

Overcoming Barriers to Mental Health Care for Residents

Stuart Slavin, MD, MEd

Josepha Cheong, MD

Jessica Bienstock, MD, MPH

Carol Bernstein, MD

Introduction

Residency training is associated with significant challenges to mental health and well-being. Long hours, exposure to illness and death, increases in responsibility and expectations, constant change, demanding environments, and mistreatment by patients and fellow staff can all contribute to stress and distress during training that can push even well-adapted people to their limits.¹ Clinical environments vary widely in the degree of psychological and social support available to residents and fellows, and the long work hours often lead to limited opportunities to see family and friends. Perhaps not surprisingly, residents have been found to suffer from significant rates of depression. A meta-analysis by Mata et al in 2015 found a depression rate of 28.8%, and this rate does not appear likely to have declined since that time.² In addition, suicide, while not higher than rates seen in the general population, is the second leading cause of death in residents.³

Concerns about resident well-being over the last decade have prompted significant action by programs and institutions across the country. The well-being movement has emphasized wellness programming but is not ensuring that residents who need mental health care can receive it in a timely and convenient manner. The graduate medical education (GME) community needs to continue to assist residents in coping with the stress and pressures of residency training (such as interventions designed to foster resiliency), but also to make certain that it is engaging in efforts to help those who are suffering from mental illness or sustained changes to their mental health that may impair their daily function. The Accreditation Council for Graduate Medical Education (ACGME) stipulates in its Common Program Requirements that programs, in partnering with sponsoring institutions, must provide

“access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, 7 days a week.”⁴

There are significant barriers to accessing mental health care in residency training. A number of studies have examined barriers to mental health care as perceived by residents, but little has been written about programs and strategies to overcome these barriers. In a meeting of the Well-Being Subcommittee of the Education Committee of the ACGME Board of Directors in 2023, 2 board members (J.C, J. B.) felt that it would be beneficial to explore how programs and institutions are working to overcome these barriers to best meet the ACGME requirement for mental health services.

In this article, we will review what residents perceive as barriers to mental health care. We will then review strategies and programs that are currently being used at some institutions to address these barriers, with the goal that other institutions may learn from these examples as they work to promote access to care for their own residents and fellows.

Barriers to Mental Health Care in Residency

Several studies have explored resident perceptions of barriers to mental health care. In a multi-institutional study conducted from 2007 to 2009, Guille et al surveyed first-year residents about perceived barriers to care.⁵ In 2013, Ey et al surveyed residents and fellows at Oregon Health & Sciences University and asked what factors might limit their ability to access mental health services.⁶ Aaronson et al surveyed all trainees at McGaw Medical Center at Northwestern University in 2017 and asked them to rate to what degree a number of factors affected their decision to seek mental health care.⁷ Finally, in 2022, internal medicine residents at Montefiore Medical Center (MMC) were surveyed and asked what factors have influenced or would influence their decision to seek mental health care. The findings from these studies are summarized in the TABLE.

DOI: <http://dx.doi.org/10.4300/JGME-D-24-00409.1>

Editor's Note: The ACGME News and Views section includes data reports, initiatives, and perspectives from the ACGME and its Review Committees. The decision to publish the article is made by the ACGME.

TABLE

Perceived Barriers to Access of Mental Health Care for Residents

Factor	Guille ⁵	Ey ⁶	Aaronson ⁷	MMC
Lack of time (including taking a break from clinical work)	92	67	77	87
Preference for self-management	75			
Documentation in electronic medical record			61	
Confidentiality	57	21	60	
Cost	50		57	61
What others might think			55	
Prefer provider outside institution			55	59
Convenience	62		53	83
Stigma	52		40	
Others' confidence in ability		23	45	57
Future employability		22	40	48
Don't know where to go			28	63
Concerns about fellowship			25	
Means I'm weak			19	
Providers won't understand			12	24
Do not feel my problems are important			9	24
Do not feel mental health care will be useful	25	27	5	15

Abbreviation: MMC, Montefiore Medical Center.

