Chapter 24
Saskatchewan Health Authority—Treating Patients at Risk of Suicide in Northwest Saskatchewan

1.0 Main Points

This chapter reports on the processes the Saskatchewan Health Authority uses to treat patients at risk of suicide in northwest Saskatchewan. Communities in northwest Saskatchewan include North Battleford, Lloydminster, Meadow Lake, and La Loche.

The rate of suicide has been consistently higher in northwest Saskatchewan than the rest of the province for the last three years. In 2018, the average suicide rate (per 100,000) was 27.9 in northwest Saskatchewan compared to the provincial average of 18.7. This higher rate increases the importance of the Authority appropriately treating patients at risk of suicide in this part of the province.

The Authority has effective processes to treat patients at risk of suicide in northwest Saskatchewan, other than the following areas. The Authority needs to:

- Work with other parties to analyze key data about suicide rates and prevalence of suicide attempts to rationalize services available to patients at risk of suicide. Systematic analysis of trends by hospital and by geographical region could better inform treatment program planning and implementation.

- Offer ongoing staff training for assessing and managing suicide risk. Not providing ongoing training increases the risk staff may not follow practices the Authority expects and may result in patients receiving inconsistent care.

- Conduct psychiatric evaluations for emergency department patients at high risk of suicide, as required. Not having psychiatric consultations prior to discharging a patient after an attempted suicide increases the risk of those patients not receiving needed support and treatment.

- Consistently follow up with patients at risk of suicide after emergency department discharge to encourage treatment, where needed. Proactive follow-up care promotes care continuity and continued suicide risk assessment and management.

- Address barriers to effective use of telehealth (videoconferencing) for psychiatric consultations.

- Determine reasons why patients miss scheduled mental health outpatient service appointments. Such information would help the Authority assess the appropriateness of its services to patients at risk of suicide.

- Conduct risk-based file audits of patients at risk of suicide and periodically inspect the safety of facilities providing services to these patients. Conducting audits of patient files would help supervisors actively monitor and support staff. Periodic inspections of facilities will help to identify and address any patient safety risks.

2.0 INTRODUCTION

Not every person who contemplates suicide will access health care services for help but for people who do access health care services, they should be screened for risk of suicide. Suicidal behaviour is one of the most common and stressful psychiatric emergencies. There is neither a single explanation for suicide attempts nor any simple solution to treatment. Health care providers play a key role in early detection and intervention with patients who are at risk of suicide.[1]

2.1 Suicide Rates Are Higher in Saskatchewan

One of the public health and safety issues Saskatchewan faces is suicide. Based on annual rates of suicide per 100,000 population for 2013–16, Saskatchewan's three-year average rate of 14.9 suicides is significantly higher than the Canadian average rate of 11.7 suicides for the same period.[2]

According to Statistics Canada in 2016, suicide was the ninth leading cause of death in the nation. On average, 10 people die by suicide daily in Canada. Of the approximately 4,000 annual deaths by suicide, 905 individuals lived with a mental health problem or illness. Death by suicide for children, youths (ages 10 to 19 years) and young adults (ages 20 to 29 years) remains the second leading cause of death after accidents in Canada. Additionally, for every suicide there are 25 to 30 suicide attempts on average.[3]

Certain individuals are at a higher risk of suicide than others. For example, men are three times more likely to die by suicide than women, while women are three-to-four times more likely to attempt suicide than men. As such, hospitalization rates for women attempting suicide are 1.5 times greater than men.[4]

The Saskatchewan Coroners Service reported 2,000 people in Saskatchewan lost their lives to suicide between 2005 and 2018.[5] Consistent with national statistics, the highest numbers of suicide in Saskatchewan were among children, youths, and young adults. The highest number of suicide for men were in the age group of 20 to 29. The highest group for women who died by suicide were those between ages 10 and 19.

Research shows multiple factors influence individuals attempting or committing suicide. Common risk factors for suicide include mental disorders (particularly depression or substance abuse), and some physical illnesses.[6] Other determinants may include marital breakdown, economic hardship, changes in physical health, a major loss, or a lack of social support.[7]

[1] Ministry of Health, *Saskatchewan Suicide Framework for Saskatchewan Health Care Providers*, 2012.
[2] www.suicideinfo.ca/resource/cross-canada-comparison-statistics/ (21 May 2019)
[3] Public Health Agency of Canada, *Suicide in Canada – Current Context*, 2016.
[4] Statistics Canada. *Suicide Rates: An Overview, 2017*. Catalogue no. 82-624-X.
[5] Saskatchewan Coroners Service, *Suicides by Year, Sex and Age Group, Saskatchewan, 2005 to 2018,* (17 January 2019).
[6] www.conferenceboard.ca/hcp/provincial/society/suicides.aspx?AspxAutoDetectCookieSupport=1 (16 January 2019).
[7] Health Canada. *Suicide in Canada: Update of the report of the task force on suicide in Canada*, 1994.

2.2 Role of the Health Care System in Suicide Prevention and Intervention

Research also shows that many individuals who die by suicide either were in treatment or received recent treatment from health care providers. About 45% of those who died by suicide saw a primary care physician in the 30 days before they died.[8] A 2015 Canadian study showed that 30% of people who died by suicide ages 11 and older visited an emergency department in the month prior to their death.[9]

Suicide in health care settings is a serious adverse event affecting health care providers in addition to the individual's family and community. When individuals die by suicide, their family and friends often experience shock, anger, guilt, and depression.[10]

Suicide is a complex issue, and no one determinant alone is enough to be the cause. Whether the risk factors result in suicide is partly determined by the level of support a society provides toward addressing root causes, raising awareness, and investing in multi-sectoral suicide prevention strategies.[11] It is important to acknowledge that, similar to other medical conditions such as heart attacks, not all suicides are entirely preventable.

Health care services can offer a significant role in preventing suicide by screening for suicide risk and appropriately following up on positive screens. Routine screening might detect individuals thinking about suicide during office visits.[12]

The public health system failing to assess suicide risks may result in missed opportunities to identify suicide-prone individuals and to provide timely treatment to help them address contributing factors. Not doing so, may subsequently result in fatal consequences.

2.3 Saskatchewan Health Authority is Responsible for Implementing the *Saskatchewan Suicide Framework*

Under *The Provincial Health Authority Act*, the Ministry of Health is responsible for the strategic direction of the health care system, and the Saskatchewan Health Authority is responsible for the planning, organization, delivery and evaluation of the health services as permitted by *The Provincial Health Authority Act*.

In 2012, the Ministry of Health and several former regional health authorities developed the *Saskatchewan Suicide Framework* for provincial health care providers to use for assessment and management of people at risk of suicide.[13] The Framework recognizes health care providers play key roles in early detection and intervention for people at risk of suicide. See **Figure 6** for details about the Framework. The Authority makes the Vice-President of Integrated Northern Health responsible for overseeing the delivery of health services to patients, including using the Framework, in northwest Saskatchewan.

[8] Ahmedani B., Simon G., et al. *Health care contacts in the year before suicide death*. J Gen Intern Med. 2014;29(6):870–7.
[9] Vasiliadis H. *Factors associated with suicide in the month following contact with different types of health services in Quebec*. DOI: 10.1176/appi.ps.201400133, 2015.
[10] www.cdc.gov/violenceprevention/suicide/fastfact.html (14 May 2019).
[11] www.conferenceboard.ca/hcp/provincial/society/suicides.aspx?AspxAutoDetectCookieSupport=1 (16 January 2019).
[12] Ahmedani B., Simon G., et al. *Health care contacts in the year before suicide death*. J Gen Intern Med. 2014;29(6):870–7.
[13] www.sken.ca/saskatchewan-suicide-framework/ (21 May 2019).

Health care facilities in northwest Saskatchewan serve a population of about 100,000 (slightly less than ten percent of Saskatchewan's total population). They employ about 4,160 health care providers.

