Hello PASPDI members: I hope you are all doing well as the Spring semester comes to a close!

The month of May is observed as Mental Health Awareness Month, which will be the focus of our May journal. Mental health is a sensitive topic; it is something that we have all experienced in some way, shape, or form. Mental health encompasses our emotional and psychological state of mind, as well as our social well-being.

Please note that this article will discuss mental health topics such as suicide, which may be triggering for some. If you are struggling with your mental health, please see the end of this article for mental health resources that are available to you.

In the past few years, mental health has gained more recognition in health care and society as a whole. As students and future providers, we must not only pay close attention to symptoms of mental health disorders in our patients, but also to our own mental states in order to live healthy lives while also providing quality care. In this journal, we will focus on mental illnesses that are common in health care providers and students, sources of mental health disparities in the US, as well as what can be done to mitigate these disparities.

For starters, there are over 26.1 million Americans lacking any type of health insurance (United States Census Bureau). Due to being uninsured, these Americans do not have access to adequate treatment for mental health disorders. Moreover, it wasn't until the Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 that all large employer insurance plans were required to cover mental health services, in the same way as medical and surgical services (Baumgartner, *et al*). Before this, many insurance companies were able to deny treatment for mental illnesses that they deemed unnecessary. This has added to the systemic stigma that surrounds mental health, and has increased the amount of people in the older population who do not receive treatment for their mental health.

Studies have shown that 65.7% of people who have mental health disorders go untreated (Mongelli, *et al)*. This is a dangerous statistic. Due to the risks associated with having an untreated mental disorder, such as the development of disability, suicidal thoughts, or inflicted harm towards others, treatment of mental health should be a priority, and therefore more accessible. Further, untreated mental illness is a major cause of homelessness, which often leads to drug and alcohol abuse. People who are homeless often struggle with bipolar disorder, paranoia, schizophrenia, PTSD, depression, and severe anxiety. Going off of this, people who are homeless who do not have access to health care often resort to self-medicating, which can lead to a substance disorder (Murray). In the same way, people who do not have insurance or do not have the resources to receive mental health treatment often turn to street drugs to self-medicate, which leads to addiction.

Unfortunately, populations within racial-ethnic minority groups experience profound mental health disparities. For example, African American patients are more likely to be diagnosed with schizophrenia rather than bipolar disorder, leading to treatment with antipsychotics instead of SSRIs. This leads to ineffective treatment, and adverse side effects. Additionally, African Americans have higher rates of severe depression, and yet lower rates of treatment, than whites (Mogelli, *et al)*. These findings are most likely due to racial bias within health care.

In order to mitigate these inequities, providers should be required to go through cultural-competency training, as well as be trained to recognize psychiatric disorders across cultural boundaries. Minority groups are also less represented in research studies, which further adds to their underrepresentation. In some cultures and minority groups, there can be a distrust and poor acceptance of mental health issues; this further leads to underrepresentation in research due to these individuals choosing to not seek help. Specifically, people of African, Latin American, and native or indigenous ancestry represent under 4% of the 35 million samples included in the Genome-Wide Association Study (Mogelli, *et al).* If we do more research that is inclusive of minority populations, this can lead to better health outcomes overall, due to having an increased understanding of how to treat and recognize mental health disorders.

On another note, data has shown that individuals who identify as part of the LGBTQ+ community experience greater rates of depressive episodes, substance misuse, suicidal ideation, and suicidal attempts compared to the general population. Further, members of the LGBTQ+ community have a 120% higher risk of homelessness (Murray). This can potentially be attributed to job discrimination, as LGBTQ+ individuals may not be hired due to discrimination against their identity.

The discrimination that the LGBTQ+ community faces is associated with their experience of social isolation, as well as the violence that targets their communities, which further triggers mental illness. Also, despite homosexuality being removed from the DSM as a mental diagnosis, some practitioners still suggest conversion therapy (Mogelli, *et al)*. Interventions that seek to change a patient's sexual orientation are harmful and unethical, only adding to the health care disparities faced by these patients.

Some people who are transgender will experience gender dysphoria, which is the psychological disturbance that stems from the difference between one's sex that is assigned at birth, and one's gender identity (Turban). Unfortunately, transgender individuals face high rates of discrimination, and 41% of transgender individuals in the National Transgender Discrimination Survey admitted to having thoughts of suicide (Su, *et al)*. This research has also shown that 28% of transgender individuals postpone care due to discrimination, and that 48% postpone health care because they cannot afford it (Su, *et al)*. It is necessary that as providers, we

do not discriminate against our patients based on their gender or sexual identity, in order to give them the health care that they deserve.

What can be done to mitigate these mental health disparities faced by LGBTQ+ communities? First, the evidence suggests that there is a lack of education in medicine regarding different gender and sexual identities. Gender and sexual identity education should become a necessary part of medical training, along with that of cultural-competency. A decrease in the stigma against the LGBTQ+ community would only increase the amount of patients within the community who choose to seek care, due to feeling accepted and welcomed (Mogelli, *et al).*

It cannot be emphasized enough that medical providers themselves are susceptible to severe mental illness. Burnout among health care providers and students is prevalent in our society. Burnout is a mix of emotional exhaustion, depersonalization, and reduced personal accomplishment. Shockingly, more than 400 physicians a year commit suicide, likely stemming from high levels of depression that come along with burnout (Strehman, *et al*). Additionally, one study showed that burnout was prevalent in 64% of rurals PAs (Johnson, *et al*). Another study found that self-reported scores equally encompassed the nine major depressive disorder symptoms (depressed mood, anhedonia, appetite-weight change, sleep change, psychomotor disturbance, fatigue, self-blame, cognitive impairment and suicide ideation) between a group of people with depression and a group of people with burnout (Bianchi). This demonstrates how high rates of depression are specifically relevant to medical providers.

What about mental illness among physician assistant students? A recent study including 320 PA students found that PA students, similar to medical students, have a higher prevalence of depression and anxiety compared to the general population (Johnson, *et al*). As students in a rigorous physician assistant program, it is easy to understand why burnout, depression, and anxiety are so common. Let this data be a reminder that you are not alone; we are in this together, and we must take care of our mental state at all times.

What are the warning signs of mental illness? See this link for the warning signs of mental illness, as well as where to get help:
https://www.nami.org/About-Mental-Illness/Warning-Signs-and-Symptoms

Finally, it must be emphasized that we should all be advocates for those who may be struggling with their mental health. It is often the case that those struggling with mental health lack the resources, motivation, or support to seek help or treatment. We encourage you all to be mental health advocates: check in on your friends. Educate yourself on signs of mental health disorders. When you see something, say something. You have the power to change lives.

Thank you for taking the time to read this month's journal! Please reach out to us for more information, or if you have any questions.

Take care,
PASPDI Board, Class of 2022

Mental Health Resources:

- **University Counseling Center Services**: https://www.studentaffairs.pitt.edu/cc/services/
  - *You can schedule independent therapy, group therapy, and other wellness services for free through the counseling center.*
  - *Lillie: I cannot emphasize the counseling center enough; it truly got me through some of the most difficult times in my life.*
- **Resolve Crisis 24 Hour Service number**: 1-888-796-8226
  - https://www.upmc.com/services/behavioral-health/resolve-crisis-services
  - *This crisis service is free to all Allegheny County residents. You can call whether it is depression, substance abuse, feelings of loneliness; you can call for any problem big or small.*
- **National Suicide Prevention Lifeline**: 1-800-273-8255
  - *Operated by the American Foundation of Suicide Prevention; free and confidential support for people in distress, as well as prevention and crisis resourceses*

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