Recognizing and Supporting Students in Crisis

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Disclosures

- I have no actual or potential conflict of interest in relation to this program/presentation.

Objectives

- Discuss statistics and trajectory of medical student with personal and/or professional distress.
- Identify common barriers to care for medical students struggling with mental or emotional crises.
- Recognize medical students on a spectrum of dysfunction from distressed to dangerous.
- List traits common to depressed, suicidal, and substance abusing students.
- Discuss the protocol for non-emergency and emergency referrals and available resources.

Would this concern you?

- An OMS III is showing up late to clinic. Patient presentations are poorly organized and seem hastily put together. His clothing is often wrinkled and his white coat is stained with spilled food/drinks. He rarely engages in conversation with the team and eats lunch in his car alone. He often whispers to himself under his breath and has made a few concerning statements about how it is important to "unify the collective" or else face "mass destruction" after the upcoming election.
- A third-year student tells another student they are seriously considering dropping out of medical school because "it's just too much for me right now". They have failed one COMAT and are struggling with the course work for this rotation. They ask their fellow student if they would be willing to take their pet "just in case something happened…"
- A student whose previous preceptors have said was well prepared starts asking for days off for transient illnesses, fails to finish work on the wards and doesn't properly hand off patients to the next student. When on rounds she seems distracted or zoned out. She often disappears from the unit for a few hours each day and can't be found. She leaves as soon as allowed to do so.

The statistics don't lie…

50-60% of medical students experience "burn out" [1]

~27% suffer from depression [2]

- 15-30% higher than general population

~11% have suicidal ideation[3]

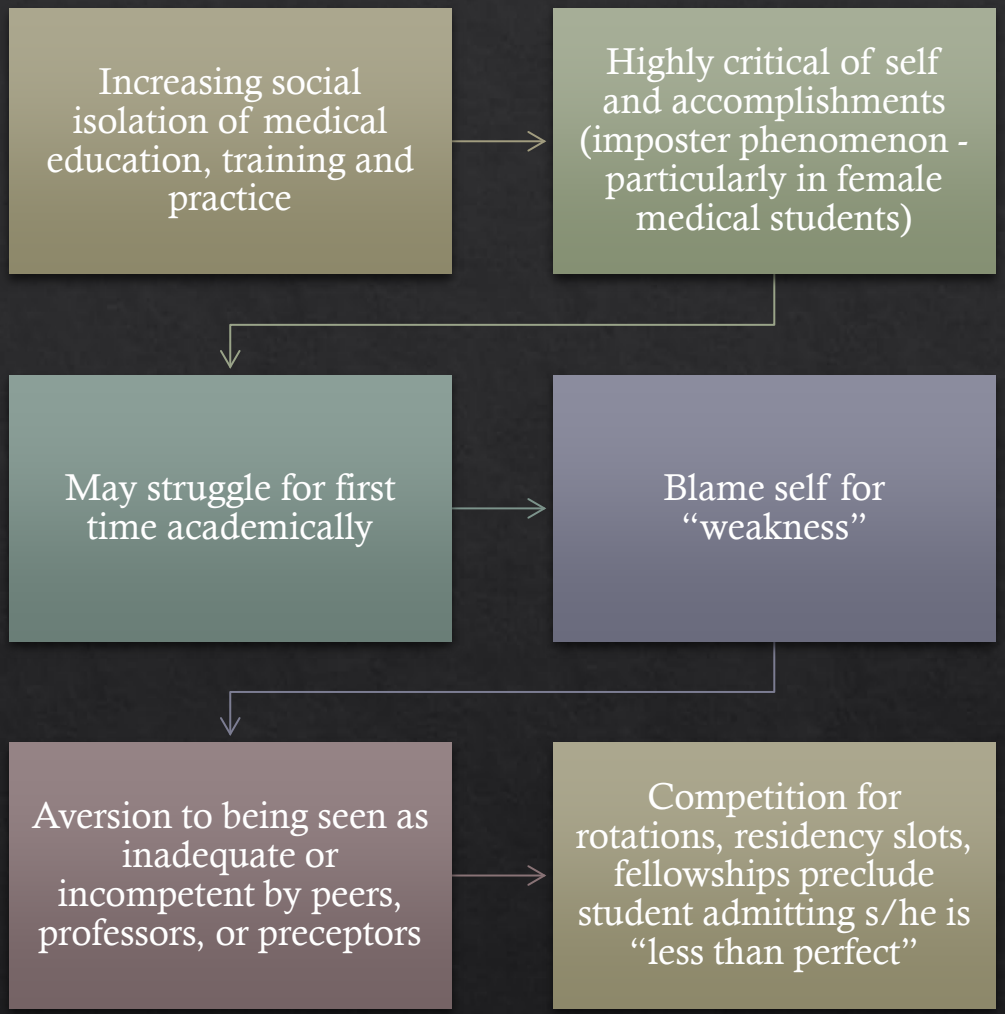
- 76% higher risk of suicide for female doctors compared to non-medical profession population[3]
- 5% higher risk of suicide for male doctors[3]