Note: Percent of residents responding that this factor is a perceived barrier.

Of the perceived barriers to care, time was the highest rated in all 4 studies. Structural factors of services were highly rated and included convenience, concerns about documentation in the electronic health record, cost, and knowledge of how to access care. Issues related to stigma were also viewed as significant barriers to care and included what others might think, others' confidence in their ability, and believing that "seeking care means I'm weak." Finally, concerns about potential efficacy as well as beliefs that the therapist would not understand and that therapy would not be helpful were less commonly cited but noted by some respondents.

Programs and Practices

The lead author on this article (S.S.) interviewed more than a dozen directors of mental health programs and GME wellness leaders from across the country about their programs and the following is a summary of those findings.

Overcoming Structural Barriers

Robust and highly utilized mental health programs at several institutions, including Oregon & Health Sciences University, Indiana University, University of Southern California (USC)-Keck School of Medicine, and BJC Medical Center/Washington University, have features that address a number of highly ranked

structural barriers to care. Mental health services at these institutions are specifically designated for residents, though some also serve medical students and faculty. They are separate from institutional Employee Assistance Programs (EAPs) and have dedicated full-time staff. Most, if not all, services are provided at no cost to the residents; insurance is not billed and there are no copays in most cases. Their records are not part of the hospital electronic health record system, and some do not use electronic health records at all, resulting in diminished concerns about confidentiality. Options for non-program associated care are available if that is preferred. Fitness for duty assessments are handled separately and are not part of these programs.

Some highly successful and utilized mental health programs, such as the one at University of California, Davis, are embedded within hospital EAP programs, but have dedicated staff for residents. In addition to providing one-on-one care, this dedicated staff works to build strong relationships with department and program leadership as well as with residents.

Clearly, not all institutions have the resources or capacity to replicate the models at these large academic institutions. However, some features of these models can be incorporated at smaller, less-resourced institutions. Dedicated staff who primarily serve residents and are familiar with the stresses of residency, provision of no-cost care, and a separate medical record system are key features that are likely to promote higher utilization of services by residents.

Other strategies and programs, often low cost, have been developed at institutions across the country to overcome barriers to seeking care. Several are described as follows:

1. The transition to residency can be a hectic and demanding time as many residents relocate to new cities and adjust to new institutions and new roles. For incoming residents who have prior mental health issues and have been receiving ongoing care from therapists, it can be difficult to establish care with a new mental health professional. At Johns Hopkins University School of Medicine, the designated institutional official (DIO) sends an email to all newly matched residents soon after Match Day providing them with information about how to access mental health practitioners and primary care physicians within the university health system so that they can establish connections before they arrive for orientation, should they choose to do so.
2. Opt-out mental health appointments early in residency are becoming more widespread. At HCA Healthcare, a pilot opt-out program at one hospital dramatically increased resident utilization of mental health services. These programs may be effective at overcoming several barriers to care, including concerns about efficacy, unfamiliarity with the nature of services and how to access them, and stigma surrounding seeking care.
3. Convenience of scheduling is another important feature of successful programs. Some institutions have web portals that allow easy scheduling of appointments. Others also obtain automatic referrals when 24/7 crisis services are used to make follow-up appointments easier to arrange.

Time was cited as the leading barrier to seeking care in all 4 studies. Concern about time includes difficulty finding appointment availability at convenient times, especially those that do not conflict with clinical responsibilities. When institutions have dedicated staff to treat residents, there is usually greater understanding of scheduling challenges. Several mental health program directors spoke of being aware of certain time periods, such as didactic afternoons, or lighter clinical months, in which it would be relatively easy for a resident to leave to attend therapy appointments. At USC-Keck School of Medicine, 30- to 40-minute appointments are offered to make it easier for residents to find time over lunch or during a noon conference. The majority of the most successful programs have off hours appointments available, including early morning, evenings, and

weekends, but the hours are relatively limited, in part because the program directors think residents should be able to receive care during work rather than during personal time. In addition, hiring therapists who are willing to work significant evening and weekend hours can be challenging. Finally, at times, residents may need to leave their clinical duties to access care, and making sure that program directors, faculty, and residents create an atmosphere in which doing so is not viewed negatively or as shirking of duties is of vital importance.

