Accredited CME Activity

Update on the UC San Diego Healer Education Assessment and Referral (HEAR) Program

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Continuing Medical Education Information

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This activity is provided by the Federation of State Medical Boards.

Learning Objectives

Upon completion of this activity, participants should be able to:

- *Recognize the current scope of suicidal ideation among medical students and residents*
- *Describe the basic structure, methodology and approach of the UC San Diego HEAR program*
- *Discuss the impact and results achieved by the UC San Diego HEAR program*

Method of Participation

This article is one of four in this CME section that must be read in order to receive CME credit. The others are "Physician Mental Health: An Evidence-Based Approach to Change," "FSMB Efforts on Physician Wellness and Burnout," and "Facilitating Help-Seeking Behavior Among Medical Trainees and Physicians Using the Interactive Screening Program."

After reading all four of the articles, CME participants should log-in and register for the CME activity at the web address provided in the "How to Participate in the CME Activity" document, and complete and submit the online post-test and evaluation. The post-test includes questions about each article. The FSMB policy on wellness and burnout is not required for CME credit. It is provided as a supplemental resource.

ABSTRACT: Burnout, depression and suicide are rampant amongst health care professionals. Current evidence shows the problem is worsening. In the aftermath of physician suicides, the Physician Wellbeing Committee created the UC San Diego Healer Education Assessment and Referral (HEAR) Program in 2009 in collaboration with the American Foundation for Suicide Prevention (AFSP). This article chronicles the HEAR program from inception through June 2017. Initially created to address medical students, residents and faculty physician duress, HEAR has now expanded to embrace pharmacists, nurses and clinical staff within UC San Diego Health. HEAR operates through two mechanisms: 1) a program of ongoing education and outreach, and 2) encouragement of all personnel to annually engage in the online, anonymous, interactive screening program, created by the AFSP (known as SDSQ at UC San Diego Health). Since inception in May 2009 through June 2017, 1,537 UC San Diego health care

personnel have been screened, 320 individuals have dialogued with a counselor either in person, by phone or electronically, and more than 300 have been referred confidentially for evaluation and treatment by a mental health professional, usually a community psychiatrist. While tracking death by suicide remains challenging, we have reason to believe that the prevalence of suicide has diminished during this time. The UC San Diego HEAR Program is one cost-effective model for addressing this current crisis in U.S. health care. This AFSP model has been adopted by many other schools of medicine and is now ready for use with clinicians of all disciplines.

And whoever saves a life, it is considered as if he saved an entire world.
—Mishnah Sanhedrin 4:5; Babylonian Talmud Tractate Sanhedrin 37a

Introduction

Burnout, depression, and suicide are plagues upon the medical and nursing professions. While career-related stress, dissatisfaction and disappointment among physicians have been recognized for decades,[1,2] burnout, defined by the experience of job-related emotional exhaustion, detachment and/or a sense of lack of meaningful accomplishment, is increasing.[3-5] Untreated depression is common[6] and suicide rates are higher than in the general population.[7] Similarly, residents and medical students suffer alarming rates of burnout, depression and suicidal ideation. [8,9] For residents, burnout rates of 45–60% have been reported[10] and a 2015 meta-analysis of 17,500 resident physicians covering a 50-year time span estimated that 29% experienced significant depressive symptoms.[11] Another prospective intern cohort found that 24% of interns developed suicidal thoughts within months of beginning internships.[12] Similarly, burnout rates rise dramatically for medical students shortly after beginning medical school.[9,13] A 2016 meta-analysis of studies of medical students from 43 countries showed a global prevalence of major depression (27.2%) and current suicidal ideation (11.1%).[14] Among U.S. resident physicians, suicide is the leading cause of death for males and second leading cause of death for all residents.[15] Stigma and fear of negative repercussions drive many physicians and medical students to forego treatment, self-medicate or obtain informal "treatment" from colleagues.[16] Although there is less research on suicide in nursing, it is believed that mental health problems and suicide rates are at least as severe for nurses, and perhaps greater.[17-19]

WHILE CAREER-RELATED STRESS, DISSATISFACTION AND DISAPPOINTMENT AMONG PHYSICIANS HAVE BEEN RECOGNIZED FOR DECADES, BURNOUT, DEFINED BY THE EXPERIENCE OF JOB-RELATED EMOTIONAL EXHAUSTION, DETACHMENT AND/OR A SENSE OF LACK OF MEANINGFUL ACCOMPLISHMENT, IS INCREASING.