An estimated 300-400 physicians commit suicide in the United States each year

The trajectory…

- Enter medical school with mental health profile similar to peers in other academic graduate programs
- But…end up with "burn out"
  - emotional exhaustion
  - detachment
  - low sense of accomplishment
- OR…clinical depression – medical illness requiring intervention
- Don't seek treatment despite better access to care
- Cope via dysfunctional behavior (i.e., substance abuse, eating disordered behaviors, etc.)
- Less likely to receive appropriate care or even recognize need for intervention

Theoretically…



Professional vs. Personal Distress[1]

- Medical students with professional distress or **"burn out"** are more likely to:
  - Admit to cheating on exams
  - Lie about lab studies or physical exam findings
  - Have less altruistic views of role as physician
- Medical students with personal distress or **depression** are NOT susceptible to these unprofessional behaviors or beliefs but **are prone to**:
  - Relationship distress
  - Substance abuse
  - Self injury/suicide

What are we modeling?

Survival of the fittest mentality in medical school (from both peers and faculty)

If this is the way the students view one another, how does that translate to how they view their patients with mental illness or distress?

Are we modeling compassion and empathy?

Or are we further stigmatizing mental health issues?

Barriers to care

- Personal narcissistic injury: “How can I now say I need help? I’ve always had everything under control.”
- Reluctance to access counseling due to confidentiality concerns: ”What if my friends/family/colleagues find out?”
- Future concerns: ”How will clinical depression (or any mental health issue) look on my residency application? I’ll never get into a decent program.”
- Further future concerns: “What if I can’t get a medical license?”

- Others specific to DCOM?

Range of Behavior

- Distressed
- Disturbed
- Disruptive
- Dangerous
- A few extras…
  - The Suicidal Student
  - The Depressed Student
  - The Substance Abusing Student

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Distressed Student

- Academic decline
- Poor attendance in clinic, on rounds, for grand rounds
- Dependency – relies on others to take notes, keep up with scheduled events i.e., "the only reason I knew we were doing this lab today is because _____ mentioned it…"
- Listless, anergic, drowsy
- Changes in personal hygiene
- Overly nervous, fearful, anxious
- Repeated requests for special concession (need to take off early, come in late, can't take quiz/ test with rest of group, extended deadlines for presentations or other work)***
- Recent major stressor (death, divorce or break up, violence)

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Disruptive Student

- Persistent interference with teaching
- Knows it all, knows more than attending, uses every opportunity to "one up" the attending's knowledge
- Argumentativeness, monopolizes team's time
- Irritable, unruly, abrasive behavior
- Bizarre behavior

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Dangerous Student

- Expression of suicidality or has made suicidal gesture
- Self injury/mutilation
- Threats to others
- Carrying or brandishing a weapon
- Intimidating behavior including inappropriate touch, invasion of personal space, harassment, stalking.

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The Suicidal Student

- Usually subtle presentation. Tip offs include:
  - Hopelessness
  - Futility
  - Severe loss or threat of loss (frequently of an intimate relationship)
  - Suicide plan with details
  - History of suicidal thoughts, gestures, attempts
  - Substance Abuse – current or past
  - Feelings of alienation and isolation***
  - 80% of students with suicidal intent give warning.

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The Depressed Student

- Constellation of possible symptoms:
  - Guilt
  - Low self esteem
  - Worthlessness or inadequacy
  - Decrease or increase in appetite
  - Difficulty sleeping
  - Limited or no interest in previously pleasurable activities
  - Psychomotor agitation or retardation
  - Suicidal ideation

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The Substance Abusing Student

- Most common substance of abuse in this population is alcohol (legal, available, socially acceptable)
- Be alert to student with memory loss, change in hygiene/appearance, deteriorating performance in class
- Also be on alert for students engaging in abuse or diversion of stimulants***
  - Binge studying/all-nighters/cram sessions
  - Euphoria, rapid speech, listlessness, jitteriness

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What can I do to help?

