Implementing Suicide Risk Screening to Support Physicians Engaged in Physician Health Program Monitoring

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Background

Physician health programs (PHPs) are organizations dedicated to the dual missions of: 1) supporting and advocating for physicians with potentially-impairing conditions (e.g., substance use or psychiatric disorders), and 2) working to protect patients from harm.[1] Many participants are referred to their state PHP following occupational, interpersonal, legal, and/or health-related consequences of their disorder. Thus, the initial phase of PHP involvement may represent a high risk period. Specifically, those who experience significant shame or fear loss of their reputation, career, ability to practice, and/or financial stability may be at increased risk for suicidal ideation/attempts. However, no currently available data document rates of suicidality among physicians participating in PHPs.

Methods / Approach

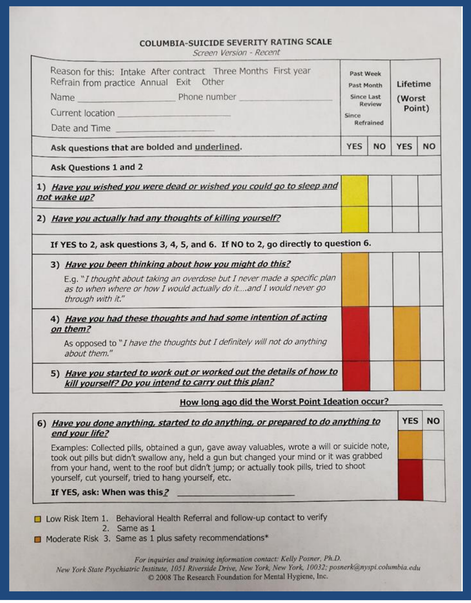
Following staff training, all new referrals were evaluated with the screening version of the Columbia-Suicide Severity Rating Scale (C-SSRS)[2]:

- at PHP intake
- after signing their monitoring agreement
- following high-risk events (e.g., job loss, relapse, divorce)
- annually throughout monitoring

Chart reviews were conducted to assess the results of screening for new physician referrals in their first year of monitoring.

The 235 referrals included:

- 188 physicians (76.1% male)
- 30 residents (76.7% male)
- 17 medical students (76.5% male)



COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

Reason for this: Intake After contract Three Months First year
Refrain from practice Annual Exit Other

Name _____ Phone number _____

Current location _____

Date and Time _____

Past Week / Past Month / Since Last Review / Since Refrained — Lifetime (Worst Point)

Ask questions that are bolded and underlined.	YES	NO	YES	NO
Ask Questions 1 and 2				
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***				
2) ***Have you actually had any thoughts of killing yourself?***				
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.				
3) ***Have you been thinking about how you might do this?*** E.g., "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it.*"				
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"				
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***				

How long ago did the Worst Point Ideation occur?

	YES	NO
6) ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: When was this?** _____		

Low Risk Item 1. Behavioral Health Referral and follow-up contact to verify
2. Same as 1
Moderate Risk 3. Same as 1 plus safety recommendations*

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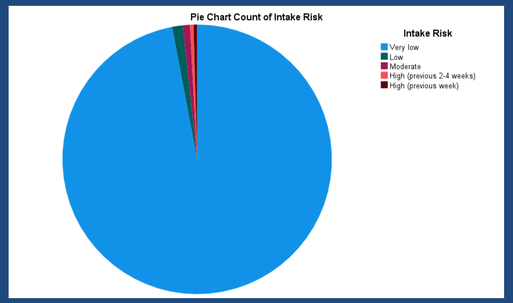
Results

At intake, the majority reported "Very Low" (n = 228, 97.0%) or "Low" (n = 3, 1.3%) risk on the C-SSRS.

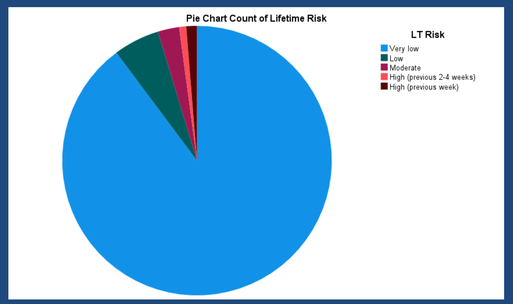
- 2 individuals (0.9%) reported "Moderate" risk
- 2 (0.9%) reported "High" risk.

In cases of risk, PHP staff took appropriate actions to ensure their safety:



- Mental/behavioral health referral (n = 2)
- Removing access to danger/contact support/Call 911 (n =3)
- Individual was currently hospitalized (n =1)

With regard to lifetime risk, 6 individuals (2.6%) reported "Moderate" risk history, and 5 (2.2%) reported "High" risk history.



At 2 weeks, 98% of screened participants (N = 95) were "very low risk," 2% "low risk"

At 3 months, 100% of screened participants (N = 86) were "very low risk"

39 individuals were followed for a full year, with 100% rated as "very low risk" at the one-year mark.

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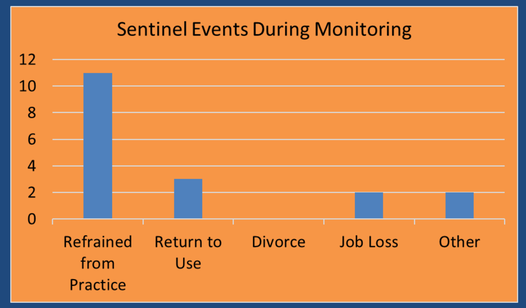
16 physicians experienced at least one sentinel event during monitoring:



No screens <u>during ongoing monitoring</u> resulted in greater than "Low" risk, including those conducted after sentinel events.

- One physician attempted suicide while in residential treatment following a return to substance use.
- There were no completed suicides during the study.

Conclusions

PHP staff often interact with physicians during a time of increased psychosocial vulnerability.

Although the modal suicide risk rating among physicians referred for PHP services was low, a minority of individuals reported high risk and likely benefitted from timely identification and intervention.

Implementing a structured suicide risk screening protocol as part of PHP monitoring is an efficient and effective way to potentially save physician lives.

References

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2. Posner K, Brown GK, Stanley B, et al. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. *Am J Psychiatry*. 2011;168(12):1266-1277. doi:10.1176/appi.ajp.2011.10111704