A 2016 META-ANALYSIS OF STUDIES OF MEDICAL STUDENTS FROM 43 COUNTRIES SHOWED A GLOBAL PREVALENCE OF MAJOR DEPRESSION (27.2%) AND CURRENT SUICIDAL IDEATION (11.1%).

In 2008, after averaging approximately one physician or medical student suicide annually over a decade, the UC San Diego Physician Well Being Committee (PWBC) recognized the significance of the problem and vowed to make a change. Not a single one of those that died had come to the PWBC for help. We consulted the American Foundation for Suicide Prevention (AFSP) for guidance. With the help of AFSP and the financial support of the CEO of UC San Diego Health and the Vice Chancellor and Dean of the UC San Diego School of Medicine, the HEAR (Healer Education, Assessment and Referral) Program was born in 2009.[20] The only cost was for one full-time Program Counselor (a medical social worker [MSW], and the licensing cost of AFSP's online interactive screening program [ISP]).

The HEAR Program was built upon a set of guiding principles that are important to understand. All those who serve and suffer from burnout or depression and all of those who chose to take their lives had health insurance and access to good care. Access alone is insufficient since internal barriers can prevent many from availing themselves of mental health care, even when symptoms are severe and

suicide risk is high.[6] Likewise, it would have been insufficient for HEAR to maintain open office hours and expect suffering colleagues to simply walk in for help.

Therefore, the HEAR Program was built upon a confidential and *aggressive* two-pronged approach: 1) education and outreach, with the goal of removing the stigma associated with help-seeking behavior, especially related to mental health; and 2) proactive identification of suffering, at-risk colleagues in order to provide support, help remove internal barriers, and refer to mental health care.

Methodology

The basic processes of the UCSD HEAR Program have not changed much since its inception.[20-23] The program is led by a multi-professional team of mostly volunteers who serve on the HEAR Committee. Initially, the HEAR Committee consisted of faculty from several medical school departments and the Physician Well Being Committee. The initial target groups served were medical students, residents, fellows and faculty physicians. Though the rate of pharmacist suicide is unknown, pharmacists were identified as high risk for burnout and depression,[24] and HEAR was expanded to include the School of Pharmacy. Subsequently, a pharmacy representative was added to the committee. Soon thereafter, medical student and resident representatives were added. In 2016, after it became clear that suicide was an issue among nurses, we again expanded the committee to include nurses. Currently, HEAR can be accessed by any employee of UC San Diego Health, including all hospitals, clinics, research programs, and teaching programs and our affiliated teaching centers: the Veterans Administration Medical Center in La Jolla and Rady Children's Hospital. To accommodate this expansion, the HEAR program was given a small pilot grant from the UC Office of the President to increase counselor time to two full-time employees and provide salary support to the HEAR Committee chair for supervision and support.[19] In return the program would now be offered to all clinical staff. Currently, the UCSD HEAR committee consists of faculty from the Schools of Medicine and Pharmacy, clinical staff, nurses, residents, fellows, students and one health care chaplain — a total of about 30 people at any given time. Though a core group attends meetings, others volunteer in outreach activities such as lectures and incident debriefings.

CURRENTLY, *HEAR* CAN BE ACCESSED BY ANY EMPLOYEE OF UC SAN DIEGO HEALTH, INCLUDING ALL HOSPITALS, CLINICS, RESEARCH PROGRAMS, AND TEACHING PROGRAMS AND OUR AFFILIATED TEACHING CENTERS...