Preceptor may be the 1st person to recognize when a student is in distress

You are NOT expected to provide professional mental health counseling

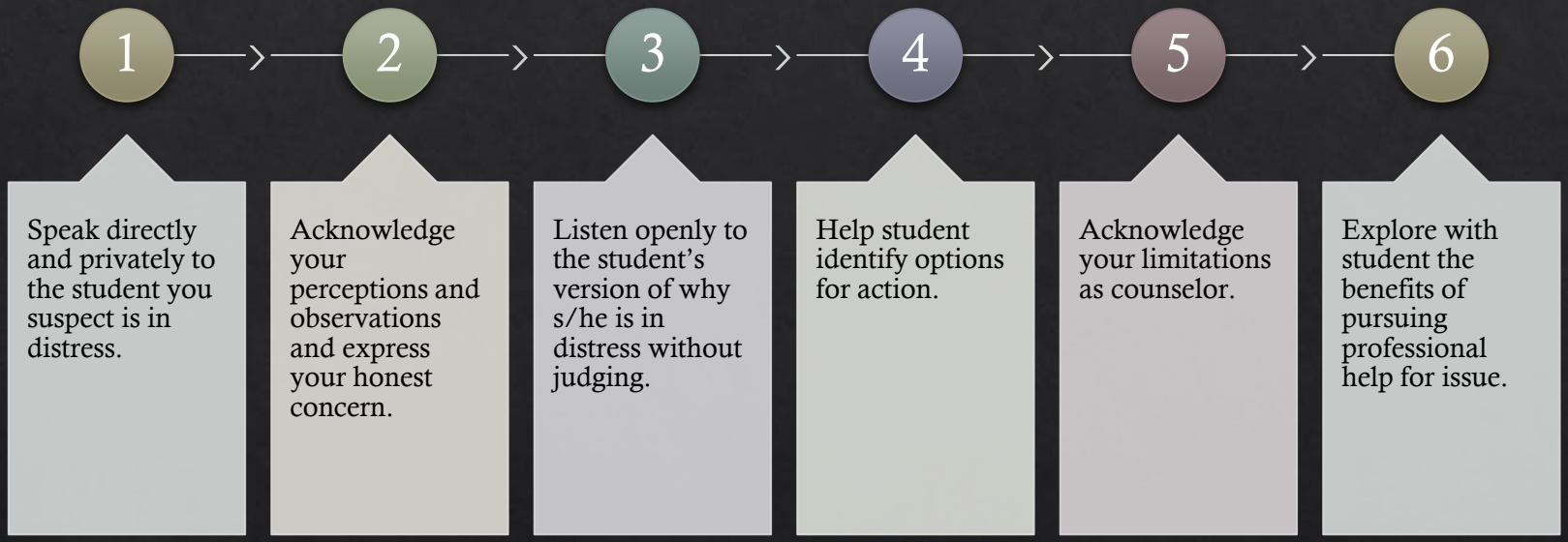
You ARE expected to alert site coordinator (non emergency) or clinical dean (emergency).

Non-emergency student referral

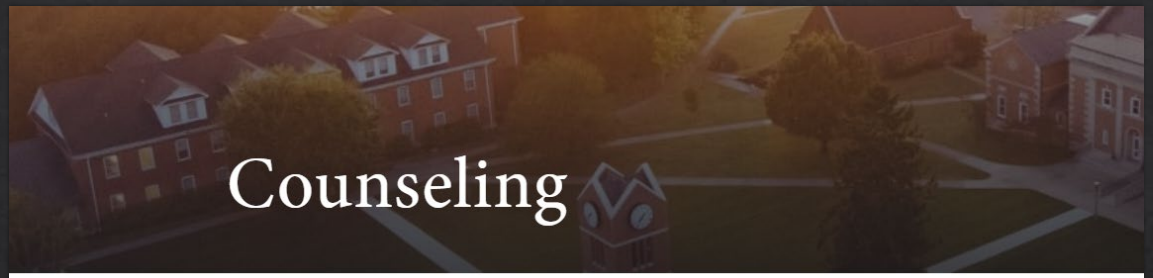
Examples of non-emergency referrals

- Depression without any thoughts of self harm or harming others, no immediate danger
- Anxiety – performance based, testing, interpersonal without any thoughts of self harm or harming others, no immediate danger
- Distress due to recent life event – death, divorce, relationship issues, failedof COMLEX Level 1 or 2-CE, failed COMAT, questioning medical career without any thoughts of self harm or harming others, no immediate danger
- Substance using student without risk of withdrawal or medical need for detox, without any thoughts of self harm or harming others, no immediate danger
- Off meds or unable to see therapist – causing impairment but without any thoughts of self harm or harming others, no immediate danger

