Chapter 20
Saskatchewan Health Authority—Treating Patients at Risk of Suicide in Northwest Saskatchewan

1.0 Main Points

In Saskatchewan, approximately 195 people die by suicide each year.[1] In northern Saskatchewan, suicide is the leading cause of death for people aged 10 to 49.[2]

The Saskatchewan Health Authority has more work to do in regards to treating patients at risk of suicide in northwest Saskatchewan. By November 2022, we found it implemented two recommendations, and partially implemented six recommendations, we first made in 2019.

The Authority conducts risk-based file audits of patients at risk of suicide in northwest Saskatchewan to determine whether staff appropriately completed suicide risk assessments and safety plans for patients. It also periodically inspects the safety of the inpatient facility (i.e., Battlefords Union Hospital) providing services to those patients.

The Authority needs to conduct further work in the following key areas:

- Formally analyze key data about suicide rates and prevalence of suicide attempts to rationalize services available to patients at risk of suicide. Reviewing trends and documenting analysis of key data can inform the planning and implementation of treatment programs.
- Conduct suicide screening of all patients to ensure psychiatric evaluations for emergency department patients at risk of suicide occur prior to discharge. This helps ensure patients receive 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.
- Analyze reasons why patients at risk of suicide do not attend their scheduled appointments for mental health outpatient services or videoconferencing. While the Authority started compiling some data about reasons patients miss their appointments, analysis of this information can help the Authority assess the appropriateness of its services and address any barriers to services.
- Centrally track training completed by staff working with mental health and addictions patients and patients at risk of suicide to ensure they receive the appropriate training (e.g., able to identify suicide risks).

[1] The average number of suicides between 2015 and 2021. www.suicideinfo.ca/local_resource/suicide-stats-canada-provinces/ (30 March 2023).
[2] *Pillars for Life: Saskatchewan Suicide Prevention Plan*. p. 2.

2.0 Introduction

2.1 Background

Under *The Provincial Health Authority Act*, the Ministry of Health is responsible for the strategic direction of the healthcare system, and the Saskatchewan Health Authority is responsible for the planning, organization, delivery and evaluation of the health services it provides.

One of the public health and safety issues Saskatchewan faces is suicide. Based on the annual rates of suicide per 100,000 population for 2018–20, Saskatchewan's three-year average rate of 17.9 suicides is significantly higher than the Canadian average rate of 11.5 suicides for the same period.[3]

In 2020, the Government of Saskatchewan released *Pillars for Life: The Saskatchewan Suicide Prevention Plan* to help reduce risk factors related to suicide.[4] The Plan notes that in northern Saskatchewan, suicide is the leading cause of death for people aged 10 to 49.[5]

The Authority's northwest integrated service area is one of its six service areas, and encompasses those healthcare facilities serving communities in northwest Saskatchewan (e.g., North Battleford, Lloydminster, Meadow Lake) and far northwest (e.g., Buffalo Narrows, La Loche, Île-à-la-Crosse).[6] These facilities serve a population of about 80,000 and employ over 4,000 healthcare providers.[7]

2.2 Focus of Follow-Up Audit

This chapter describes our first follow-up audit assessing the status of eight recommendations we made in our *2019 Report – Volume 2*, Chapter 24, about the Authority's processes to treat patients at risk of suicide in northwest Saskatchewan.[8] We concluded for the 12-month period ended August 31, 2019, the Authority had, other than the areas identified in our eight recommendations, effective processes to treat patients at risk of suicide in the northwest integrated service area.

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Authority's progress toward meeting our recommendations, we used the relevant criteria from the original audit. Authority management agreed with the criteria in the original audit.

To complete this follow-up audit, we interviewed key Authority staff responsible for providing services to people at risk of suicide in northwest Saskatchewan. We examined the Authority's centralized mental health and addictions IT system and assessed relevant documents such as procedures, facility inspection results, and file audit results. We also tested a sample of files of patients at risk of suicide.