Telehealth has become increasingly widespread and can help with the time barrier, as residents do not have to travel to a therapist's office. Telehealth can also reduce concerns about confidentiality and stigma as residents know that they will not have to sit in waiting rooms. One of the challenges, however, is finding a confidential and quiet place for residents to have virtual visits if they occur during working hours. As telehealth has expanded, it is critically important for institutions to provide convenient, private, and comfortable space for residents to engage with their therapist virtually.

Residents may have concerns about potential efficacy as well as misconceptions about care. Dedicated staff who primarily or exclusively provide care for residents can also conduct talks, workshops and support groups; meet during orientation to build trust; and can be available for group support after adverse events. Specialized staff who work primarily with residents will also be more likely to be familiar with issues residents face and may therefore be seen as more credible and potentially effective. This model may not be economically feasible at very small institutions, however, and other strategies to promote belief in potential efficacy should be made by program and institution leadership.

If having dedicated staff for residents is not feasible, institutions and program leadership can still provide key messaging to residents about mental health care. These messages should begin in orientation and be reinforced over the course of the academic year. Some important messages cited by mental health service leaders include the following.

- Residents often respond well to therapy; they tend to be “great” patients and are often able to readily incorporate mental health strategies into their lives.
- Residents may believe that seeing a therapist will lead to a long-term commitment to therapy. Mental health service leaders reported that residents who seek mental health care, on average, see a therapist for 3 to 4 visits, a statistic that should be shared widely with residents.

- Mental health services are not only indicated for those who are depressed or anxious. Mental health care can assist with traumatic clinical experiences. Therapy can also address problematic mindsets such as impostor phenomenon or maladaptive perfectionism or assist with developing self-compassion.
- Mental health services are also not only indicated for work-related issues. Therapy can be helpful to residents dealing with personal stressors such as dealing with an ailing parent, relationship challenges, loneliness, or other life challenges.

Stigma remains an obstacle to mental health care in medicine, though many of the directors feel that the current generation of residents may feel it less intensely. Mental health service leaders noted that the degree of stigma varies significantly across specialties and programs, remaining stronger in some departments than in others. All felt that engaging with program and department leadership to encourage destigmatizing messaging to and from faculty and fellow residents is critically important to change culture around mental illness and mental health care. Mental health service leaders felt that it was particularly useful if faculty, particularly senior leaders, are able to show vulnerability and discuss their own challenges and struggles.

MedStar Health approaches the stigma issue by offering what they term “coaching services” by licensed clinical social workers in their unit, based on the concept that some residents might be more willing to see a coach than a therapist. Referrals for mental health care can then be made by the coaches if indicated.

GME leaders need to recognize that cognitive processes may become distorted as individuals become more depressed. Individuals who, when well, express no concerns about stigma and seeking help, may change their views under the influence of clinical depression, leading them to become more reluctant to seek care. At Duke Medical Center, the DIO asks each resident during orientation to write a letter to themselves about what steps they would take if they struggled with mental health issues. The letters are then placed in self-addressed sealed envelopes, and midyear around the holidays are mailed out so that residents can see what they had written at the start of the academic year.

Efforts also can and should be made to eliminate stigmatizing questions from applications for hospital credentials. The Dr. Lorna Breen Heroes Foundation has developed a simple toolkit to provide a roadmap for removing these questions.⁸

Isolation can make accessing care more difficult. Peer support and psychological first aid training can be useful in ensuring that peers and faculty have the necessary skills to connect effectively with those who are suffering and who may be reluctant to seek care. Online resources to teach the skills necessary for psychological first aid are readily available.⁹⁻¹²

Conclusion

Barriers to care and stigma remain widespread and contribute to low utilization of mental health services by residents and fellows. Creative approaches outlined in this article provide a range of strategies and key program features that have the potential to increase mental health care utilization and improve the psychological well-being of our learners.

