The Journal of Nursing Administration

Suicide Prevention: A Healer Education and Referral (HEAR) Program for Nurses

--Manuscript Draft--

Manuscript Number:	
Full Title:	Suicide Prevention: A Healer Education and Referral (HEAR) Program for Nurses
Article Type:	Manuscript
Keywords:	suicide; workplace; nurses; occupational health; delivery of health care; secondary traumatic stress; stress: psychological
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Manuscript Region of Origin:	UNITED STATES

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MeSH terms: suicide, workplace, nurses, occupational health, delivery of health care, secondary traumatic stress, stress: psychological,

Grant funding: Internal: University of California Office of the President, 1 year Safety Grant.

Title: Suicide Prevention: A Healer Education, Assessment and Referral (HEAR) Program For Nurses

Abstract **(Limit 150)**

Objective: To describe the pilot expansion of a proactive suicide risk-screening program, initially designed for medical students and physicians, to nurses.

Background: Nurses are more likely to complete suicide than the general population. The HEAR program detects at-risk physicians and facilitates referral to mental health care. Nothing similar has been available for at-risk nurses. Local nurse suicides served as the catalyst to extend the HEAR program to nurses.

Method: Education, outreach and an encrypted, online, anonymous risk screening were conducted to identify and refer nurses with depression and suicide risk.

Results: 149 (6%) of 2475 nurses completed questionnaires; 11 (7.4%) reported current active thoughts or actions of self-harm, 18 (12.1%) reported previous suicide attempts and 65 (44%) were rated as high risk. 12 nurses accepted referral for further treatment.

Conclusions: An encrypted anonymous risk screening is effective at identifying nurses at risk and referring them to treatment.

Suicide Prevention: A Healer Education, Assessment and Referral (HEAR) Program For Nurses

Suicide risk in healthcare

The World Health Organization reports that one person dies every 40 seconds by suicide. [1] In the United States, suicide is the cause of death in approximately 38,000 citizens a year. [2] Suicide is now the 10th leading cause of death in the United States, occurring at a rate of 13 per 100, 000 of the population.[3] While overall mortality rates are decreasing in the United States, suicides are on the rise.[3] Health care providers may be at especially high risk.[4] The purpose of this manuscript is to describe the results of a suicide prevention program developed for nurses.

Rates of suicide among U.S. physicians are much higher than those of the general population.[5] A 2004 meta-analysis showed that compared to an age, gender, and education-matched comparison group the relative risk for suicide was 1.41 for U.S. male physicians and 2.27 for U.S. female physicians.[6] About 300 to 400 U.S. physicians take their lives each year, a number roughly equivalent to two average medical school classes.[7]

The incidence of nurse suicide in the United States is less well studied or established. However, in a 2001 study on occupational risks, it was reported that when adjusted for gender the odds ratio for a nurse dying of suicide was 1.58 greater than the working-age population.[4] We recently conducted a regional pilot confirming that nurses were at 3 times the risk of the general population and that female nurses were 3 times the risk as the general female population.[8]

Physician suicide prevention: Development of Healer Evaluation Assessment and Referral Program (HEAR)

At our own organization, prior to 2009, approximately one medical student, resident, or faculty member was taking his/her own life annually. A confidential survey demonstrated a self-reported rate of 29% for depression, a >3% rate of current suicidal ideation and a 6% rate of serious drinking among residents and faculty.[9] After digesting this disturbing data, the Physician Well-Being Committee (PWBC) began to investigate options for creating a suicide prevention program. In the summer of 2008 a group of medical

faculty in collaboration with the American Foundation for Suicide Prevention (AFSP) founded the Suicide Prevention and Depression Awareness Program,[10] which has become better known today as the Healer Education Assessment and Referral (HEAR) Program.