...THE UCSD *HEAR* COMMITTEE CONSISTS OF FACULTY FROM THE SCHOOLS OF MEDICINE AND PHARMACY, CLINICAL STAFF, NURSES, RESIDENTS, FELLOWS, STUDENTS AND ONE HEALTH CARE CHAPLAIN — A TOTAL OF ABOUT 30 PEOPLE AT ANY GIVEN TIME.

Our counselors are the pistons of the HEAR engine. They organize meetings and educational events, attend HEAR presentations, maintain regular communication with AFSP's ISP team, vigilantly attend to the Stress and Depression Screening Questionnaire, and provide personalized case management for everyone accessing help through HEAR. The counselors devote a large amount of effort to shepherding participants in a case-managed approach, customizing referrals to community mental health professionals, and assuring timely referrals to insurance-specific providers. One of their key responsibilities is to maintain a list of providers who will accept referrals of at-risk health care clinicians. This allows for at-risk professionals to obtain mental health care outside of their workplace.[25]

Going forward, we anticipate maintaining the added support that had been provided by the recent pilot program. In addition, we plan to broaden our target group to include health care professionals within the organization's key affiliate programs. This includes trainees at the Rady Children's Hospital and the VA San Diego Healthcare System. Our coverage currently extends to many thousands of health care personnel. The HEAR committee will also take a leadership role in the upcoming UCSD Care for the Caregivers' Peer Support Program. This program will be funded by the UC Office of the President, administered through UCSD Risk Management, and include

training and managing a large cadre of volunteer peer supporters, mounting a "critical incident" staff support program with debriefings and crisis interventions, as necessary, and initiating formal Schwartz Rounds®.[26] Schwartz Rounds are interdisciplinary meetings that encourage patient-centered dialogue specifically encouraging open and honest discussion of the social and emotional aspects of care in actual patient cases. Schwartz Rounds currently take place in about 600 hospitals and other health care organizations worldwide. Training and membership is offered through the Schwartz Center for Compassionate Healthcare®.

We obtained UCSD IRB approval to evaluate HEAR and describe outcomes while maintaining participant confidentiality.

Education to remove the stigma associated with help-seeking and mental health

Our educational outreach program is based upon a commitment to provide at minimum a one-hour didactic and interactive program to every clinical unit, department, and division on a three-year cycle. These programs cover the topics of burnout, depression, substance abuse, and suicide, especially in health care professionals and students. Recently, we have added a preventive focus as well, featuring curriculum in self-care, wellness, and resilience. Above all, we make every effort to remove the stigma of mental illness that, for centuries, has been a damaging hallmark of our culture. This work requires a constant commitment to educating colleagues and the public. We provided one formal presentation per week during FY 2016–2017.

Additionally, we have provided formal and informal consultations. We supported the development of a wellness program designed to mitigate burnout in radiologists. Increasingly, our work extends to other local hospitals and medical groups. Variants of our HEAR presentation have been given at national and international conferences and will be delivered at the 2017 meeting of the Association of American Medical Colleges (AAMC). The internal educational programs bring a face to the program so that participants know that the counselors and physicians behind the screening are approachable and knowledgeable, forming a trusting relationship which encourages participation. We have found that after even sparsely attended educational programs there is a pulse in screening activity or requests for information stimulated largely through word-of-mouth.

OUR EDUCATIONAL OUTREACH PROGRAM IS BASED UPON A COMMITMENT TO PROVIDE AT MINIMUM A ONE-HOUR DIDACTIC AND INTERACTIVE PROGRAM TO EVERY CLINICAL UNIT, DEPARTMENT AND DIVISION ON A THREE-YEAR CYCLE.

