Last year, a medical student jumped from her apartment and died after attempted resuscitation in our emergency department. Although it's always a shock when someone in our community takes her own life, the unfortunate truth is that these events are no longer an anomaly for physicians. They serve as a constant reminder of how much medical training takes from us. I fear we're always on the precipice of the next casualty—that the next suicide will be that of a colleague, co-resident and friend. I want to change how we treat resident mental health so that we stop losing smart, compassionate people to the brutal challenges of medical training.

To combat this, I'd propose to develop both a crisis prevention and crisis response protocol at my institution. To make this easy to implement, it would consist of introducing a mental health component to pre-existing infrastructures within our program.

First, I would borrow a preventative intervention used by psychiatrists: a safety planning intervention (SPI), a document that helps to identify coping strategies and resources that cab be used during episodes of a mental health crisis. (A copy of the plan can be found below.) Because the SPI is supposed to be created during a non-crisis period, every intern would be given one to complete during intern orientation—a month where interns are not working clinically and have regular and routine schedules and lower levels of stress. Incorporating this into the resident curriculum also sends the message that the program is invested in protecting the mental health of its residents. Residents have biannual meetings with an associate program director, at which I propose the director formally inquire about the resident's emotional well-being, including reviewing the warning signs identified by the resident on their individualized SPI. Both interventions help to create a safety net, helping to capture at-risk residents, who may not proactively reach out for help.

Second, I propose to create a crisis response plan so that the residency program is prepared if something bad does occur. Recognizing that difficult events can trigger strong emotions, especially in at-risk residents, my goal in having a response plan is to quickly ensure a network for social support at the outset of any crisis. We currently have a "disaster tree" so that residents can be contacted in the event of a physical emergencies. An analogous emotional disaster tree ought to be drafted so that all residents receive a personal phone call to ensure their safety, acknowledge the difficulty of the transpired events, and provide reassurance that they have someone in the program to speak to if needed. After these initial phone calls, mental health professionals should be made available (ideally at the next conference day) to provide counseling to the group as well as to serve as resources for individuals who need them. Limited mental health resources can often present a challenge in these situations, but one of the benefits of training in New York City is that we can use an already existing network of NYC programs, through All NYC EM to pool resources. I would work with All NYC EM to create a contract to provide previously identified mental health providers in the event that any one training program suffers a crisis. This allows for access to more resources and offers the additional benefit that residents may feel more comfortable being able to seek help from outside their institution.

Implementing these simple measures would go a long way toward normalizing conversations about mental health and creating a culture in which physicians are comfortable seeking help.

References:

1. Brown, G. K. (2015). *Safety planning and structured follow-up: A brief intervention for suicide prevention in emergency department settings*. Paper presented at the International Summit on Suicide Research (ISSR), New York, USA. Retrieved from http://suicideresearchsummit.org/science-of-the-congress/plenary/

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
1.
2.
3.

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):
1.
2.
3.

Step 3: People and social settings that provide distraction:
1. Name:
Phone
2. Name
Phone
3. Place
4. Place

Step 4: People whom I can ask for help:
1. Name:
   Phone
2. Name
   Phone
3. Name
   Phone

Step 5: Professionals or agencies I can contact during a crisis:
1. Clinician Name
   Phone
   Clinician Pager or Emergency Contact #
1. Clinician Name
   Phone
   Clinician Pager or Emergency Contact #

Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:
1.
2.
3.