A detailed description of the HEAR program, which is now provided in over 60 campuses including eight medical schools, is provided elsewhere[10,11]; a brief summary follows. HEAR was designed to provide service to all physicians, residents, and medical students of the organization's hospitals, clinics, and affiliations. After the first year, the School of Pharmacy was added. The membership of HEAR represents each of the major constituencies, including including faculty representatives from several departments in the School of Medicine, Pharmacy, the PWBC, medical students, residents and program counselors. HEAR is designed with a two-pronged approach. The first is a regular 3-year cycle, face-to-face ("Grand Rounds") presentation designed to provide education on burnout, depression, and suicide; de-stigmatize depression; and acquaint all attendees with the membership and function of HEAR. The second is an encrypted, confidential and anonymous Web-based screening, assessment and referral program based on one created by the AFSP. People are encouraged to access and participate in the web-based screening as a result of the face-to-face presentations and by way of a powerful annual email message issued by the Dean of the School of Medicine. Two 0.5 FTE program counselors/coordinators review the communications through the encrypted website at least daily, communicate with the physicians/students, and make appropriate plans to meet with him or her, if acceptable.

At this point the careful reader will understand that an actively suicidal physician could potentially access the website and we would be helpless to know their identity. Because of this, this dilemma was presented to the leadership of our School, the CEO of our medical center, the Medical Ethics Committee, the individual members of HEAR, and a number of faculty, residents, and medical students. The response was unanimous that the greater good would be served through prioritizing absolute privacy. To date, this has proven to be a wise course without adverse events.

Between May 6, 2009 through May 20, 2016 a total of **1558** medical students (N=519), pharmacy students (N=90), resident physicians and fellows (N=341), and medical school faculty (N=502) completed the anonymous online Stress and Depression Screening Questionnaire. Of these, 112 individuals have

dialogued with the program counselor online, by telephone (n=49), and/or in person (n=63). These comprise the majority of the 180 individuals who accepted referrals for formal mental health evaluation and/or treatment during that timeframe. The vast majority of referred participants reported that they would not have sought treatment if not for the HEAR Program. Instead of the expected 1 suicide per year, there has been only 1 suicide in the 6 years since the program has been operational. Additionally, a total of four original research articles have been published describing HEAR program activities and outcomes.[10-13]

The American Medical Association has called out the HEAR program as an exemplar in suicide prevention [14]; a testimony to the success of the program. Looking back it is also unclear why HEAR was built initially for only physicians and medical students, rather than all of the healthcare professionals of our medical system, but that deficiency is being rectified presently.

Catalyst: Nurse suicides within the workforce

Nurse suicides within our own workforce served as the catalyst for expanding this project. After a literature review, and then learning about the successful program initiated to abate physician suicide in our own organization[10], an action plan was set to extend the physician program to nurses instead of replicating it in a parallel structure. The first step of extending the program to all staff was to pilot the extension to nurses.

Ethical oversight

The HEAR program development and expansion was excused from Investigational Review Board (IRB) oversight as a quality improvement initiative (IRB excusal #161812). Oversight for the extension of the HEAR program to nurses was provided by the Risk Management Department and the Healer Education and Referral (HEAR) Committee.

Methods

How it works (Figure 1: Process)

The HEAR program includes a service of education, outreach and referrals. To begin the process education was delivered in three iterative Grand Rounds formats. These were one-hour offerings describing the risks of burnout, depression and suicide. A member of the nursing staff who had suffered from depression and suicidal ideation offered an emotional testimony about how treatment saved her life. A presentation was also delivered at the Nursing Leadership meeting explaining the aims of the program and how it would be implemented. Lastly, a huddle topic fact sheet was developed (Figure 2) [Editor: This could be an online supplement]. In this organization huddle topics are deployed when information needs to be disseminated in a rapid fashion to large numbers. The huddle topic fact sheet is a 1-2 page information sheet. Unit level managers and/or charge nurses then deliver the information at every shift for approximately two weeks until all staff have heard the message. Following the huddle efforts, the Chief Nurse Officer sent the invitation for screening (Figure 3) [Editor: This could be an electronic supplement].

Proactive vs. Passive

It should be noted that this project proactively reaches out to employees to consider self-screening instead of waiting for them to seek help. This is different from the Employee Assistance Program (EAP), which is a third party contracted service where employees may seek out the help of counselors. There were no changes made to EAP during the pilot. The HEAR program complimented but did not alter or replace EAP.