[3] www.suicideinfo.ca/local_resource/cross-canada-comparison-statistics/ (27 March 2023).
[4] www.saskatchewan.ca/government/health-care-administration-and-provider-resources/saskatchewan-health-initiatives/suicide-prevention-plan (27 March 2023).
[5] *Pillars for Life: Saskatchewan Suicide Prevention Plan*. p. 2.
[6] Prior to creation of the Saskatchewan Health Authority in 2017, the former Keewatin Yatthé Health Region served communities in the far northwest and the former Prairie North Health Region served communities in the northwest.
[7] Information provided by the Saskatchewan Health Authority.
[8] *2019 Report – Volume 2*, Chapter 24, pp. 197–222.

3.0 Status of Recommendations

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at November 30, 2022, and the Authority's actions up to that date.

3.1 More Formal Data Analysis Needed

We recommended 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. (*2019 Report – Volume 2,* p. 207, Recommendation 1; Public Accounts Committee agreement March 1, 2022)

Status—Partially Implemented

The Saskatchewan Health Authority analyzes some key data about rates and prevalence of suicide attempts to rationalize services made available to patients at risk of suicide, but further analysis is needed.

Given mental illness is a common risk factor for patients at risk of suicide, the Authority offers various mental health services in northwest Saskatchewan and offers the first service (i.e., the first appointment with a counsellor or psychiatrist) based on the seriousness of a patient's presenting symptoms. The Authority expects patients assessed as having more medically urgent conditions to be seen before those with less urgent conditions.

See **Figure 1** for the maximum length of time a patient should have to wait for their first offered service.

Figure 1—Target Timeframes for Outpatient and Psychiatry Services

Presenting Symptoms	Service Response Target
Very Severe	Patient seen within 24 hours
Severe	Seen within 5 days
Moderate	Seen within 20 days
Mild	Seen within 30 days

Source: Information provided by the Saskatchewan Health Authority.

The Authority tracks and reports to senior management monthly on whether it is meeting the target wait times for outpatient and psychiatry services in the northwest integrated service area**.**

We reviewed two months of service-response reports and found the Authority is not always meeting its response targets. For example, in September 2022, in the adult mental health outpatient unit:

- 100% of the patients assessed as severe were seen within 5 days
- 67% of the patients assessed as moderate were seen within 20 days
- 72% of the patients assessed as mild were seen within 30 days

When the Authority does not meet its response targets, the Authority documents its corrective action plan outlining the root cause, as well as the proposed actions to address the issue. For example, in September 2022, the Authority noted staff vacancies caused the delays and, although the Authority was recruiting, it had not found any acceptable candidates.

Management indicated the Authority did not meet its targets in September 2022 due to vacancies in three of its six psychiatrist positions in northwest Saskatchewan.[9]

We found the Authority could do more analysis of key data about rates and prevalence of suicide attempts to rationalize services made available to patients at risk of suicide.

As noted in our original audit, good practice suggests focusing on certain key measures—suicide rate, hospitalization rate for self-injury, and emergency department rate (see **Figure 2**)—to assess services provided to patients at risk of suicide.

Figure 2—Suggested Key Measures of Suicide Programing

Suggested Measure
• **Suicide rates**: the mortality rate for deaths due to intentional self-inflicted injury • **Hospitalization rate for self-injury**: suicide attempts and non-suicidal self-harm related to injuries or poisoning[A] • **Emergency department rate for self-inflicted injury**: suicide attempts and non-suicidal self-harm related to injuries or poisoning[A]

Source: *Tracking progress in suicide prevention in Indigenous communities: a challenge for public health surveillance in Canada*, bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-018-6224-9 (22 March 2023).
[A] Non-suicidal self-harm is an intentional self-injury without the desire or intention to die (e.g., accidental overdose, self-cutting without intention to die).

Suicide rates

The Saskatchewan Coroners Service provides data to the Authority, at the Authority's request, including the year of death, location/community, age, gender, and race of individuals who completed suicide. We found that after the Authority analyzed the data for communities in the far northwest area of the province (e.g., Buffalo Narrows, La Loche, Turnor Lake, Île-à-la-Crosse), it added additional staff to support those communities at the highest need (i.e., with the highest rate of suicide).