Identifying at-risk colleagues and treatment referrals

The second prong of the HEAR Program is the interactive screening program (ISP), which after undergoing trials at UCSD is now customized to each institution. It is currently implemented in more than 125 universities, 20 hospitals/medical schools, and several law enforcement and corporate settings. The UCSD specific version is called the Stress and Depression Screening Questionnaire (SDSQ). ISP is an anonymous, web-based interactive screening and referral program licensed by AFSP.[27] This website and online platform could not have been safely created without the expertise of AFSP. Its ongoing functionality requires regular communications with AFSP personnel to coordinate programming and database management. Clinicians and faculty access this website and complete the SDSQ. When an individual completes the SDSQ, the program's online algorithm distributes the participants' responses into one of three tiers of risk. The counselors review this data and everyone participating in the SDSQ receives a personalized response within 48 hours. All high-risk responses (tiers 1 and 2) are urged to call or email the counselor to arrange a private, confidential, in-person meeting. Email communication through the website remains encrypted and confidential, so it is possible for our counselors to have continuing dialogue without knowing the participant's identity. Since this has the potential for an ethical dilemma, the program was reviewed and approved by the UC San Diego Medical Center Medical Ethics Committee. The approval was based on the principle that the greater good is served by the promise of confidentiality and privacy. Moreover, the program is not defined as clinical in nature, but rather as focused on outreach, education and referral. It serves as a catalyst to access existing clinical resources. The promise of privacy is one of the critical aspects of the program's success, since fear of punitive

consequences keeps many health care professionals suffering in silence.[28]

The clinicians and faculty are encouraged to access the HEAR website and complete the SDSQ in several ways. At least once annually, the Vice Chancellor and Dean of the UC San Diego School of Medicine (for faculty) or the Chief Operating Office (for hospital staff) send a powerful and impassioned appeal asking them to complete the SDSQ, even if they are feeling well. The letter is very clear about the importance of screening as a measure of self-care. At the conclusion of every HEAR presentation, the presenter encourages each person in the audience to immediately complete the SDSQ. The HEAR program counselor sends an email invitation to all attendees to complete the confidential online questionnaire. Similar appeals, highlighting the anonymous and confidential nature of participation, are made at various meetings throughout the year.

THIS PAST YEAR, AFTER EXPANSION OF THE PROGRAM TO HOSPITAL STAFF, AS THE SERVICES AND SKILLS OF THE MEMBERS OF THE *HEAR* COMMITTEE WERE RECOGNIZED, REQUESTS WERE RECEIVED ORGANICALLY FOR EMOTIONAL DEBRIEFINGS AFTER SIGNIFICANT CRITICAL INCIDENTS.

This past year, after expansion of the program to hospital staff, as the services and skills of the members of the HEAR committee were recognized, requests were received organically for emotional debriefings after significant critical incidents. The HEAR committee responded to this unexpected request for service and provided group debriefings as the need arose. These debriefings further stimulated use of the SDSQ. The debriefings are held at a date, time and place of the requestor's preference and include members of all disciplines affected by the situation. The Risk Management Department began informing the HEAR committee of situations which they had clinically debriefed that would also benefit from psychological debriefing.

Results

Between May 2009 and the end of July 2017, a total of 1,454 medical students, 1,850 house staff (interns, residents and fellows), and 1,794 faculty members were invited to complete the anonymous SDSQ.

During FY 2016–2017 alone, 725 individuals completed the SDSQ: 82 medical students and pharmacy students; 78 interns, residents, and fellows; 185 nurses; 74 faculty; 12 pharmacists; and 294 "role unknown" individuals. A total of 60 of those screened accepted referrals to a community psychiatrist during the past fiscal year alone. The subset of "role unknown" are likely individuals who prefer not to disclose their role/position for fear of identification, which further speaks to the desire of participants to remain anonymous (Table 1).

AT THE CONCLUSION OF EVERY *HEAR* PRESENTATION, THE PRESENTER ENCOURAGES EACH PERSON IN THE AUDIENCE TO IMMEDIATELY COMPLETE THE SDSQ. THE *HEAR* PROGRAM COUNSELOR SENDS AN EMAIL INVITATION TO COMPLETE THE ONLINE QUESTIONNAIRE.