Staffing

The HEAR program was originally staffed with two .5FTE counselors (Masters of Social Work or Doctorate of Psychology prepared) to deploy the screening to physicians and housestaff. A psychiatrist provided back up to the counselors. To extend the pilot to the entire staff it was anticipated that up to 2.0 FTEs counselors would be required plus .35 FTE psychiatry hours for education and treatment. These three people also provided educational outreach upon request. Partial financial support ($168,660) for the pilot was received through a one-year University of California Office of the President Safety Grant.

Survey

The survey and electronic encryption for the HEAR program was developed in collaboration with the American Foundation for Suicide Prevention (AFSP).[10] When participants enter the system, they create a personal username and password. The survey consists of 6 demographic, 1 open-ended descriptive and 38 screening questions. The screening questions have previously been found to detect those at risk for depression and suicidality who should be referred for counseling and was originally developed in collaboration with the American Foundation of Suicide Prevention. [10] The previously validated PHQ-9 depression screening survey is embedded within the survey.[15] The original screening survey was modified only to add a demographic category for nurses. Very little demographic data is requested so that respondents feel comfortable completing the survey without risk of identification. The survey can be both anonymous and confidential due to encryption. Only the respondent can break the code to self-identify. Respondents can choose to have anonymous on-line counseling, anonymous or confidential verbal phone counseling or confidential in-person counseling. When indicated by the content of the communication, counselors also offered referral of respondents to treatment.

Those who agreed to treatment were referred using a pre-selected panel of therapists and psychiatrists who open their panels for timely response to members of this program. Thoughtful creation of a referral panel is necessary to assure timely treatment because of the high-risk nature of depression and suicide risk. Standard crisis counseling was also available as indicated for those with immediate threat of self-harm. Because nurses may be covered by their spouse's insurance, and have a broad selection of insurance coverage to choose from within the workplace, the mental health insurance coverage of nurses was unknown. Therefore, the psychiatrist for this project was prepared to support nurses who required treatment but were under-insured for mental health issues in cases where referrals were impeded due to insurance.

The screening software sorts respondents into three tiers based on risk: tier 1 is highest risk, tier 2 is moderate risk, and tier 3 is low risk. The PHQ-9 depression risk screening that is embedded within the survey has a total score of 27. A score >15, or 10-14 plus previous suicide attempt, or current suicidal ideation, unable to function, or scoring 'most or all of the time' for anxiety, rage, panic, loss of control, desperation, results in a tier 1 score. A score of 10-14 without previous suicide attempt, coupled with

problems with drug, alcohol or eating score a tier 2. Others are tier 3, minimal risk. [11] When a questionnaire is completed, the software generates an email to the counselors alerting them of the respondent's tier and providing a link to the questionnaire. The counselors review all new questionnaires and post a personalized and detailed assessment using a suggested template for each tier level. In the assessment, the counselor introduces herself, gives her contact information, and sensitively addresses areas of greatest concern and offers empathy and support, when indicated. For tier 1 and tier 2 respondents, the counselor invites them to contact her to schedule an in-person meeting for additional support and resources. She also offers other ways to communicate, such as a phone call or the anonymous dialogue feature on the website where the respondent is only identified by their username. Tier 1 respondents are also provided crisis numbers and are encouraged to use them or go to the nearest Emergency Room, if they are in crisis. For tier 3, most often, the counselor writes that the questionnaire indicated no significant issues at this time; however, the counselor is always available to them to answer questions, or provide support and/or referrals, when needed.

The anticipated response rate of nurses to the invitation for screening was unknown. It could be anticipated that responders would self-sort based upon presumed need, but there was no pre-established evidence with which to predict response volume. Therefore, the invitation email was sent to nurses following completion of the response to the yearly survey to physicians and housestaff. Staggering the email distribution was intentionally planned so that the response time by counselors would not be delayed.

Results

Quantitative

In the first three months of the pilot 149 (6%) of 2475 nurses responded to the invitation for screening. Of them, 65 (44%) were classified as high risk. All of those respondents received on-line communication from a qualified counselor. Forty one (28%) of those also received in-person or verbal counseling. Of these, 5 were phone sessions, 3 were in-person, and 33 were online anonymous dialogues. Twelve nurses accepted referral for further treatment. Of those that accepted referral for treatment 5 were high risk, 4 were moderate risk, and 3 were unknown risk as they called without doing the on-line screening, but indicated that they were indeed a nurse. As Table 1 demonstrates, >40% of the respondents had

moderate or greater levels of depressive symptoms, Seven percent had recent thoughts of taking their own lives, 12% reported previous suicide attempts and 11% were screened as currently “suicidal”. The majority endorsed a number of intense, disturbing and distressing feeling states and 28% endorsed “dinking too much”. More detailed mental health dimensions are reported in Table 1.