For example, between 2004 and 2022, La Loche had the highest number of suicides (40% of all suicides) in the far northwest. Since our 2019 audit, Authority management indicated the Authority established a health educator position in La Loche to focus on suicide risk assessment, prevention, intervention, and follow-up services. The Authority also created two mental health counsellor positions in La Loche and Île-à-la-Crosse. These individuals work in emergency departments and are trained in suicide risk assessment, interventions, prevention, and safety planning.

However, we found the Authority only analyzed coroner data for the far northwest. It did not obtain coroner data to complete analysis for other communities in the northwest integrated service area such Meadow Lake, Lloydminster, and North Battleford. Without fully analyzing data from all communities in the northwest, the Authority may not identify areas that need additional services.

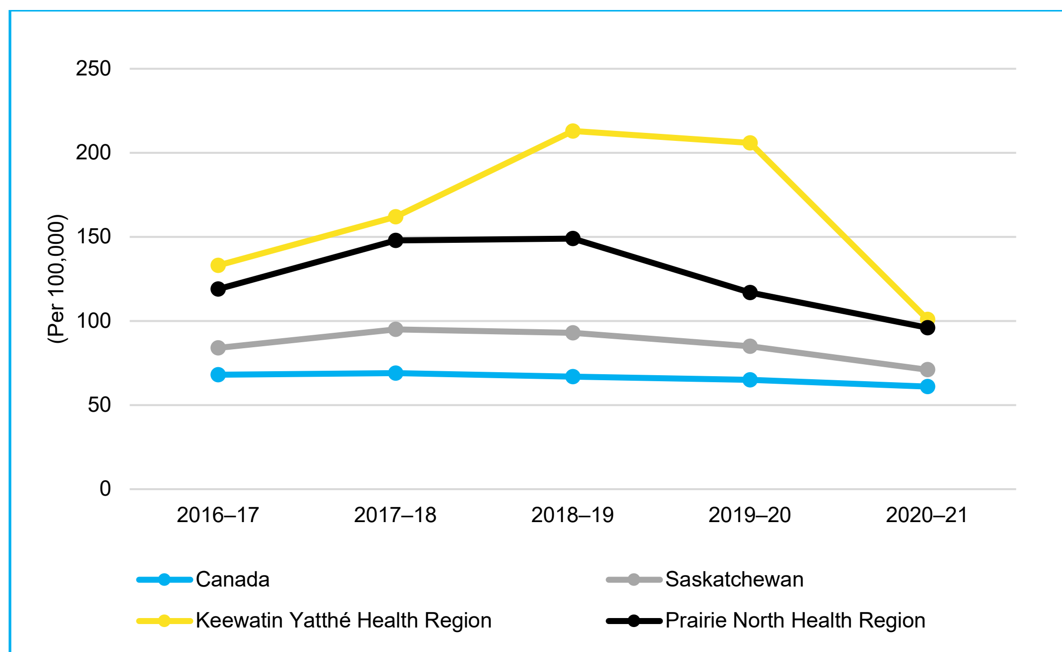
[9] At March 2023, management indicated the Authority had four psychiatrist positions vacant.

Hospitalization rate for self-injury

The Authority indicated it reviews data from the Canadian Institute for Health Information on reasons for self-harm hospitalizations; however, it could not provide evidence of how it used this information to support further analysis or decision-making.

We found the rate of self-injury hospitalizations in the former Prairie North Health Region and Keewatin Yatthé Health Region from 2016 to 2020 was consistently higher than the provincial rate over the last four years (see **Figure 3**). Northwest Saskatchewan is comprised primarily of these former regions.

Figure 3—Rate of Self-Injury Hospitalizations per 100,000 Population in Canada, Saskatchewan, former Prairie North Health Region, and former Keewatin Yatthé Health Region, 2016–21



Source: Canadian Institute for Health Information, yourhealthsystem.cihi.ca/hsp/ (27 March 2023).

Emergency department rate for self-inflicted injury

For the purpose of our audit, the Authority provided us with a listing of individuals admitted to emergency departments in northwest Saskatchewan with a diagnosis of suicide ideation (suicidal thoughts), self-harm, or attempted suicide. We found the Authority does not produce this listing for its own analysis on a periodic basis.