Table 1
Stress and Depression Screening Questionnaire (SDSQ)
TOTAL RESULTS (July 2016–June 2017)

	Medical and Pharmacy Students	House Staff	Faculty	Nurses	Pharmacists
Total Number	578	800	1744	2,475	120
Completed ISP	82 (14%)	78 (10%)	74 (4%)	185 (7%)	12 (10%)
Dialogued with Counselor	10 (12%)	30 (38%)	9 (12%)	40 (22%)	4 (33%)
Accepted Referral*	7 (70%)	20 (67%)	4 (44%)	26 (65%)	3 (75%)

*Several individuals felt dialogue with counselors was all they needed and some (especially nurses) already were in treatment; one additional referral was accepted from an individual who did not specify a position.

Table 2
Stress, Depression, Suicide Risk and Treatment, May 2009–June 2017

	Students N=508	House staff N=407	Faculty N=425	Nurses*** N=185	Pharmacists*** N=12
Moderate or greater depression (PHQ >10)	23.2%	27.3%	13.4%	38.9%	16.7%
Life too stressful*	34.4%	46.2%	41.0%	41.1%	50.0%
Feeling intensely lonely*	19.3%	22.4%	6.6%	23.4%	8.3%
Feeling hopeless*	10.5%	13.0%	5.7%	15.9%	0%
Feeling desperate*	9.1%	10.1%	3.5%	8.7%	0%
Drinking too much*	15.8%	20.4%	21.2%	26.6%	16.7%
Past suicide attempt(s)	1.4%	3.2%	2.1%	10.8%	0%
Current thoughts about taking own life**	9.6%	9.6%	6.8%	7.6%	0%
Current medication for depression	7.1%	11.6%	9.9%	20.5%	8.3%
Counseling or therapy	13.2%	7.7%	10.2%	15.2%	8.3%

* Responded as "a lot of the time" or "most of the time."
** Responded as "some of the time," "a lot of the time" or "most of the time."
*** Nurses and pharmacists joined the ISP in June, 2016.

Table 3
Dialogue and ISP Referral, May 2009–June 2017

	Students N=508	House staff N=407	Faculty N=425	Nurses* N=185	Pharmacists* N=12
Number who Dialogued with counselor	91 (17.9%)	102 (25.1%)	84 (19.8%)	39 (21.2%)	4 (33.3%)
Online	64	61	61	23	2
Phone	9	22	11	9	1
In-person	18	19	12	7	1
Referred thru ISP**	57	66	42	28	3

* Nurses and pharmacists joined the ISP in June, 2016.
** About as many referrals came directly from counselors or committee members independent of the ISP.

Since inception, May of 2009 through June 2017, 1,537 individuals completed the SDSQ. Of these, 23.2% of students, 27.3% of house staff, 13.4% of faculty, and 38.9% of nurses were identified as having moderate to high risk of depression (PHQ>10). Except for pharmacists, 7% to 10% of those completing the SDSQ reported suicidal ideation (Table 2). All of those individuals received referral information. Of this group, 320 individuals initiated further face-to-face, phone, or electronic contact through the secure SDSQ platform (Table 3). Of those, 57 chose face-to-face encounters, the remainder choosing telephone or anonymous communication through the encrypted site. It was initially concerning for HEAR committee members to learn that many participants favored an ongoing anonymous online relationship with our counselors. This phenomenon may reflect concern for confidentiality and fear of professional ramifications to transparency: persistent barriers to pursuing needed mental health treatment.[28] Also, it is clear that many prefer accessing this service after hours or on weekends, so our dedicated counselors make themselves available 24 hours a day, seven days a week. Though difficult to sustain, it is important for centers that may be launching similar programs to anticipate that high-risk participants will perform the

screening off-hours, requiring a response outside traditional business hours.