Qualitative

Stressors were listed in open-ended comments. These were categorized into work, home or mixed. Of the 149 nurses, there were 108 comments; 24 work-related, 44 home-related and 40 mixed. Work stressors included issues with management, work volume, staffing, resources, changing departments, new hospital opening, health and sleep issues related to shift work, feeling unappreciated at work, stress related to learning new skills or teaching others, lateral violence and emotional burden of caring for patients. Home stressors included wedding stress, marital strain, financial issues, personal, family or pet health issues, grief, current events in the world, lack of purpose in life, childcare, infertility, academic stress, feeling alone after moving to the area, and personal or family drug or alcohol use. No negative comments about the program were received. Positive comments about the program are included (Table 2).

Feasibility

No nurses who accepted treatment reported an issue with under-insured mental health coverage. No nurses required immediate crisis intervention. Even though the nurse email invitations to take the survey were sent out all at once, and then again in 2 weeks, the response to the screening staggered back over 2 months. The two 0.5 counselors increased hours to full time for the three months following the nurse screening. These 2.0 FTEs were able to manage the responses without delay given the response volume and staggered response times. The 3 “Grand Rounds” presentations were modestly attended (10-20 participants each) and could not be relied upon as the only method of communication for this subgroup of hospital personnel. However, those who attended did help to spread the word about the program to others. Although offered to all departments, only one department requested an onsite explanation at the staff meeting. This onsite explanation generated increased responses to the survey. We suspect that the Huddle process was the most comprehensive approach to communicating with nurses, but are not able to formally evaluate this.

Discussion

To our knowledge, this is the first report that describes a systematic program to screen, assess and refer nurses at risk for suicide. These preliminary results strongly suggest that such a program is enthusiastically welcome, feasible, acceptable and needed. We found nurses who responded to the HEAR survey to report staggering rates of suicidal thoughts, comparable to, if not even greater than, attending level faculty physicians at the same institution taking the same survey.[13] Nurses appear even more likely than their physician counterparts to report thinking they would be better off dead (10.1% vs. 8.4%), of taking their own lives (7.4% vs. 6.6%), of having a suicide plan (4.7% vs. 1.8%); and to have taken a recent action of self-harm (2.0% v. 0.0%) or previously making a suicide attempt (12.1% vs. 2.3%). Compared to physicians, the HEAR algorithm also identified a higher rate of nurses at overall "high risk" (44% vs 26.5%).[13]

It was unanticipated that some nurses would prefer to contact the HEAR counselors by phone without doing the screening. However, the outreach and screening process helped them to find the phone number to report their stress and need for treatment. We were gratified to learn that so many nurses took advantage of the opportunity to dialogue with the HEAR counselors (N=41) and that 12 individuals, at least 9 of whom were rated as moderate to high suicide risk, accepted referrals for mental health care within such a short time-line.

The open-ended comments shed further light on the importance of programs like HEAR for nurses. The comments provided insight into root causes of workplace stress and valuable information to inform future action planning. Comments confirmed the need for more support services, attention to team building, efforts to improve relationships between hospital management and front-line staff, staffing considerations, positive feedback and shows of appreciation. Perhaps most meaningful, nurses praised the organizational leadership for inviting them to engage in the survey; caring enough to reach out and providing a resource for those who were suffering.

Limitations

Low turnout at Grand Rounds and the relatively low response rate (6% compared to 11% of faculty physicians in the first year of HEAR) are both limitations of the project.[9] Efforts at increased program marketing are needed to increase the screening rate. Providing continuing education programs such as resiliency training advertised through the education department education calendar may increase visibility and screening.