Between December 1, 2021, and July 31, 2022 (eight month period), we found the Authority admitted 120 individuals (2018–19: 273) to emergency departments in Saskatchewan's northwest with a diagnosis of suicide ideation, self-harm, or attempted suicide. However, management indicated the list does not include all individuals up to July 2022 as the Authority has not completed coding (i.e., diagnosis of suicide ideation, self-harm, or attempted suicide) of all individuals admitted to emergency departments.

Reviewing trends and performing analysis of key data can inform the planning and implementation of treatment programs. It would also help the Authority determine whether it gives individuals at risk of suicide in northwest Saskatchewan sufficient access to services and whether the programs make a difference.

3.2 Training Provided to Staff, But Not Centrally Tracked

We recommended the Saskatchewan Health Authority give suitable training to staff located in northwest Saskatchewan caring for patients at risk of suicide. (*2019 Report – Volume 2,* p. 211, Recommendation 2; Public Accounts Committee agreement March 1, 2022)

Status—Partially Implemented

The Saskatchewan Health Authority determined mandatory training required for staff working with patients at risk of suicide, but does not have a centralized tracking system to monitor staff completion of training.

In June 2021, the Authority implemented a work standard outlining the minimum mandatory orientation and training for staff caring for patients at risk of suicide.

Upon hire, and annually thereafter, the Authority requires staff working with mental health and addictions patients and patients at risk of suicide to complete training on identifying suicide risks, and completing assessment forms and safety plans. The Authority augments this training with on-the-job training (e.g., staff may complete training on a hypothetical or actual clinical case to ensure competency). The Authority also requires staff be trained on IT systems (i.e., Mental Health and Addiction Information System, Level of Care Utilization System) used in mental health and addictions units.

The Authority recognizes staff (i.e., clinicians) have varying degrees of training, experience, and competency in relation to working with patients at risk of suicide (e.g., assessing risk, triaging, interventions, safety planning). Therefore, the Authority expects staff, in consultation with their manager, to determine their need for further training. For example, further training may include Applied Suicide Intervention Strategies Training or Critical Incident Stress Management.

We found the Authority does not have a system or process to track training completed by staff. In November 2022, management indicated the Authority is looking at implementing processes to track mandatory staff training. Management indicated all 16 mental health and addictions clinicians who were not previously trained received Applied Suicide Intervention Strategies Training in 2019–20 and 2020–21.

Not centrally tracking staff training increases the risk of staff, who work with patients at risk of suicide, missing key training courses. Not providing consistent training to staff increases the risk that staff may not follow the practices the Authority expects and may provide patients with inconsistent care.

3.3 Suicide Screenings and Psychiatric Consultations Not Always Completed

We recommended 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. (*2019 Report – Volume 2,* p. 214, Recommendation 3; Public Accounts Committee agreement March 1, 2022)

Status—Partially Implemented

The Saskatchewan Health Authority does not always follow its established protocols to screen patients for risk of suicide and provide psychiatric consultations to patients accessing emergency departments who are at high risk of suicide.

The Authority requires staff to screen patients admitted to emergency departments for risk of suicide using a standard suicide-screening assessment. If staff determine the patient is high risk of suicide, the Authority expects staff to consult with a psychiatrist or senior clinician prior to patient discharge.

We tested 30 files of patients admitted to emergency departments for suicide ideation, self-harm, or attempted suicide. We found three instances where the Authority did not screen patients to determine their suicide-risk levels. As such, we were unable to determine these patients' need for psychiatric consultations. The Authority did not provide such consultations to these patients prior to their discharge. These patients had yet to access mental health and addiction services in northwest Saskatchewan at the time of our testing.

Emergency department staff inconsistently following the Authority's protocols to screen patients for suicide and consulting with psychiatrists prior to patient discharge (when necessary) 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.