Preceptor's facilitation of referral



https://www.lmunet.edu/counseling/



- StudentLife by Empathia Online Mental Health Tools →
- Contact your Counselor →
- Counseling Survey →
- FAQs →
- Mental Health/Life Threatening Emergencies →
- Resources →
- Schedule an Appointment →
  - Harrogate, TN and DVTC Ewing, VA
  - Knoxville, TN
  - Tampa FL, Corbin KY, Lexington KY, Chattanooga TN
- Services Provided →

StudentLife by Empathia

- 24/7, expanded mental health and daily life services
- providing students with expert assistance and practical resources for addressing mental health concerns, substance abuse, personal problems, balancing school, etc.
- Faculty and staff also have access to a 24/7 consultation service that can assist with addressing student performance and wellbeing, as well as crisis situations.
- StudentLife is free and confidential support with a focus on addressing barriers to academic success.
- Mental health support is available in such areas as:
  - Stress, depression and personal problems
  - Balancing school and personal needs
  - Relationship concerns
  - Alcohol or drug dependency
  - Managing anger or other negative emotions

Non-Emergency Notification process

- Notify your Site Coordinator.
- Site Coordinator can reach out to Office of Clinical Education Anita Sutton who can alert Dr. Cassi Jones/Dr. Charles Clinch/Dr. James Toldi
- Dr. Snodgrass - available for consultation if you are on the fence about whether the student needs referral. Text me at 404-317-6277 so I will know to pick up.

Emergency Student Referral

Emergency Mental Health Referral

Emergency: Extended sites/Off campus

1. **Call 911**
2. **Go to the nearest hospital emergency room**
3. **Call the LMU Office of Mental Health Counseling to speak to a mental health professional 423.869.6277**

- Students experiencing a mental health emergency (threat to self or others) will be transported to the local hospital emergency room by ambulance or campus safety officers for safety and liability reasons. As per the law in Tennessee, the local crisis services team will evaluate the student and make appropriate referrals. Our primary goal is the safety and well-being of all of our students. The Office of Student Services will contact parents/guardians in the event of a hospitalization, per campus policies and procedures.

Examples:

Suicidality

Threatening or aggressive behavior

Inability to care for oneself

Reported assault/trauma

In need of medical intervention/detox for alcohol or any substance

After safety is ensured:

- Preceptor is to notify Dean of Clinical Education directly:
  - Dr. Cassi Jones (Harrogate): 423-869-7131 or
  - Dr. Charles Clinch (Knoxville): 865-338-5794 or
  - Dr. James Toldi (Orange Park, FL): 423-869-6439

When In Doubt re: Potential Referral…

Dr. Snodgrass

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office 6468

cell 404-317-6277 (text first pls so I will know to pick up…)

Any questions?

In summary…

- Statistically over half of medical students experience burnout, more than a quarter depression, and >1:10 experience suicidality.
- The trajectory is bleak unless we model compassionate self-care and provide encouragement and support for struggling students.
- When concerned about a student, consider whether the student is distressed, disturbed, depressed, or disruptive.
- If non-emergent, contact your site's rotation coordinator.
- If emergent, call a clinical dean directly.
- Reach out to LMU DCOM if you have any concerns about any of our students – we are here to help you and to implement a safe and effective plan for our student.

Sources

1. **Dyrbye, Lotte. "Fixing medical student and resident burnout". 16, Aug. 2023. AMA. https://www.ama-assn.org/medical-students/medical-student-health/fixing-medical-student-and-resident-burnout-acph-keynote-0**
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3. Claudia Zimmermann, Susanne Strohmaier, Harald Herkner, Thomas Niederkrotenthaler, Eva Schernhammer. Suicide rates among physicians compared to the general population in studies from 20 countries: gender-stratified systematic review and meta-analysis. *BMJ* 2024;386:e078964..\
4. University of California Santa Cruz Counseling and Psychological Services, 2024. Accessed 09/23/2024. https://caps.ucsc.edu/responding-to-distressed-students.html