, Sarah Warzecha, MSW and Dr. Rachael Kishton.

Title

Connecticut's Urban Service Track (UST)/AHEC Scholars Program is designed to engage students across various health disciplines in clinical, didactic, and community-based activities that draw attention to and build skill sets that can address the needs of Connecticut's urban underserved communities. Students from the UST were encouraged to supplement these efforts through participation in monthly interest group meetings for the 2020-2021 academic year. As part of the Behavioral Health Interest Group, we used this time to research the history of behavioral and mental health for minority communities in Connecticut and how we may be able to take steps to reduce the disparities recognized in these underserved communities by increasing access to resources for providers, and therefore, their patients.

UST scholars conducted a retrospective cross-national analysis of behavioral and mental health epidemiology in minority communities with a focus on disparities in Connecticut. Data was gathered from public resources including the CDC, WHO surveillance database, and _____.

- Compare mental and behavioral health disorders and outcomes based on race, with a focus on minority communities
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- Further studies are warranted to assess how community-based health resource lists distributed via community or religious leaders (i.e. through churches, apartment complex committees, etc.), and community-based health centers may increase access to patients with mental and behavioral disorders to get the care they need.
- Addressing disparities in technology, transportation, language barriers, and vaccine hesitancy are all necessary measures to ensure reduction in COVID-19 morbidity and mortality across racial and ethnic minorities.
- UST Scholars should focus on the effects of the nationally implemented health equity strategies in minority communities in future studies.

Figures to add for results section for CT

Copy paste the following bar graphs (or make into a bar graph w diff. format)

1. **COVID-19 Cases, Rate per 100,000, Associated Deaths, and Number Hospitalized by County**

1. Cases and Deaths by Race and Ethnicity

From this link: https://data.ct.gov/stories/s/COVID-19-Daily-Report/q5as-kyim/

change below image into a table - Table Title: "CT Race and Hispanic Origin Distribution 2019"

Race and Hispanic Origin	
White alone, percent	79.7%
Black or African American alone, percent (a)	12.2%
American Indian and Alaska Native alone, percent (a)	0.6%
Asian alone, percent (a)	5.0%
Native Hawaiian and Other Pacific Islander alone, percent (a)	0.1%
Two or More Races, percent	2.5%
Hispanic or Latino, percent (b)	16.9%
White alone, not Hispanic or Latino, percent	65.9%

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Figures to add for results section for WV

Race	Percentage of population	Percentage of cases	Percentage of deaths
African n alone	4%	4%	2%
n alone	<1%	0% 1	0% 1
an and r alone	<1%	0% 1	0% 1
dian or e alone	<1%	0% 1	0% 1
e races	<1%	0% 1	0% 1
e alone	93%	94%	96%
e alone	2%	3% 1	2% 1

change this into a table thru google slides and name:

TABLE NAME -

“WV Race and Ethnicity Distribution of COVID-19 Cases”

Race	Percentage of population	Percentage of cases	Percentage of deaths
Black or African American alone	4%	4%	2%
Asian alone	<1%	0%	0%
Native Hawaiian and Pacific Islander alone	<1%	0%	0%
American Indian or Alaska Native alone	<1%	0%	0%
Two or more races	<1%	0%	0%
White alone	93%	94%	96%
Some other race alone	2%	3%	2%

- Cost of services explain the disproportionate use of mental health services between whites over any other race.
- Barriers to the treatment of mental illness for racial and ethnic minority populations included low medication use, poor provider-patient communication and “persistent stigma,” according to a 2016 study published by the American Psychiatric Association.
- In addition to overall shortages, racial and ethnic minorities are underrepresented in the behavioral health workforce. The lack of culturally competent providers and services is an issue that contributes to current disparities in mental health and substance use treatment and services.
- According to the National Alliance on Mental Illness, the following barriers prevent racial and ethnic minorities from receiving appropriate care: lack of availability, ransportation, child care, difficulty taking time off work, the high level of mental health stigma in minority populations, racism, bias and discrimination in treatment settings, and lack of adequate health insurance coverage (and even for people with insurance, cost sharing makes it difficult to afford).