Northwest Saskatchewan encompasses mainly those health care facilities associated with the former Keewatin Yatthé and Prairie North health regions. Communities in the area include North Battleford, Lloydminster, Meadow Lake, and La Loche.

The average suicide rate (per 100,000 population) and self-injury hospitalization rate in this area exceeds provincial averages. For example, for the five-year period (2011–2015), the average suicide rates in the former Keewatin Yatthé health region was 37.8 and 13.0 in the former Prairie North health region, compared to the provincial average suicide rate of 11.8 for the same period.[14] In 2017–18, the self-injury hospitalization rate in the former Keewatin Yatthé health region was 126 and the former Prairie North health region was 150 (individuals per 100,000 population) compared to the provincial self-injury hospitalization rate average of 92.[15]

The higher than provincial average suicide and self-injury hospitalization rates increases the importance of treating patients at risk of suicide in this part of the province.

3.0 Audit Conclusion

We concluded that for the 12-month period ended August 31, 2019, the Saskatchewan Health Authority had, other than the following areas, effective processes to treat patients at risk of suicide in the northwest integrated service area.

With respect to services provided to patients at risk of suicide located in northwest Saskatchewan, the Saskatchewan Health Authority needs to:

- **Offer ongoing staff training for assessing and managing suicide risk**
- **Conduct psychiatric evaluations for emergency department patients with high suicide of risk, as required**
- **Consistently follow up with patients at risk of suicide after emergency department discharge**
- **Address barriers to effective use of telehealth for psychiatric consultations**
- **Determine reasons why patients miss scheduled outpatient service appointments**
- **Conduct risk-based file audits of patients at risk of suicide and periodically inspect the safety of facilities**

The Authority needs to rationalize services made available to patients at risk of suicide.

[14] Vital Statistics data provided by the Ministry of Health (July 2019).
[15] Canadian Institute of Health Information website: www.yourhealthsystem.cihi.ca/hsp/indepth;jsessionid=Blaud91nenpGkpI+DNkH9CMy.yhs?lang=en#/indicator/042/2/C7082/N4IqKgTgpgdgJgeQG5QmAlgWygYQC4QA2IAXKDFOgOYAWARgPYCuEAzqQNog4DsADAA4eIADTd-ATj4gAugF85QA (7 July 2019).

Figure 1—Audit Objective, Criteria, and Approach

Audit Objective: The objective of this audit is to assess whether the Saskatchewan Health Authority has effective processes for the twelve-month period from September 1, 2018 to August 31, 2019 to treat patients at risk of suicide in the northwest integrated service area.

The northwest integrated service area is one of the six service areas of the Authority. The area mainly includes the former Keewatin Yatthé and Prairie North health regions. Communities in the area include North Battleford, Lloydminster, Meadow Lake, and La Loche.

The audit did not include patients residing in special care homes within the northwest integrated service area, or in the Saskatchewan Hospital North Battleford.[A] Also, the audit did not include patients who sought medical assistance in dying nor assess the appropriateness of medical decisions related to patients at risk of suicide.[B]

Audit Criteria:

Processes to:

1. Assess patients for risk of suicide
   - 1.1 Provide health care providers with clear guidance on assessing suicide risk (e.g., protocols, procedures, ongoing education and training)
   - 1.2 Use standard suicide risk assessment tools
   - 1.3 Establish suicide risk level (e.g., assess patients in timely manner)
   - 1.4 Allocate appropriate resources (e.g., services, beds, staff)
2. Implement appropriate treatment and monitoring strategies
   - 2.1 Determine urgency of service based on assessed risk level
   - 2.2 Maintain policies and procedures for guiding patient treatment and monitoring
   - 2.3 Document treatment plan and monitoring strategy in a timely manner
   - 2.4 Treat in accordance with plan, addressing immediate safety needs promptly
   - 2.5 Reassess patient's suicide risk consistent with monitoring strategy
3. Monitor the quality of suicide risk assessment and treatment
   - 3.1 Determine specific quality indicators (e.g., readmissions, wait times)
   - 3.2 Evaluate service performance information against indicators (e.g., complaints, critical incidents)
   - 3.3 Maintain quality assurance processes (e.g., periodically review patient files for compliance with policies)
   - 3.4 Take action where required

Audit Approach:

To conduct this audit, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Authority's processes, we used the above criteria based on related work, reviews of the literature including reports of other auditors and *The Saskatchewan Suicide Framework*. The Authority's management agreed with the above criteria.

We examined Authority's policies and procedures that relate to suicide assessment and treatment for services provided in northwest Saskatchewan. We interviewed staff in this area responsible for providing services to people at risk of suicide. We visited health care facilities in North Battleford, Buffalo Narrows, and La Loche to observe emergency department, inpatient and outpatient services, and tested 37 files of patients at risk of suicide.

[A] The Saskatchewan Health Authority operates Saskatchewan Hospital North Battleford on behalf of the Ministry of Health to serve patients from across the province who need longer-term psychiatric rehabilitation and whose needs cannot be met in local inpatient mental health facilities. www.pnrha.ca/programs_services/Pages/Saskatchewan-Hospital---North-Battleford.aspx (25 September 2019).

[B] Patients who meet the criteria set in *The Medical Assistance in Dying Act* (Canada).

4.0 Key Findings and Recommendations

4.1 Varying Services Available for Patients at Risk of Suicide But Unclear if they are in the Right Locations

The Saskatchewan Health Authority makes available varying health care services in northwest Saskatchewan to identify and treat patients at risk of suicide. However, the Authority has not rationalized whether these services are accessible where most patients need them.

Range and Location of Services Available to Northwest Saskatchewan

Patients at risk of suicide typically access health care services by going to an emergency department or outpatient services.[16]

- The Authority makes emergency services available in Beauval, Buffalo Narrows, Île-à-la-Crosse, La Loche, Lloydminster, Macklin, Meadow Lake, North Battleford, Turtleford, Spiritwood, Unity, and Wilkie.[17] Emergency departments assess patients at risk of suicide and direct them to the appropriate services (e.g., outpatient or inpatient mental health or addictions services).

Recognizing mental illness as a common risk factor for patients at risk of suicide, the Authority offers the following mental health services in northwest Saskatchewan:

- Outpatient services (direct clinical and counselling)

  The communities of Beauval, Île-à-la-Crosse, La Loche, Lloydminster, Meadow Lake, North Battleford, and Unity each provide mental health outpatient services from Monday to Friday from 9 a.m. to 5 p.m. direct clinical and counselling services are available through walk-in clinics or by appointment. In addition, Authority staff can travel between smaller communities when needed.

  Patients requiring psychiatric services must have a referral from a physician and either travel for face-to-face sessions to locations with psychiatrists or receive services via telehealth (i.e., videoconferencing technologies). The Authority employs (either directly or through contract) psychiatrists in Lloydminster Hospital and Battlefords Union Hospital along with other locations in the province (e.g., Saskatoon).[18] Psychiatrists are available by appointment for outpatient services, or through the emergency department.

- Inpatient services (provided in a hospital outside of an emergency department)

  Patients requiring mental health inpatient services must have a referral from a physician, and travel to North Battleford (Battlefords Union Hospital) or to other facilities with such services. See **Figure 2** for inpatient mental health services available across Saskatchewan.

As indicated in **Figure 2**, Battlefords Union Hospital's mental health inpatient department has 22 adult beds. It does not have adolescent inpatient beds, but, occasionally, youth patients may stay in the adult beds.