References

1. Hu YY, Ellis RJ, Hewitt DB, et al. Discrimination, abuse, harassment, and burnout in surgical residency training. *N Eng J Med*. 2019;381(18):1741-1752. <https://www.nejm.org/doi/full/10.1056/NEJMsa1903759>
2. Mata DA, Ramos MA, Bansal N, et al. Prevalence of depression and depressive symptoms among resident physicians: a systematic review and meta-analysis. *JAMA*. 2015;314(22):2373-2383. doi:10.1001/jama.2015.15845
3. Yaghmour NA, Brigham TP, Richter T, et al. Causes of death of residents in ACGME-accredited programs 2000 through 2014: implications for the learning environment. *Acad Med*. 2017;92(7):976-983. doi:10.1097/ACM.0000000000001736
4. Accreditation Council for Graduate Medical Education. Common program requirements. Accessed May 21, 2024. https://www.acgme.org/globalassets/pfassets/programrequirements/cpreresidency_2023.pdf
5. Guille C, Speller H, Laff R, Epperson CN, Sen S. Utilization and barriers to mental health services among depressed medical interns: a prospective multisite study. *J Grad Med Educ*. 2010;2(2):210-214. doi:10.4300/JGME-D-09-00086.1
6. Ey S, Moffit M, Kinzie JM, Choi D, Girard DE. “If you build it, they will come”: attitudes of medical residents and fellows about seeking services in a resident wellness program. *J Grad Med Educ*. 2013;5(3):486-492. doi:10.4300/JGME-D-12-00048.1
7. Aaronson AL, Backes K, Agarwal G, Goldstein JL, Anzia J. Mental health during residency training: assessing the barriers to seeking care. *Acad Psychiatry*. 2018;42(4):469-472. doi:10.1007/s40596-017-0881-3

8. Dr. Lorna Breen Heroes' Foundation. Accessed December 18, 2023. <https://drlornabreen.org/removebarriers/>
9. Center for the Study of Traumatic Stress. Psychological first aid: how you can support well-being in disaster victims. Accessed December 18, 2023. <https://dl.acgme.org/learn/course/grief-leadership-leadership-in-the-wake-of-tragedy-1/uniformed-services-university/well-being-resource-articles?page=4>
10. Learn at ACGME. Psychological First Aid (PFA). Accessed December 18, 2023. <https://dl.acgme.org/learn/course/covid-19-well-being-resource-library/ptsd/administering-psychological-first-aid>
11. Mayo Clinic Youtube page. Make the difference: preventing medical trainee suicide. Accessed December 18, 2023. <https://www.youtube.com/watch?v=I9GRxF9qEBA>
12. Association of American Medical Colleges. Stress first aid for health care professionals: recognize and respond

early to stress injuries. Accessed December 18, 2023. https://edhub.ama-assn.org/steps-forward/module/2779767?resultClick=1&bypassSolrId=J_2779767



Stuart Slavin, MD, MEd, is Vice President for Well-Being, Accreditation Council for Graduate Medical Education (ACGME), Chicago, Illinois, USA; **Josepha Cheong, MD**, is Professor of Psychiatry, University of Florida School of Medicine, Gainesville, Florida, USA, and a Member of the Board of Directors, ACGME, Chicago, Illinois, USA; **Jessica Bienstock, MD, MPH**, is Professor of Gynecology and Obstetrics and Designated Institutional Official, Johns Hopkins School of Medicine, Baltimore, Maryland, USA, and a Member of the Board of Directors, ACGME, Chicago, Illinois, USA; **Carol Bernstein, MD**, is Professor, Departments of Psychiatry and Behavioral Sciences and Obstetrics and Gynecology and Women's Health, Albert Einstein College of Medicine, Bronx, New York, USA, and Senior Scholar, ACGME, Chicago, Illinois, USA.

Corresponding author: Stuart Slavin, MD, MEd, Accreditation Council for Graduate Medical Education, Chicago, Illinois, USA, sslavin@acgme.org