Of the more than 320 individuals HEAR has referred for ongoing mental health care, 196 have come directly from the ISP. The others contacted HEAR counselors or committee members for referrals directly, bypassing the ISP mechanism. The vast majority of referred individuals stated that they would not otherwise have sought help without this program. Given the concentrated percentage of participants stratified to high risk, we feel that the interactive online nature of the program is reaching a group refractory to standard approaches to wellness.

There have been two suicides among UC San Diego medical and pharmacy students, residents, fellow and physician faculty since 2009, and none in nurses or other professional health care staff since they were added to the HEAR umbrella. Although the numbers are too small to perform statistical analysis, based on the rate of suicide in the UC San Diego academic and clinical community before 2009, we have observed six fewer suicides than in the same timespan previously.

Discussion

Because of the highly confidential nature of HEAR and our reliance on the anonymous, encrypted SDSQ website, our outcomes are limited to symptoms endorsed, dialogue content with counselor including topics such as working through perceived barriers to help-seeking, and whether a referral was provided. However, based on an estimated 320 mental health referrals from May 2009 through June 2017, most of whom attested that they would not have sought help were it not for HEAR, we feel confident of the program's efficacy. Additionally, through aggregate data analysis of UCSD's SDSQ data, we find significant rates of engagement with the program counselor when privacy is protected and when screening responses are addressed in a customized, compassionate manner. Although admittedly anecdotal, HEAR Committee members believe we are making progress towards removing the stigma of mental health and help-seeking behavior in our university. The increasing frequency of requests for presentations and the level of engagement of participants both during and following these presentations also provide qualitative evidence of the impact of the program.

OF THE MORE THAN 320 INDIVIDUALS *HEAR* HAS REFERRED FOR ONGOING MENTAL HEALTH CARE, 196 HAVE COME DIRECTLY FROM THE ISP...THE VAST MAJORITY OF REFERRED INDIVIDUALS STATED THAT THEY WOULD NOT OTHERWISE HAVE SOUGHT HELP WITHOUT THIS PROGRAM.

Importantly, the screening (SDSQ) component of HEAR, which utilizes AFSP's ISP Program, does not leave participants to take the next step on their own. No one, not even human resources personnel or health care administrators, has access to a participant's private information. Therefore, we warn the medical education community, especially in light of recent ACGME requirements for residency programs to screen trainees, that universal screening must be accompanied by the critical protections that ISP and HEAR provide. Assurance of privacy coupled with the customized caring response of a trained counselor is needed for success. Screening on its own could have unintended consequences without interaction and aftercare. Distress and suicide risk would be left in the same state that we are trying to change: silent, unattended, under-treated or self-medicated.

IMPORTANTLY, THE SCREENING (SDSQ) COMPONENT OF *HEAR*, WHICH UTILIZES AFSP'S ISP PROGRAM, DOES NOT LEAVE PARTICIPANTS TO TAKE THE NEXT STEP ON THEIR OWN. NO ONE, NOT EVEN HUMAN RESOURCES PERSONNEL OR HEALTH CARE ADMINISTRATORS, HAS ACCESS TO A PARTICIPANT'S PRIVATE INFORMATION.

The UC San Diego HEAR Program has operated on a modest budget and proved to be remarkably cost-effective. Over the eight-year history of this program, the annual budget has essentially been the salary and benefits of one to two MSW/MFT/LCSW level health professionals. The financial benefits to the institution, while hard to quantify, are not hard to imagine. Mitigating burnout and improving access to mental health resources have been shown to reduce absenteeism,[29] sick days,[29] patient satisfaction[30] and employee turnover.[29] Although we have not tracked these metrics, the types

of resources that HEAR provides are known to provide such benefits.[31,32] It has been shown that the turnover and replacement of one faculty physician, on average, costs $1 million.[33] A recent informal analysis at the UC San Diego Medical Center shows the overall cost of replacing one nurse is $300,000 (Beverly Morris, RN, personal communication). Moreover, the work and existence of the HEAR Program helps to improve morale, elevating the image of the institution.