Also, as shown in **Figure 2**, the occupancy rate for North Battleford inpatient beds in 2016–17 was 83.5%. The occupancy rate was lower in 2017–18 (60.1%) and 2018–19 (72.4%).[19]

[16] The scope our audit did not include patients coming to general practitioners (family physicians) with suicidal thoughts.
[17] Based on information provided on websites of former health regions that now comprise the northwest integrated service area (i.e., Keewatin Yatthé, Prairie North, Prince Albert Parkland, Heartland).
[18] As of August 2019, there were four Authority-contracted psychiatrists who provide services to Battlefords Union Hospital. These psychiatrists also provide services to Saskatchewan Hospital North Battleford. There were four fee-for-service psychiatrists that provide services to Lloydminster Hospital, as well as have their own practices.
[19] Saskatchewan Health Authority (northwest integrated service area), *Inpatient Statistical Report 2017–2018 and 2018–2019*.

Figure 2—Mental Health Inpatient Services Across Saskatchewan

Integrated Area	Facility	In 2016–17				2016	
		# of Beds	Patient Days	Average Daily Patient Census	Occupancy Rate[A]	Population Served[B]	% of Total Provincial Population
North West	Battlefords Mental Health Centre – Adult	22	6,721	18	83.5%	100,842	9.2%
	Total	**22**	**6,721**				
South West	Swift Current Mental Health Centre – Adult	10	2,590	7	70.8%	130,600	11.93%
	Moose Jaw Mental Health Centre – Adult	12	3,373	9	76.8%		
	Total	**22**	**5,963**				
North East	Prince Albert Mental Health Centre – Adult	29	9,183	25	86.5%	142,965	13.06%
	Prince Albert Mental Health Centre – Adolescent	10	3,082	8	84.2%		
	Total	**39**	**12,265**				
Regina	Regina General Hospital – Adult	50	18,313	50	100.1%	241,686	22.07%
	Regina General Hospital – Adolescent	10	3,243	9	88.6%		
	Total	**60**	**21,556**				
Saskatoon	Saskatoon Dubé Centre – Adult	54	21,481	59	108.7%	299,660	27.36%
	Saskatoon Dubé Centre – Adolescent	10	3,355	9	91.7%		
	Total	**64**	**24,836**				
South East	Weyburn Mental Health Centre – Adult	10	2,353	6	64.6%	179,330	16.38%
	Yorkton Mental Health Centre – Adult	15	2,314	6	42.1%		
	Total	**25**	**4,667**				
Total		**232**	**76,008**	**208**	**89.5%**	**1,095,083**	**100%**

Source: Ministry of Health, *2017–18 Community Program Profile* and Ministry of Health data with addition of related integrated service area; 2016 population data supplied by the Ministry of Health based on the 2016 Census. Note: table excludes the Saskatchewan Hospital North Battleford.

[A] Occupancy rate: Average daily census/ rated bed capacity.

[B] The number of people who live in the various integrated areas (based on 2016 Census) who may be served by the Authority.

Better Data Analysis Needed for Patients at Risk of Suicide to Rationalize Services

The Saskatchewan Health Authority has not sufficiently rationalized whether services available to patients at risk of suicide in northwest Saskatchewan address the demand for services in this area. This is, in part, because it does not have complete key data. Also, we found its analysis of existing key data was limited.

At August 2019, the Authority has not implemented IT systems to track the services provided to patients at risk of suicide in all of its facilities in northwest Saskatchewan. Rather, many facilities (particularly those serving smaller communities) keep manual records on the delivery of many services making data collection and analysis labour intensive.

To assess services provided to patients at risk of suicide, good practice suggests focusing on four key measures—suicide rate, hospitalization rate for self-injury, emergency department rate for self-inflicted injury, and prevalence of suicide attempts.[20] *The World Health Organization Practice Manual* (2016) suggests using two sources of information about suicide attempts: medical records (usually hospital records) and self-reported attempts of suicide (public surveys).[21]

As shown in **Figure 3**, we found complete data is largely available for some of the measures. We further note as the Authority continues to move forward in its adoption of IT systems related to delivery of health services to these patients, these systems will enable the Authority to collect data related to the suggested measures.

Figure 3—Availability of Data for Suggested Key Outcome Measures of Suicide Programing

Suggested Measures	Potential sources of Saskatchewan data	Is generally complete data available? If not, what is missing
Suicide rates – the mortality rate for deaths due to intentional self-inflicted injury	Saskatchewan Coroners Service data – the rate of suicide (published annually) Vital Statistics database (maintained by eHealth Saskatchewan)	Partial – Coroners data does not include place where person lived (only where they died). Vital Statistics database included a number of deaths without a cause indicated.
Hospitalization rate for self-injury – suicide attempts and non-suicidal self-harm related to injuries or poisoning [A]	Saskatchewan Health Authority discharge database – number of patients discharged from the mental inpatient department in North Battleford, and the area to which the patient is discharged	Yes

[20] Tracking progress in suicide prevention in Indigenous communities: a challenge for public health surveillance in Canada, www.bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-018-6224-9/figures/1 (27 September 2019).
[21] World Health Organization, Practice Manual for Establishing and Maintaining Surveillance Systems For Suicide Attempts And Self-Harm, 2016 www.who.int/health-topics/suicide#tab=tab_1 (10 September 2019). The Manual provides guidance on establishing and maintaining surveillance systems for suicide attempts and self-harm. Surveillance systems provide information to decision-makers responsible for planning, funding, delivering, and evaluating interventions that fall under the umbrella of suicide prevention.

Suggested Measures	Potential sources of Saskatchewan data	Is generally complete data available? If not, what is missing
Emergency Department rate for self-inflicted injury – suicide attempts and non-suicidal self-harm related to injuries or poisoning [A]	Emergency department IT systems in use by some Saskatchewan hospitals; these IT systems track reasons for emergency visits, including intentional self-harm, (e.g., suicide attempts).	No – not all Saskatchewan emergency departments have IT systems. Emergency departments in many smaller communities maintain manual patient files. See **Section 4.2**.
Prevalence of suicide attempts and thoughts – % of population who report having attempted suicide or having serious thoughts about suicide (in the past year or lifetime)	A Canadian Community Health Survey done occasionally by Statistics Canada obtains and tracks this information.	Partial – data does not provide details beyond the provincial level (i.e., community level)

Source: Provincial Auditor Saskatchewan adapted from *Tracking progress in suicide prevention in Indigenous communities: a challenge for public health surveillance in Canada*, www.bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-018-6224-9/figures/1 (27 September 2019).
[A] Non-suicidal self harm is an intentional self-injury without the desire or intention to die (e.g., accidental overdose, or self-cutting without intention to die).

Our analysis of the data available at August 2019 related to patients at risk of suicide in northwest Saskatchewan found the following.

- The rate of suicides per 100,000 population in northwest Saskatchewan was consistently higher than the provincial rate for the last three years. See **Figure 4** for the suicide rates per 100,000 population over the last three years.

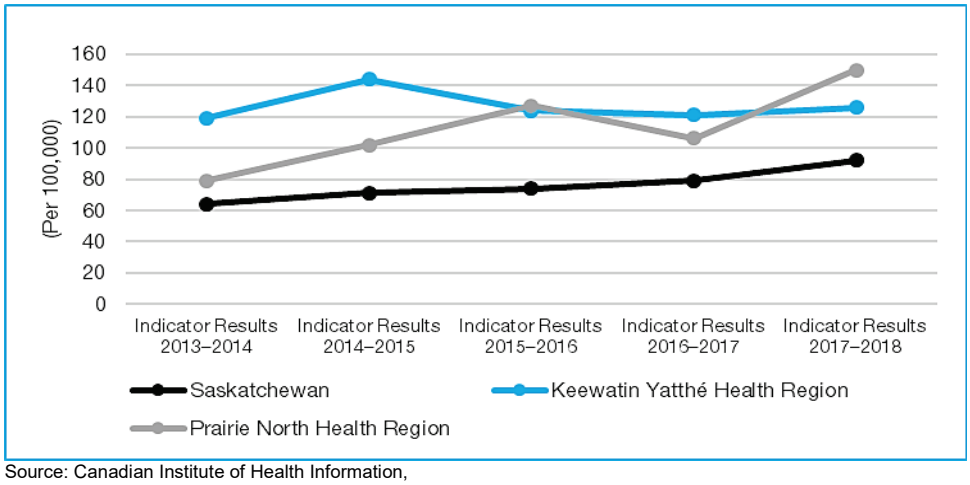
Figure 4—Suicide Rates per 100,000 Population in Saskatchewan, 2016–2018

Location/Year	2016	2017	2018
Northwest Saskatchewan	18.8	25.9	27.9
Saskatchewan	16.4	15.8	18.7

Source: Provincial Auditor of Saskatchewan, based on information from the Saskatchewan Coroners Service, the Ministry of Health, and Statistics Canada. Rates are calculated as the total number of deaths by suicide in a given year, divided by the total population that year, and multiplied by a factor of 100,000.