3.4 Further Assessment of Videoconference Use for Psychiatric Services Needed

We recommended the Saskatchewan Health Authority address barriers to using videoconferencing to provide psychiatric services to communities in northwest Saskatchewan. (*2019 Report – Volume 2,* p. 215, Recommendation 4; Public Accounts Committee agreement March 1, 2022)

Status—Partially Implemented

While the Saskatchewan Health Authority has taken steps to address patient barriers in using videoconferencing to provide psychiatric services in northwest Saskatchewan, more work is needed.

We found patients continue to poorly utilize videoconferencing to access psychiatric services in the far north (i.e., Beauval, Buffalo Narrows, La Loche, and Île-à-la-Crosse). The no-show rate for videoconferencing appointments for northwest Saskatchewan (including communities in the far north, as well as Meadow Lake, Turtleford, and Loon Lake) was 36% between January 1, 2022 and November 15, 2022 (compared to least 50% in 2019).

We found the Authority does not track or assess why patients are not showing up for their videoconferencing appointments. Management indicated the Authority stops using videoconferencing at various times in several communities based on psychiatrist availability. For example, the Authority stopped using videoconferencing in La Loche in December 2022. It expects to re-establish videoconferencing in this community in June 2023.

The Authority has taken steps to improve its videoconferencing system. For example, in 2020, the Authority implemented a new videoconferencing system providing more flexibility for patients and clinicians. Rather than travelling to a specific facility to carry out a videoconferencing appointment, patients and clinicians can access the appointment from anywhere through an application installed on a computer or mobile device. Removing the need for patients to go to a specific facility to access videoconferencing removes travel, as well as weather and time barriers.

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

3.5 Analysis of Barriers for Missed Appointments Needed

We recommended the Saskatchewan Health Authority analyze reasons patients at risk of suicide miss appointments for mental health outpatient services to help address barriers. (*2019 Report – Volume 2,* p. 217, Recommendation 5; Public Accounts Committee agreement March 1, 2022)

Status—Partially Implemented

The Saskatchewan Health Authority compiles data to help understand reasons patients missed their scheduled appointments for mental health outpatient services, but the Authority has not analyzed the information to identify barriers for why patients do not attend scheduled appointments.

In September 2019, the Authority implemented a work standard providing clear guidance to staff for contacting patients who miss their scheduled appointments. The Authority requires staff to attempt contacting the patient within one hour of missing their appointment and again the next day if the first attempt was unsuccessful. Staff must also complete a form documenting the dates and times staff attempted to contact the patient. If the attempt was successful, staff document the patient's reason for not attending the appointment (e.g., sick, tired, forgot, feeling okay, feeling down/depressed, no child care, no transportation, receiving other services).

In September 2022, the Authority began compiling data for the reasons why patients miss their scheduled appointments. As shown in **Figure 4**, the Authority was unable to contact patients for 50% of missed appointments during September and October 2022. We also found 19% of the patients forgot about their appointment and 14% had a schedule conflict.

Figure 4—Reasons Why Patients Miss Appointments in September and October 2022

Reason for Missed Appointment	September 2022		October 2022		Total	
	No Show	%	No Show	%	No Show	%
Unknown/unable to contact	19	43%	20	59%	39	50%
Forgot	9	21%	6	17%	15	19%
Schedule conflict	8	18%	3	9%	11	14%
Miscommunication	3	7%	1	3%	4	5%
Service no longer needed	1	2%	3	9%	4	5%
Other (e.g., slept in, no child care, tired/feeling down, sick)	4	9%	1	3%	5	7%
Total	**44**		**34**		**78**	

Source: Adapted from information provided by the Saskatchewan Health Authority.

As of November 2022, the Authority had yet to complete an assessment of the data to identify the barriers for why patients missed their scheduled appointments.

In addition, during our testing of 16 scheduled appointments, we found the Authority did not attempt to contact four patients and complete the required form to document reasons why patients missed their appointments. When Authority staff do not complete the required form, the data about reasons why patients miss appointments (see **Figure 4**) does not include information for all patients, and this will impact the Authority's analysis.

Insufficiently analyzing reasons for missed appointments for outpatient services in northwest Saskatchewan reduces the Authority's opportunities to identify and help patients overcome barriers to attending appointments (e.g., sending appointment reminders to limit the number of patients who forget their appointments).