Given that 44% of nurse respondents screened as high risk, it can be assumed, and was anticipated, that response was biased towards those who felt they might have an issue that needed to be addressed. We do not find that a problem in that our goal is to reach out to those at risk and provide referrals for care. However, one must not use this data as an estimate of incidence or generalize to other populations.

Conclusion

Proactive risk screening was well-received by nurses. This pilot offers a replicable strategy to address mental health risks associated with workplace stress. Thus far, twelve nurses have been referred to treatment who would not otherwise have sought treatment on their own and valuable information regarding the depth and breadth of workplace stress has been obtained. Next steps are to extend the pilot to the general hospital staff while implementing more aggressive measures to enhance attendance at presentations and participation in the survey.

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Acknowledgements

To those we have lost with hopes that learning from their sacrifice brings us closer to understanding how to better serve others in need.

4. Tables (information in 2 or more columns)

Table 1: Frequencies of Mental Health Dimensions

	n (% Yes) or Mean (SD)
Depression (PHQ-9) (past 2 weeks) (n=149)	
Mean Total PHQ-9 Score (items 1-8)	8.56 (5.64)
None to Minimal Depression (0-4)	44 (29.5)
Mild Depression (5-9)	45 (30.2)
Moderate Depression (10-14)	36 (24.2)
Moderately Severe to Severe Depression (15-27)	24 (16.1)
Suicidal Thoughts and Behaviors	
(PhQ9 item) Having thoughts that you would be better off dead or thoughts of physically harming yourself (past two weeks) (n=148)	15 (10.1%)
Thoughts about taking own life (past two weeks) (n=149)	11 (7.4%)
Done things to hurt self or put life in imminent in danger (past two weeks) (n=148)	7 (4.7%)
Planned ways of taking own life (past two weeks) (n=149)	3 (2.0%)
Ever made suicide attempt (lifetime) (n=148)	18 (12.1%)
Total considered currently 'suicidal'*	17 (11.4%)
Intense Feeling States (past 4 weeks)	
Feeling nervous or worrying a lot (n=149)	127 (85.2%)
Becoming easily annoyed or irritable (n=149)	140 (94.0%)
Feeling your life is too stressful (n=149)	129 (86.6%)
Having arguments or fights (n=147)	85 (57.8%)
Feeling intensely anxious or having anxiety attacks (n=149)	90 (60.4%)

Feeling intensely lonely (n=149)	78 (52.3%)
Feeling intensely angry (n=149)	71 (47.7%)
Feeling hopeless (n=147)	54 (36.7%)
Feeling desperate (n=148)	43 (29.1%)
Feeling out of control (n=144)	69 (47.9%)
Alcohol and Drugs (past 2 weeks)	
Drinking alcohol (including beer or wine) more than usual* (n=149)	57 (38.3%)
Feeling like you were drinking too much (n=149)	42 (28.2%)
Feeling that your work or school attendance or performance was affected by your drinking (n=148)	141 (95.3%)
Using drugs (such as marijuana, cocaine, etc.) or taking prescription medications without medical supervision (n=148)	8 (5.4%)
Eating (past 4 weeks)	
Feeling that you can't control what or how much you eat (n=148)	83 (56.1%)
Feeling overly concerned about staying thin or losing weight (n=146)	85 (58.2%)
Making yourself vomit after eating (n=149)	3 (2.0%)
Current Treatment	
Medication for anxiety (n=149)	28 (18.8%)
Medication for depression (n=149)	28 (18.8%)
Medication for stress (n=148)	10 (6.8%)
Medication for sleep (n=148)	39 (26.4%)
Medication for pain (n=148)	22 (14.9%)

Counseling or therapy (n=148)	69 (47.9%)

* ‘Suicidal’: score of 1, 2, or 3 on recent thoughts of taking one’s own life; doing things to harm oneself; planning ways to take own life, or the suicidal ideation item of the PHQ-9.