- The rate of self-injury hospitalizations in the former Prairie North Health Region and Keewatin Yatthé Health Region from 2013 to 2018 was higher than the provincial rate over the last five years (see **Figure 5**). Northwest Saskatchewan is comprised primarily of these former regions.

Figure 5—Rate of Self Injury Hospitalizations per 100,000 Population in Saskatchewan, former Prairie North Health Region, and former Keewatin Yatthé Health Region, 2013–2018



Source: Canadian Institute of Health Information, www.yourhealthsystem.cihi.ca/hsp/indepth;jsessionid=Blaud91nenpGkpI+DNkH9CMy.yhs?lang=en#/indicator/042/2/C7082/N4IgKgTgpgdgJgeQG5QmAlgWygYQC4QA2IAXKDFOgOYAWARgPYCuEAzgQNog4DsADAA4eIADTd-ATj4gAugF85QA (27 September 2019).

- The emergency department rate for self-inflicted injury was not available for all emergency departments in northwest Saskatchewan as not all departments have related IT systems. For those that did, we found, for 2018–19, 107 patients came to the emergency department in North Battleford due to self-harm, 70 in Lloydminster, and 96 in Meadow Lake. The number of patients were similar in 2017–18 (North Battleford: 130, Lloydminster: 58, Meadow Lake: 85).[22]

- The prevalence of suicide attempts and suicidal thoughts data obtained though the 2015 Canadian Community Health Survey projected (based on about 65,000 Canadian respondents) 112,200 people in Saskatchewan aged 15 and over reported they seriously contemplated suicide in their life, and 126,900 people saw or talked to a health care professional about their emotional or mental health.[23,24] Data for northwest Saskatchewan was unavailable.

We are aware the Ministry of Health does some data analysis related to demand for health care services for policy and funding purposes. For example, the research unit within its Emergency Services Branch analyzes certain suicide rate data on an ad hoc basis (e.g., suicide mortality rates, suicide attempts in some emergency departments). The Ministry's Mental Health and Addictions Branch collects and analyzes mental health and addictions program usage data annually.

The Authority and the Ministry did not have any co-ordinated efforts to analyze data related to services to patients at risk of suicide.

We are also aware the federal government, along with the provincial government, is increasing its investment in suicide prevention programs. For example, in recent years, the federal government invested in Indigenous-focused suicide prevention programs

[22] Ministry of Health, Research Department, *Emergency department visits for self-harm in selected Saskatchewan hospitals*.
[23] The Canadian Community Health Survey does not provide details beyond the provincial level.
[24] Statistics Canada. Table 13-10-0098-01 *Mental health characteristics and suicidal thoughts*, 2015. Do76i.org/10.25318/1310009801-eng.

(e.g., federally-funded psychiatrist from Saskatoon to provide psychiatric services one day a month to patients in La Loche since 2016).[25] Also in 2019–20, Saskatchewan expected to receive $14.27 million from the federal government for improving access to mental health and addiction services.

We found funding for suicide prevention programs fragmented across provincial government agencies, the federal government, and First Nations agencies. While often these investments support multi-sectoral suicide prevention strategies, there is limited sharing of information across the multiple sectors affecting their abilities to determine if they are making a difference. Better co-ordination and analysis of multi-sector suicide prevention strategies may identify duplication or absence of services in certain communities.

Systematic trend analysis of key measures by hospital and by geographical region would inform the planning and implementation of treatment programs. It would help the Authority determine whether it gives individuals at risk of suicide in northwest Saskatchewan sufficient access to services. In addition, such analysis would help the health sector determine if its programs are making a difference.

1. **We recommend the Saskatchewan Health Authority work with others (e.g., Ministry of Health) to analyze key data about rates and prevalence of suicide attempts to rationalize services made available to patients at risk of suicide.**

4.2 Integrated Patient Files Needed

In common with other parts of the province, the Authority manually records some of the emergency, outpatient, and inpatient services it provides to patients at risk of suicide in northwest Saskatchewan. At September 2019, the Authority was in the process of implementing a new IT system called the Mental Health and Addiction Information System (MHAIS) in certain health care facilities.[26]

Staff using manual files cannot access MHAIS. As a result, they do not have the benefit of considering medical history contained in MHAIS when making care decisions. In addition, they do not have the means to share information from their manual patient files easily with other health care service providers.

Also, many patients at risk of suicide may access more than one health service (e.g., emergency department, mental health inpatient department, First Nations health facilities). Many patients from smaller communities in northwest Saskatchewan travel to larger health centres to receive services. For example, in 2018–19, 51% of the patients treated at North Battleford mental health inpatient services came from places outside of the Battlefords area.[27]

[25] As of September 2019, Authority staff indicated that another psychiatrist planned to start providing services to Île-à-la-Crosse paid for by the federal government.
[26] MHAIS is the province-wide mental health and addictions IT system. The system includes a level of care utilization tool that will help staff determine the level of care needed for patients.
[27] 204 out of 401 patients.

MHAIS can serve as a complete provincial electronic health record for mental health and addictions patients. It can become a single, provincially accessible file if facilities and health care providers have system access.

Outpatient staff in certain facilities, like North Battleford and Lloydminster, use MHAIS to document medical history, suicide risk screening, assessment and treatment progress for patients at risk of suicide receiving outpatient services. At August 2019, facilities at La Loche and Meadow Lake providing outpatient services continued to use separate manual patient files to document services provided. The Authority planned to implement MHAIS in La Loche by December 2019.

The Authority implemented MHAIS for mental health inpatient services provided in North Battleford in June 2019. However, staff continued to use separate manual patient files to determine medical history.

At August 2019, only one emergency department (North Battleford) in northwest Saskatchewan had access to MHAIS. After the Authority's investigation of an April 2019 critical incident, the Authority began giving staff at the North Battleford emergency department MHAIS access. It plans to give access to physicians at emergency departments in Lloydminster and Meadow Lake in 2019–20.

Giving emergency department staff access to MHAIS is consistent with a previously identified area for improvement by Accreditation Canada. In its last reviews of emergency departments located in northwest Saskatchewan, Accreditation Canada suggested the Authority have comprehensible shareable patient files.[28]

Not having a single file that includes all mental health services provided to a patient can impede diagnosis and provision of care for those at risk of suicide. In addition, it may create inefficiencies in the provision of care. The importance of instant access to complete information increases when physicians and psychiatrists are managing patients in life-threatening situations.

We recommended in our *2018 Report – Volume 1*, Chapter 8, that the Saskatchewan Health Authority implement a provincial integrated mental health record system to record services to mental health and addictions clients.[29]

4.3 Policies Align with Suicide Risk Framework

On an overall basis, the suicide-related policies the Authority uses in its facilities located in northwest Saskatchewan align with the *Saskatchewan Suicide Framework*.