The concepts of the HEAR Program are relatively easy to adapt, as has been reported by the UC Davis Health System.[34] Wellness models are being considered and implemented on medical campuses nationwide.[35] While we believe the HEAR program is effective, we also know it is targeted to people who are experiencing moderate to high degrees of distress. We believe the primary prevention of burnout, stress and depression is an important goal, and we are actively moving in this direction as well. Personal and institutional factors that were reported through our program to contribute to burnout and stress and could be targeted for prevention include overwork;[3] work-home conflict;[36] educational debt;[37] inadequate sleep;[38] clerical burden of the electronic health record;[3] perfectionism and other personal attributes; lack of exercise;[39,40] and mistreatment of medical students,[41] nurses[42] and other clinicians.

We are delighted to be part of a long overdue national conversation on addressing caregiver wellbeing. The National Academy of Medicine has launched an "Action Collaborative" to reduce burnout, depression and suicide and promote well-being of health professionals; it further identified clinician burnout as one its top initiatives for 2017.[43] All of the major medical education and training organizations (e.g., AAMC, ACGME, AOA, AACOM) and many specialty associations (e.g., AMA, APA) are actively promoting physician wellness and burnout prevention. The American Nurses Association (ANA) and the American Association of Critical Care Nurses (AACN) are also highly focused on workplace wellness. Collectively, the Critical Care Societies in the U.S. have begun an initiative to combat burnout in all disciplines providing care to the critically ill and injured.[17,44-48] Online resources are proliferating. Evidence-based tools are being developed, including, but not limited to, mindfulness-based programs[49] and online Cognitive Behavioral Therapy (CBT) resources.[50] While comprehensive organizational strategies to promote wellness and mitigate burnout are beyond the scope of this paper, it is clear that medical organizations have a duty to address this important issue. Deliberate, sustained efforts by medical organizations to reduce burnout, destigmatize help seeking behavior, and promote wellbeing can make a difference.[51]

Conclusion

We have briefly described the activities and outcomes of the UC San Diego HEAR Program from its inception in May 2009 through the end of FY 2016–2017.

The provision of health care can be an enormously stressful endeavor. Everywhere research has been conducted, rates of burnout, depression, and suicide among health care professionals are deemed profound.

It is time to end the stigma associated with changes in mental health and help-seeking behaviors within the health care professions. All health care professionals need to practice mutual support and sensitivity towards colleagues, which includes supporting their mental health needs.

We believe that having health insurance and access to care is important but insufficient to address mental health issues. Participants of the HEAR program who received referrals for treatment were all insured but did not use their health care benefits without the stimulus provided by the proactive screening and referral program, which provided the opportunity to work through personal, internal barriers to help-seeking. We believe that all health care professionals should be exposed to and have access to programs like the UC San Diego HEAR Program that operate from a proactive approach to education and the identification of colleagues at risk for burnout, depression, and suicide. The HEAR program has been recognized as a best practice

IT IS TIME TO END THE STIGMA ASSOCIATED WITH CHANGES IN MENTAL HEALTH AND HELP-SEEKING BEHAVIORS WITHIN THE HEALTH CARE PROFESSIONS. ALL HEALTH CARE PROFESSIONALS NEED TO PRACTICE MUTUAL SUPPORT AND SENSITIVITY TOWARDS COLLEAGUES...

by the American Medical Association,[52] yet few formalized suicide prevention programs exist for health care professions. More research and wider implementation of such programs are necessary.

Most importantly, we need to strive to identify and control the antecedents of stress and burnout and improve prevention strategies at both the individual and organizational levels.

We insist on this not only for our personal wellbeing, but with the knowledge that only healthy health care professionals can provide optimal care to their patients.[4,5] There are many paths forward, but we must move forward by all means.

As Eleanor Roosevelt once advised, "It takes as much energy to wish as it does to plan. You must do the thing you think you cannot do." ■

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