4. Tables (information in 2 or more columns)

Table 2: Positive Comments

Thank you for your prompt response. This is quite a comforting service that you provide. I thank you for chatting with me in this way. Articulating this makes me feel infinitely better & I am so thankful for this medium.
Just by taking the time to acknowledge our dialogue has been helpful. Let [The CNO] know that this has been very helpful.
Thank you for your prompt response. I am so glad that this program has been initiated to help healthcare professionals. Though I may not need your counseling at this time in my life/world, I greatly respect this outreach and am grateful we have this program at [name of organization].
I want to express how thankful I am that this program is being extended to nurses at [name of organization]. I wish that this was available to me years ago when I was struggling in private, ashamed and without any support personally or professionally….Unless you have been afflicted with this disease you cannot understand how it takes over and leaves you helpless. With this program people can feel comfortable reaching out and asking for the help they need. Therapy saved my life and I know that you will save the lives of people yet to come. You have no idea of the impact you will be having on some peoples lives. I just want to say thank you…
I appreciate knowing this exists more than I can express to you

5. Figures (information not in column format)

Click here to download 5. Figures (information not in column format) Figure 1.Process.tif

5. Figures (information not in column format)

Huddle Topic of the Week:

Healer **E**ducation, **A**ssessment and **R**eferral (HEAR) Program xxxxxx Phone xxxxx (blinded for review)

FREE SURVEY (link blinded for review)

Population: Nurses

Alignment: ANA workplace standards, ANA Code of Ethics: Self Care, UC Commitment Statement, XXX (Blinded for Review) Professional Practice Model

Educational Points

The HEAR program was once designed for physicians and medical students. It is now being offered to nurses funded through a one year grant. If successful, the organization will consider adding this service on a yearly basis.

HEAR Purpose:
Reach out to colleagues and offer anonymous screening for burnout and depression, and refer those in need to confidential and/or anonymous treatment.

GOALS:
The XXX (Blinded for Review) HEAR Program was established in 2009 to:

- Educate medical students, house-staff and faculty members about burnout, depression, and suicide
- Provide confidential, online assessment of stress, depression and other related issues
- Make personalized referrals to local mental health clinicians and other community resources

We now extend these services to you!

PROGRAM RESULTS:
From the program's inception on May 6, 2009 through May 20, 2016 a total of **1558** University of XXX (blinded for review)medical students (N=519), pharmacy students (N=90), resident physicians and fellows (N=341), and medical school faculty (N=502) have completed the anonymous online Stress and Depression Screening Questionnaire. Of the 1558 participants screened, 345 individuals have dialogued with the program counselor online, by telephone (n=49), and/or in person (n=63). Overall, **180** individuals accepted referrals for formal mental health evaluation and/or treatment. The majority of

these individuals have said that they would not have sought treatment at this time without this screening program.

What does this mean to you:

You are being offered free anonymous screening for depression and suicide risk. No one that you work with will know whether or not you completed the screening. No identifying results will be shared with your work-team. Managers and Directors will not know whether their staff have completed the screening or whether or not they were referred for treatment.

Educational Opportunities

Grand Rounds were presented in July and August. Anyone may request a program or discussion at unit or division or council meetings by contacting the references below.

Critical Thinking Points

1. How does this project align to our professional practice model?

2. Does asking about suicide cause suicide?

Content experts and contact information

(Blinded for review)

More information at: HEAR.xxxxx.edu (blinded for review)

Critical Thinking Point Answers:

1. Caring for self (the professional nurse) and others (the healthcare team) is the center part of our STARFISH model.

This program intentionally reaches out to find those who are suffering and get them the help they need in an anonymous manner.