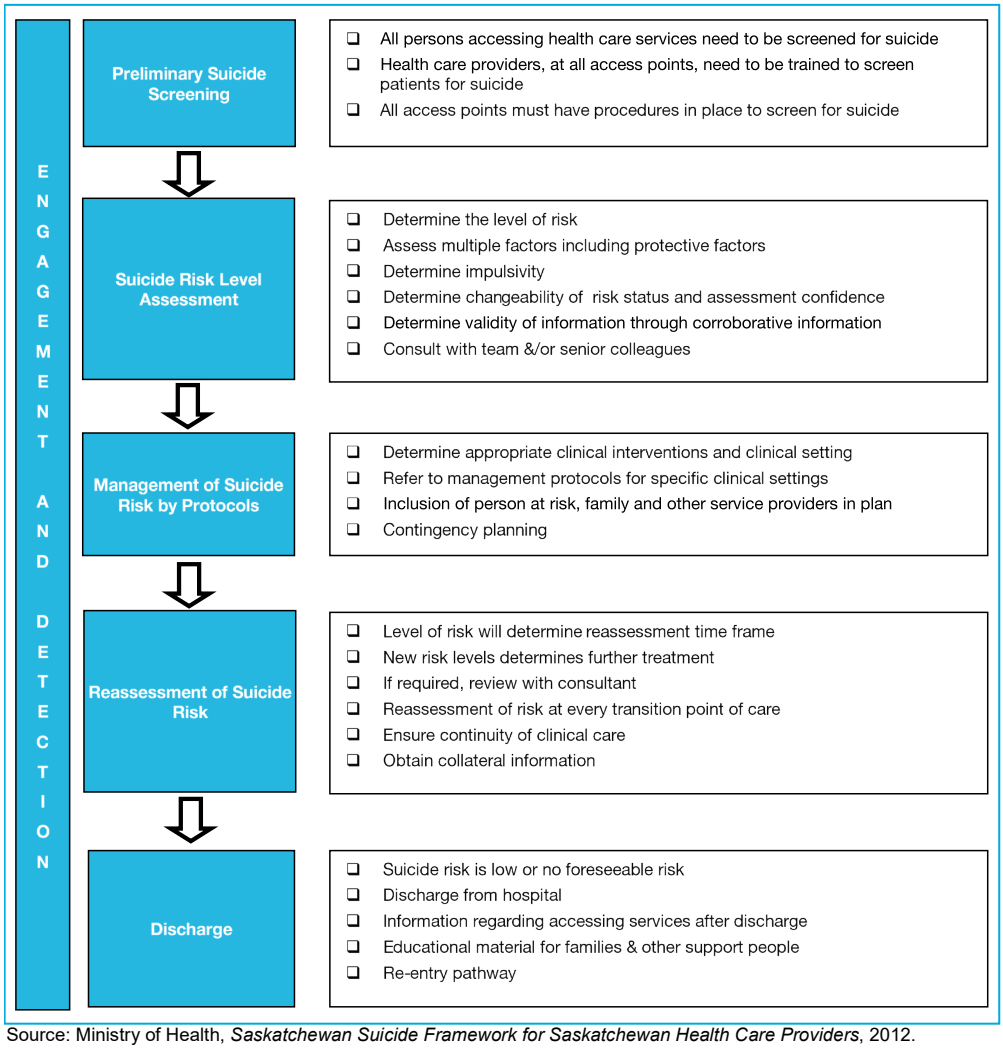
The Framework expects health care providers to screen all individuals accessing health care services through mental health, addictions, primary care, emergency, or special care homes for suicide risk. As shown in **Figure 6**, it expects health care providers to assess individuals with suicide risk, intervene, reassess, and follow up. The Framework applies to

[28] Accreditation Canada (usually every three to four years) assesses the Saskatchewan Health Authority against standards of best practice. The assessments includes a review of policies related to suicide prevention (e.g., screening and risk assessment). The latest available 2017 and 2018 Accreditation Canada reports for the former health regions in northwest Saskatchewan found emergency departments met the requirements for suicide prevention. For example, emergency departments did suicide risk assessments at every intake. They also identified areas for improvements (such as, staff training and having a comprehensible shareable patient file).

[29] See our *2018 Report – Volume 1,* Chapter 8 Recommendation 2 on page 113.

key treatment settings (e.g., emergency departments, inpatient mental health departments, outpatient clinics).

Figure 6—Framework for Suicide Risk Assessment and Management for Saskatchewan Health Care Providers



Source: Ministry of Health, *Saskatchewan Suicide Framework for Saskatchewan Health Care Providers*, 2012.

At August 2019, the Authority continued to work on establishing a common set of clinical policies to promote consistent care across the province. This includes policies related to treating patients at risk of suicide.

In the meantime, health care staff in facilities located in northwest Saskatchewan continue to use the policies of their former health regions (e.g., Keewatin Yatthé and Prairie North). This results in the Authority using multiple sets of policies to treat patients.

Our review of policies related to treating patients at risk of suicide for this area found the following. Even though the form and content of them varied, they generally provided sufficient direction. They included high-level direction for suicide screening, risk assessment, and some treatment options for patients at risk of suicide. In addition, the policies for inpatient and outpatient mental health services aligned with the Framework's guidance (see **Figure 6**).

We also noted management of these facilities continue to keep these policies current. For example, one was last updated in 2017 and the other in 2018.

Staff can access these policies in various ways. We found them sufficiently accessible. For example, staff in facilities of the former Prairie North health region access policies electronically via the intranet, whereas staff in facilities of the former Keewatin Yatthé health region access manual copies of policies.

We found the Authority used other ways to give staff detailed direction in these areas. This includes making standardized checklists available, embedding the process into related IT systems (where used), and using staff with expertise in mental health. Also at August 2019, the Authority continued to implement its patient care IT system (i.e., MHAIS) in more facilities in northwest Saskatchewan. This IT system includes a level of care utilization tool to help staff determine the level of care needed for mental health patients.

Policies promote consistent patient care and clarify file documentation expected.

4.4 Ongoing Staff Training Needed

The Authority is not giving staff at facilities in northwest Saskatchewan working with patients at risk of suicide with sufficient training on caring for these patients.

The Authority employs psychiatrists, mental health therapists, social workers, registered psychiatric nurses, and psychologists to provide mental health inpatient and outpatient services in northwest Saskatchewan.

We found more professional staff tend to work in larger communities. For example, at August 2019, the Authority has five full-time psychiatry positions in North Battleford to provide services; one position was vacant. In common with other parts of Saskatchewan, the Authority experiences challenges in employing a sufficient number of psychiatrists for northwest Saskatchewan. In addition, it contracts four psychiatrists (on a fee-for-service basis) to provide services at the Lloydminster Hospital.

Smaller communities in this area have more difficulty attracting and retaining professional mental health staff. For example, we noted outpatient services in La Loche experience chronic vacancies for its mental health positions. As of August 2019, four of seven mental health related positions remained vacant, placing additional pressures on supervisors and managers.

Also, the qualifications of staff in smaller communities caring for patients at risk of suicide varies. We found health care staff in smaller communities did not always possess the educational qualifications that aligned with their job descriptions. Rather, because of a limited supply of potential staff with preferred educational qualifications, smaller communities place a greater emphasis on hiring staff with suitable experience.

We found the Authority has not determined its training needs for staff in the area of caring for patients at risk of suicide. Rather, the Authority allows staff at individual facilities to determine and co-ordinate their own training needs, other than for staff training on new clinical-related IT systems (e.g., MHAIS).

We found the nature and extent of training varies significantly. For example, new nursing staff in the emergency department in North Battleford received on-line training related to mental health and suicide screening, whereas staff at other emergency departments we visited did not. Also, only certain mental health staff in North Battleford received one-day training on clinical interviewing of patients at risk of suicide in December 2018.

In addition, training provided did not meet the foundational training expected in the *Saskatchewan Suicide Framework*. The Framework identifies the Applied Suicide Intervention Skills Training as the foundational training for health care staff encountering patients at risk of suicide. The Framework expects all health care providers, at all access points, to be trained to screen patients for suicide.

Staff in North Battleford facilities last received the Applied Suicide Intervention Skills Training course in 2012, and staff in La Loche last received this course in 2017. Newer staff working with patients at risk of suicide at both locations would never have received this training course. For example in 2018–19, La Loche had 50% of their outpatient services staff turnover. Therefore, these staff had not received the Applied Suicide Intervention Skills Training at August 2019.

Training helps keep staff up-to-date. Not providing sufficient, ongoing training for staff treating patients at risk of suicide increases the risk staff may not follow practices the Authority expects and may provide patients with inconsistent care.

2. **We recommend the Saskatchewan Health Authority give suitable training to staff located in northwest Saskatchewan caring for patients at risk of suicide.**

4.5 Preliminary Suicide Screening Done Consistently But Not Always Referred to a Psychiatrist

Staff in facilities located in northwest Saskatchewan consistently followed established protocols to screen patients for risk of suicide, but emergency department staff did not always seeks psychiatric consultation for patients with a high risk of suicide.

Consistent with the Suicide Framework, the Authority expects all persons accessing health care services to be screened for suicide. As indicated in **Section 4.1**, patients at risk of suicide typically access health care services by going to an emergency department or to outpatient services. Preliminary suicide screening helps staff identify patients at high risk of suicide and appropriate services needed.

To guide preliminary screenings of persons accessing health care services (e.g., presenting at emergency departments, and mental health outpatient and inpatient services), the Authority gives staff standard forms to complete either manually or electronically. We found that although the questions and ways to record responses and risk level of screening varied between facilities and types of services provided, they aligned sufficiently with the expectations of the Framework.

We also found the Authority gives health care providers useful tools to help them gather sufficient and appropriate information to determine the level of a patient's risk of suicide. See **Figure 7** for preliminary questions used in screening patients for suicide risk. See **Figure 8** for the categories of information gathered to determine the suitable suicide risk level (high, medium, low or no foreseeable risk).

Figure 7—The Saskatchewan Suicide Framework Preliminary Suicide Screening Questions

1. Are you having any feelings of hopelessness, helplessness or depression?
2. Have you had any thoughts, urges or behaviors related to harming yourself?
3. Have you recently engaged in any reckless behaviour such as; abusing alcohol or drugs, reckless driving or impulsive actions?
4. Have things been so bad lately that you have thought you would rather not be here?
5. Are you thinking of suicide?
6. Have you made any current plans?
7. Do you have the means to act on your plan?

If a patient answers "Yes" to any of these seven questions, staff are to complete a more detailed suicide risk assessment to gauge their risk of attempting suicide.

Source: Ministry of Health, *The Saskatchewan Suicide Framework, 2012*, p.16.

Health care providers are to use this information to gauge a patient's mental state (e.g., feeling helpless, or having a plan to act on suicidal thoughts). For example, health care providers will likely assess, as a high risk of suicide, a patient with signs of severe depression, hostility, evidence of clear intention for suicide, currently dependent or using drugs, refusing help, and lacking supportive relationships.

The Authority expects staff to document this process using standard manual forms or inputting information into the patient's electronic mental health file (if available). Manual forms are to be retained in patient files.[30]

Figure 8—Categories of Information Used to Determine a Suicide Risk Level

'At Risk' Mental States	Suicide Attempts/ Suicidal Thoughts	Substance Use	Corroborative History	Strengths/ Supports	Reflective Practice
• Depressed • Psychotic • Hopelessness, despair • Guilt, shame, anger, agitation • Impulsivity	• Intentionality • Lethality • Access to means • Previous suicide attempt/s	• Current misuse of alcohol and other drugs	• Family, parent or guardian • Medical records • Other service provider/ sources	• Expressed communication • Availability of supports • Willingness/ capacity of supports • Safety of person and others	• Level & quality of engagement • Changeability of risk level • Assessment confidence in risk factors
There is no a definite predictor of suicide, however, in combination with good clinical judgment, such risk assessment provides a means to determine treatment.					

Source: Ministry of Health, *Saskatchewan Suicide Framework. Appendix B: Protocol for Management of Mental Health In-Patient Departments for Saskatchewan Health Care Providers*, 2012, p.18.

For each of the 14 files tested of patients who came to mental health outpatient services, files showed mental health staff completed the required suicide screening, and assessed the patient's suicide risk level. We found files sufficiently documented a patient's circumstances, risk factors, patient-provided past history, and the results of preliminary screening.

[30] The Authority does not require psychiatrists to complete a standard form.

We found the Authority had clear protocols for handling patients who came to an emergency department and indicated a plan to attempt suicide. We found the protocols consistent with the Framework. It expected health care providers to rate those patients who attempted suicide or had a plan to attempt as high risk. It also expected the staff completing the preliminary screening to consult with an emergency department physician to validate the assessed risk of suicide. Where an emergency physician agreed with a high level of risk, it expected the emergency department to consult with a psychiatrist for further assessment, and determine next steps.

We found emergency department staff in smaller communities sent patients considered to be at high risk of suicide to the North Battleford emergency department.

We found this emergency department protocol appropriately recognizes emergency department health care providers may not have specialized training to determine appropriate clinical interventions for patients at high risk of suicide. Also, the protocol is consistent with literature that suggests a patient who sees a psychiatrist after a suicide attempt is at lower risk of repeating a suicide attempt.[31]

For 23 files tested of patients who attempted suicide and came to emergency departments, we found staff did not always follow the protocols to consult with a psychiatrist prior to discharge:

- Nine files showed staff completed the preliminary suicide screening and determined suicide risk level the same day the patient came to emergency.

  However, contrary to Authority protocol, one of these patients who presented with intention of self-harm and under substance influence (i.e., suicide attempt) did not see a psychiatrist prior to discharge. The patient was screened as high risk of suicide and discharged once their body cleared the harmful substance.

- Fourteen files did not include a preliminary suicide screening. Emergency department health care providers did not do the screening because all 14 patients presented with intention of self-harm and were under substance influence at point of emergency department admission. Not screening patients under substance influence aligns with the protocol.

  For two of the 14 files, patients came to the emergency department with intention of self-harm, but did not see a psychiatrist prior to their discharge. Both patients were discharged once their bodies cleared the harmful substance. For one of the 14 files, the patient refused to co-operate, or see a psychiatrist prior to discharge.

Emergency department health care providers not consistently following the Authority's protocol to consult with psychiatrists prior to discharge of a patient with a plan to attempt suicide (e.g., overdose with intention of self-harm) increases the risk of those patients not receiving needed support and treatment. In addition, it may open the Authority to litigation if it did not provide the patient with appropriate care.

[31] M. Roelands, et. al, *Psychiatric Consultation and Referral of Persons Who Have Attempted Suicide. The Perspective of Heads of Emergency and Psychiatry Departments*, 2017, doi.org/10.1027/0227-5910/a000445.

3. **We recommend the Saskatchewan Health Authority follow its established protocols to provide psychiatric consultations to patients accessing emergency departments in northwest Saskatchewan who are at high risk of suicide.**

4.6 Analysis of Telehealth Use Needed

The Authority has not analyzed why patients at greater than a low risk of suicide are not showing up for scheduled telehealth (i.e., videoconferencing) appointments. Its provision of psychiatric services through telehealth also remains low.

Given the geographic spread and size of communities in northwest Saskatchewan, the Authority cannot offer onsite psychiatrists in all healthcare facilities. Therefore, it requires patients needing outpatient psychiatric services to book appointments and travel to larger centres like North Battleford for face-to-face sessions with psychiatrists, or to their local facility with telehealth to receive services via videoconferencing.

To receive psychiatric services in various emergency departments located in northwest Saskatchewan, the Authority has varied contractual arrangements with psychiatrists.