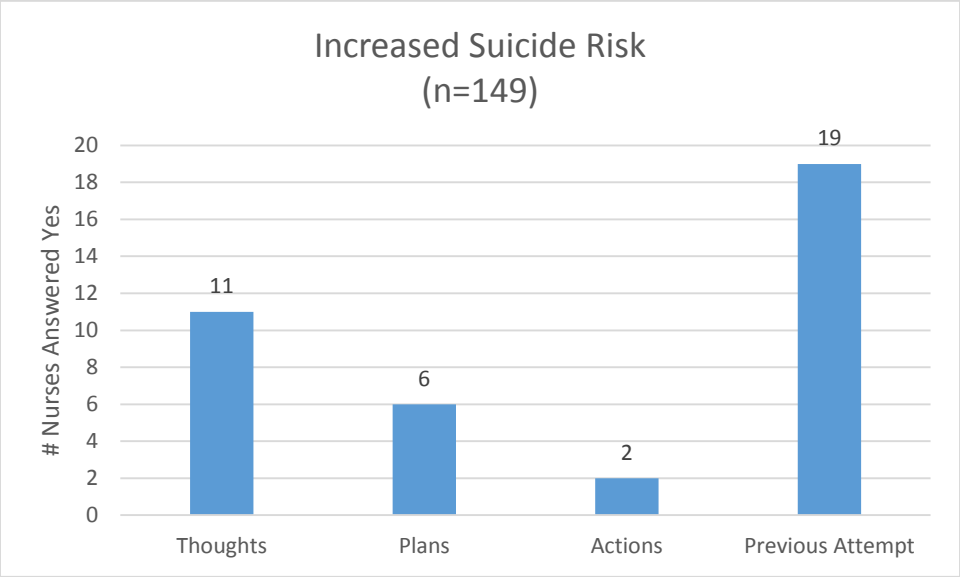
Also our leaders hope that by offering this service, it helps to demonstrate their commitment that you 'feel cared for' in the workplace. Feeling cared for is a core value within our model.

Lastly, keeping our workforce healthy is an integral part of optimizing the healing environment. Those that are experiencing burnout and clinically depressed cannot perform at their best.

2. Asking about suicide does NOT cause suicide or increase suicidal risk. Instead, it often helps those on the brink of taking action to get the help they need.

5. Figures (information not in column format)

Figure 4: Increased suicide risk



SUBJECT: New Self-Care Opportunity for Nurses: XXX HEAR Program

Dear Colleague:

Today I write to you to encourage you to participate in an important and highly successful program that was originally developed for physicians at the UC San Diego Health System: the **Healer Education Assessment and Referral (HEAR) Program.** The purpose of this important service is to confidentially identify those among us who suffer from burnout, depression, and other problems that interfere with professional and personal functioning. This year, we applied for a grant to pilot an expansion of the program to nurses and pharmacists and are proud to announce that the project has been funded.

A wealth of research shows a high prevalence of burnout, depression and sadly suicide amongst nurses. Even though UC San Diego is a stellar organization, we are not immune to this reality. I embrace the tenets of our Professional Practice Model which informs us that we must care for ourselves and others to be able to have capacity to care for others. Given what the medical staff have learned from their experience with this program (see publication attached), we now know it is best practice to reach out to those among us who suffer, remove the senseless stigma that often attaches itself to these diseases, and privately and confidentially get our friends and colleagues to effective treatment and support.

Using the following link, https://www.ucsdhear.org you will be taken to a secure, confidential website to complete a simple, brief instrument (The Stress and Depression Questionnaire) that requires less than five minutes to complete. You will be asked to choose a User ID and a password to log in. Please follow the instructions provided on the website. The User ID and password will be the only two pieces of information required to return your completed questionnaire. The website is encrypted and you will be identified only by the User ID you choose. ***Your identity will be fully protected and will remain unknown even to the members of the HEAR Program.***

Within 48 hours of submission, a trained mental health counselor will review each questionnaire submitted. This counselor will send a personal response to your User ID on the UCSD Wellbeing website, including a brief assessment of your responses and, if appropriate, recommendations for further evaluation or follow-up. You will then have the opportunity to communicate anonymously with the counselor, or face-to-face, if you choose. The goal is to help those with excessive stress, burnout, depression, or other mental health problems get the help they need and deserve.

Completing this online questionnaire and participating in this program is completely voluntary and confidential; and *I strongly urge everyone to complete the questionnaire.* These problems will be most effectively addressed by a public health approach, and this will require the cooperation of *everyone.* Furthermore, I appeal to your leadership and compassion by asking you to personally encourage those around you to invest five minutes in completing the questionnaire.

In the spirit of professionalism that characterizes our dedication to the sick and the prevention of illness in our patients, I ask you for the sake of your personal wellbeing and that of your friends, coworkers, and colleagues to take a few minutes of your time to complete and submit this questionnaire. Over the last 6 years 100s of medical staff and students have benefited from the screening and referral program. Now we would like to offer this same important service to you.

With caring,

Blinded for Peer Review
Will submit signature line upon acceptance