We found the length of time patients with a high risk of suicide wait at emergency departments to see a psychiatrist varies. The location of the emergency departments in northwest Saskatchewan where patients accessed services presented the primary variable in wait times. For example, patients at high risk of suicide accessing emergency departments located in:

- North Battleford waited, in 2018–19, on average 34 minutes (ranging from 23 minutes to 47 minutes) to see a psychiatrist in an emergency department—North Battleford retains psychiatrists on staff in its mental health inpatient department at North Battlefords Union hospital.[32]

- Lloydminster often waited more than an hour to see a psychiatrist. In March 2019, more than half of the patients in emergency waited more than one hour to see a psychiatrist—psychiatrists in Lloydminster are available under fee-for-service contracts.[33]

- Smaller communities with no psychiatrists onsite had to book appointments for either face-to-face or telehealth sessions with psychiatrists. Appointments are booked as outpatient services (Monday to Friday from 9 a.m. to 5 p.m). If a patient requires immediate psychiatric assessment, staff arrange transfer to North Battleford's mental health inpatient services via ambulance. Ground ambulance transports from La Loche take at least five hours to get to North Battleford.

- We noted mental health staff in smaller communities located in northwest Saskatchewan typically refer patients at low or moderate risk of suicide to psychiatrists located in North Battleford or Saskatoon for outpatient psychiatric services. Since 2016, patients in La Loche can also receive services from a federally-funded psychiatrist who travels from Saskatoon or conducts telehealth one day every month.

[32] Information provided by the Saskatchewan Health Authority.
[33] Information provided by the Saskatchewan Health Authority. Fee-for-service psychiatrists also have their own private practices.

We found the Authority's use of telehealth for providing psychiatric services depends on whether it has a sufficient number of psychiatrists available. For example, the Authority stopped using telehealth in 2018 because of a shortage of psychiatrists in North Battleford. It resumed its use in 2019 when it filled the vacant psychiatrist positions.

We also found patients poorly utilize telehealth to access psychiatric services in northwest Saskatchewan. For example, in both 2017 and 2019, the rate of "patient no shows" for telehealth appointments with North Battleford psychiatrists was at least 50%.

The Authority recognizes "no shows" result in a significant amount of unproductive time for psychiatrists. Psychiatrists must conduct a telehealth session in a specific room located in the Battlefords Union Hospital because the telehealth technology does not permit them to conduct sessions from their own offices.

Also, the Authority has not formally tracked or assessed why patients miss appointments. It assumes some patients may prefer face-to-face sessions with psychiatrists. It also expects some patients may have difficulty in obtaining transport to the appointment (e.g., many smaller communities do not have taxi services).

Given the geographic spread and size of communities in northwest Saskatchewan, better delivery of psychiatric services through videoconferencing can be effective. Research shows psychiatric consultations and short-term follow-ups can be as effective when delivered via telehealth as when provided face to face.[34] In addition, use of videoconferencing can help patients and psychiatrists minimize travel time and costs to attend face-to-face appointments.

Not determining reasons for poor use of videoconferencing for psychiatric services in northwest Saskatchewan communities reduces the Authority's opportunities to identify and address barriers to its use.

4. **We recommend the Saskatchewan Health Authority address barriers to using videoconferencing to provide psychiatric services to communities in northwest Saskatchewan.**

4.7 Inpatient and Outpatient Services Used to Manage Suicide Risk

Patient files show the Authority took steps, consistent with the *Saskatchewan Suicide Framework*, to manage suicide of risk of patients receiving outpatient and inpatient services.

Of the patient files we tested, 13 patients were referred to and received mental health inpatient services in North Battleford, and nine patients received mental health outpatient services. For the combined 22 patients tested, we found each patient file showed management of suicide risks. In particular, each showed mental health staff:

- Obtained the patient's medical history and assessed current mental state consistent with the Authority's protocols

[34] R. O'Reilly, et al. *Is Telepsychiatry Equivalent to Face-to-Face Psychiatry? Results From a Randomized Controlled Equivalence Trial*, Psychiatric Services, June 2007, Vol. 58, no.6.

- Used information gathered to determine clinical interventions/treatments
- Used, to the extent possible, a collaborative approach (i.e., engaging family, other supports) to help the patient stay safe and receive treatment

For nine patients who received outpatient services, we further found each patient file showed mental health staff:

- Worked with each patient to create a safety plan. Each safety plan outlined scheduled appointments and coping strategies for the patient to use when feeling hopeless or attempting suicide

For 13 patients who received inpatient services in North Battleford, we further found each patient file showed:

- Mental health staff took physical safety measures with patients at high risk of suicide (e.g., constant watch of patient, and placing patient into safe room with no physical dangers)
- Services mental health staff and psychiatrists provided, and the patient's progress

Having each patient file outline the steps taken to manage suicide risk shows what health care providers did to help patients reduce or eliminate factors contributing to suicidal thoughts or suicidal crisis.

4.8 Suicide Risk Level Reassessed at Appropriate Intervals Where Patients Available

The Authority reassessed suicide risk level of patients receiving mental health inpatient and outpatient services at appropriate intervals where patients attended appointments.

Consistent with the *Saskatchewan Suicide Framework*, the Authority uses a risk-based approach to determine when to reassess the suicide risk level of patients receiving mental health inpatient and outpatient services. As shown in **Figure 9**, it bases the frequency of reassessment on risk determined from previous suicide risk assessments. The frequency of reassessments increases as the suicide risk level increases.

Figure 9—Frequency of Suicide Risk Level Reassessments

Suicide Risk Level	Frequency of reassessment (Inpatient services)	Frequency of reassessment (Outpatient services)
High Risk	At least twice daily (i.e., every 12 hours)	Within 24 hours
Medium Risk	At least daily	Within one week
Low Risk	At least weekly	Within one month

Source: Ministry of Health, *Saskatchewan Suicide Framework. Appendix A: Protocol for Management in Community Mental Health Services*, 2012, p. 23, *Appendix B: Protocol for Management of Mental Health In-Patient Departments for Saskatchewan Health Care Providers*, 2012, p.22.

For five of nine patient files receiving outpatient services tested, we found mental health staff were unable to reassess the patient within the required timeframe. The patient either refused to receive outpatient services or did not attend booked appointments. See **Recommendation 5** about analyzing reasons for missed appointments.

For four of 13 patient files receiving inpatient services tested, we found files included psychiatrists' notes documenting informal risk assessments instead of formally completed reassessments. Once these patients discharged from inpatient services, outpatient staff booked timely appointments and followed up if patients did not attend a booked appointment.

Situational factors that contribute to suicidal inclinations are dynamic and the level of a patient's suicide risk can increase or decrease quickly. Timely reassessment of a patient's risk of suicide is essential to keeping the patient safe.

4.9 Analysis of No-Shows and Follow-Up Care Needed for Discharged ER Patients at Risk of Suicide

The Authority actively follows up with patients who received outpatient and inpatient services but does not know why certain patients do not show up for scheduled appointments.

Health care follow-ups act as a safety mechanism to check on a patient who may still be emotionally fragile.

The Authority followed its follow-up protocols for patients at risk of suicide receiving mental health inpatient and outpatient services. We found:

- For all nine files tested of patients receiving outpatient services, files clearly showed mental health staff actively followed up with patients, and attempted to contact patients when they missed appointments.

- For 13 files tested of patients receiving inpatient services, we found files showed, for patients discharged from inpatient services, mental health staff booked timely follow-up outpatient appointments. In addition, they clearly showed mental health staff actively followed up if patients did not attend a booked appointment.

However, we found patients often miss appointments, which disrupts the continuity of clinical care. For example, four of nine patients receiving outpatient services missed appointments. Not knowing why patients miss appointments reduces the Authority's opportunities to identify and help patients overcome barriers to attending appointments. Such information would help the Authority assess the appropriateness of its services for patients at risk of suicide. See **Recommendation 1**.

5. **We recommend the Saskatchewan Health Authority analyze reasons patients at risk of suicide miss appointments for mental health outpatient services to help address barriers.**

In northwest Saskatchewan, the Authority's follow-up protocols for patients at risk of suicide accessing services through emergency departments differ from those for patients accessing services through mental health outpatient services. Because the Authority does not have the same protocols, it did not always formally follow up with patients at risk of suicide after discharge from emergency departments.

For four files tested of patients who attempted suicide and were discharged from emergency departments, we did not find any evidence of the patient being referred to mental health or addictions services. We found:

- Two of the four patients later sought mental health outpatient services
- One patient did not have ongoing contact with the health system, and died five months following the emergency department visit (cause of death was undetermined)
- One other patient left before receiving a psychiatric consultation and appears to have not accessed mental health and addiction services in northwestern Saskatchewan since

The *Saskatchewan Suicide Framework* indicates the people most at-risk to die by suicide are those who attempted it in the past year. The World Health Organization estimates for every suicide in society, 20 attempts occurred.[35] Research supports contacting people and providing support after discharge from emergency departments reduces suicidal behaviours and deaths.[36] Making sure patients are all right, connecting them with services, and letting them know somebody cares can reduce the number of patients who attempted suicide from re-attempting (and reduce patients accessing emergency services).

We did not find emergency department staff referred patients to mental health outpatient services for follow-up.

We did find the North Battleford emergency department provides, upon discharge, patients who attempted suicide with an informational package. This package includes information about mental health services available along with contact details, and information to help the individual self-assess their level of suicide risk to help them decide when to seek help. It started providing this package to patients following a critical incident review in July 2019.

We did not find any other emergency departments in northwest Saskatchewan providing patients who attempted suicide with a similar information package.

Having differing follow-up protocols for patients who attempted suicide accessing health services through emergency departments from those accessing services through outpatient services may result in not providing patients with consistent levels of care. Proactive follow-up care promotes continuity of care and continues the assessment and management of suicide risk.

[35] World Health Organization, *Practice Manual for Establishing and Maintaining Surveillance Systems For Suicide Attempts And Self-Harm*, 2016, p. 6. www.who.int/health-topics/suicide#tab=tab (10 September 2019).
[36] Zalsman G, et al. *Suicide prevention strategies revisited: 10-year systematic review*. Lancet Psychiatry (2016) 3(7):646-59. doi:10.1016/S2215-0366(16)30030-X (27 September 2019).

6. **We recommend the Saskatchewan Health Authority follow up with patients (who attempted suicide) discharged from emergency departments in northwest Saskatchewan to encourage treatment, where needed.**

4.10 Risk-Based Approach to Monitoring Patient Files Needed

The Saskatchewan Health Authority does not use a risk-based approach for conducting patient file audits in the northwest Saskatchewan health care facilities. Patient file audits can determine whether staff follow policy and provide appropriate care to patients at risk of suicide.

The Framework expects former health regions to audit 10% of mental health inpatient and outpatient files monthly to determine whether files document the various items outlined in the **Figure 10**. The Framework goal was to have all required documentation in 100% of the audited patient files. The Framework did not expect audits for emergency department patient files, even though many patients at risk of suicide access services through an emergency department.

Figure 10—Required Documentation in Patient Files

- Suicide screening
- Suicide risk assessment tool utilized and assigned level of risk
- Triage action appropriate to risk level
- Consultation
- Action plan/intervention (treatment)
- Level of observation
- Discharge plan (safety plan)
- Risk level prior to discharge or leave
- Established follow up with a patient
- Evidence of follow-up

Source: Ministry of Health, *Saskatchewan Suicide Framework*, Appendix C: Facility Checklists & Access to Means Auditing, Outcome Measures and Quality Assurance for Saskatchewan Health Care Providers, 2012, p.7.

The Authority did not conduct monthly mental health outpatient file audits since April 1, 2018, or inpatient file audits since March 31, 2019 in northwest Saskatchewan health care facilities, as the Framework expects. It has never conducted audits of files for emergency department patients at risk of suicide.

Consistent with Ministry of Health expectations, the Authority gave the Ministry a summary of certain patient-file audit results (see **Figure 11**).[37]

As shown in **Figure 11**, the 2018–19 inpatient audit results from North Battleford's mental health inpatient department showed its files were not as complete as compared to the rest of the province. For example, only 79% of North Battleford inpatient files had evidence of a safety plan and follow-up care, 21% did not. Management indicated that they discussed non-compliance with staff.

[37] In 2018–19, the Ministry stopped asking for results of outpatient file audits, and only requested inpatient file audit results.

Figure 11—Results of North Battleford Mental Health Inpatient Audit File Results 2018–19

	Interventions	Safety Plan	Follow Up
North Battleford mental health inpatient audit results	100%	79%	79%
Provincial mental health inpatient audit results	87%	86%	94%

Source: Information provided by the Ministry of Health.

We also found the past inpatient and outpatient file audits conducted in northwest Saskatchewan did not cover all the requirements outlined in **Figure 10**. For example, the Authority is not confirming it does appropriate suicide screening and risk assessments in each of these settings (i.e., emergency, outpatient, and inpatient).

A risk-based approach to audits involves focusing audit effort on identified areas of high risk within an organization. For example with respect to mental health file audits, it focuses on areas (e.g., certain facilities, departments, policies, patient files) where there is higher risks of services not following policies or providing consistent treatment to patients at risk of suicide.

Conducting systematic risk-based audits of patient files would help supervisors and management actively monitor staff and help identify areas needing improvement. Not following policy may result in inadequate services provided to patients at risk of suicide.

7. **We recommend the Saskatchewan Health Authority conduct risk-based file audits of patients at risk of suicide in northwest Saskatchewan.**

4.11 Safety Inspections of Facilities Required to Reduce Suicide Risks

The Saskatchewan Health Authority does not routinely inspect facilities providing mental health services in northwest Saskatchewan to identify safety risks for patients at risk of suicide.

The Saskatchewan Suicide Framework requires annual facility safety inspections of inpatient facilities. It includes a checklist to aid in these inspections. The purpose of inspections is to identify obstructions to staff observation of high-risk patients (e.g., furniture or room design) and physical structures that patients could use in attempting suicide (e.g., shower fittings, internal piping, and door knobs).

We found staff conducted quick visual reviews of all inpatient rooms to identify any obvious safety risks every 12 hours (e.g., plastic bags, items with cords). The staff documented the completion of these visual reviews in a log. We found the scope of these reviews are narrower than the Framework expects (e.g., assessing whether curtain rails or bed frames are collapsible).

The Authority does not formally inspect the safety of facilities periodically in northwest Saskatchewan used to provide mental health inpatient services or emergency department services to patients at risk of suicide.

Not doing periodic (e.g., annual) robust inspections of facilities used to care for patients at risk of suicide increases the risk of not sufficiently identifying and addressing safety risks.

8. **We recommend the Saskatchewan Health Authority periodically inspect the safety of its facilities in northwest Saskatchewan providing services to patients at risk of suicide.**

4.12 Critical Incidents Acted Upon

The Authority followed its established process to identify, report, and investigate critical incidents related to patients who died by suicide and to act on results.

The Authority has a well-defined and understood process to identify and handle critical incidents including incidents when a recent patient dies by suicide. Saskatchewan Critical Incident Reporting Guideline requires the Authority to report all critical incidents to the Ministry of Health.[38]

We found the Authority internally investigates the incident, identifies factors contributing to the incident, and makes recommendations for process improvements. It reports the results of its investigations to the Ministry.

From April 2018 to August 2019, it investigated eight critical incidents related to recent patients who died by suicide in northwest Saskatchewan. In addition, it was investigating two critical incidents that occurred in summer 2019.

We found the Authority submitted the eight investigation reports to the Ministry as expected. In addition, we noted the Authority acted on or was actively considering how best to address recommendations included in reports.

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[38] Critical incident is a serious adverse health event including, but not limited to, the actual or potential loss of life, limb or function related to a health service.

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