3.6 Follow Up with Discharged Patients Not Always Done

We recommended the Saskatchewan Health Authority follow up with patients (who attempted suicide) discharged from emergency departments in northwest Saskatchewan to encourage treatment, where needed. (*2019 Report – Volume 2,* p. 219, Recommendation 6; Public Accounts Committee agreement March 1, 2022)

Status—Partially Implemented

The Saskatchewan Health Authority does not always follow up with patients discharged from emergency departments (who attempted suicide) in northwest Saskatchewan to encourage treatment, where needed.

Upon discharge, emergency departments refer patients who attempted suicide to outpatient services (e.g., addictions counselling, psychiatric care) or inpatient services. The Authority expects mental health and addictions staff to follow up with patients needing

outpatient services the next business day and determine further referrals or follow up appointments.

The timeliness of follow up appointments depends on the patient's assessed suicide risk at the time of discharge (i.e., patients assessed at moderate suicide risk have scheduled appointments to reassess suicide risk within five days; high-risk patients are reassessed within 24 hours).

We tested 30 patient files and found the Authority referred all patients to outpatient services. However, the Authority did not follow up with five patients timely, or not at all, following their discharge.

We found the Authority:

- Referred three patients to a third-party outpatient service provider (e.g., youth and family support programs, tribal councils) at the patient's request. The Authority did not follow up with these patients. In one instance, a patient was brought to the emergency department again three days after their discharge.

- Did not follow up with two patients after referral to the Authority's outpatient services. These patients had yet to access mental health and addiction services in northwest Saskatchewan at the time of our testing—both approximately eight months since their discharge.

Following up with patients after discharge decreases the risk of patients not receiving the care they need. Proactive follow up promotes continuity of care and continues the assessment and management of suicide risk.

3.7 Risk-Based Audits of Patient Files Completed Regularly

We recommended the Saskatchewan Health Authority conduct risk-based file audits of patients at risk of suicide in northwest Saskatchewan. (*2019 Report – Volume 2,* p. 220, Recommendation 7; Public Accounts Committee agreement March 1, 2022)

Status—Implemented

The Saskatchewan Health Authority conducts risk-based file audits of patients at risk of suicide in northwest Saskatchewan.

In 2021–22, the Authority implemented a work standard requiring monthly audits, as set out by the Ministry of Health.[10] The Ministry requires the Authority to audit 10% of all patient files assessed as high or severe risk of suicide to determine whether staff appropriately completed suicide risk assessments and safety plans for patients.

[10] The Ministry of Health's *Saskatchewan Suicide Framework* required the Authority to audit 10% of all mental health inpatient and outpatient files assessed as high or severe risk. In 2020, the Ministry replaced the Framework with the *Saskatchewan Pillars of Life Plan*. The Plan does not specify the number of files the Authority must audit, but does require the Authority to implement our recommendations from 2019, including the need to conduct risk-based file audits. Management indicated the Ministry elected to continue to follow the *Saskatchewan Suicide Framework,* requiring the Authority to audit 10% of all patient files assessed as high or severe risk.

We reviewed the Authority's audits conducted in May and September 2022. The audits included both inpatient and outpatient files. We found the Authority audited 14 files (10 high or severe risk, and four low or moderate risk) in both May and September 2022 for the northwest region. We found the Authority's audits determined all 28 files complied with the work standard or had reasonable explanations for variances (e.g., low risk patient files do not require a safety plan). We also found the Authority audited more than the required 10% of high or severe risk files—77% in May and 67% in September.

Completing risk-based audits of patient files helps the Authority identify areas needing improvement. It also helps reduce the risk that staff are not providing adequate care to patients at risk of suicide.

3.8 Inspections of Facilities Completed

We recommended the Saskatchewan Health Authority periodically inspect the safety of its facilities in northwest Saskatchewan providing services to patients at risk of suicide. (*2019 Report – Volume 2,* p. 221, Recommendation 8; Public Accounts Committee agreement March 1, 2022)

Status—Implemented

The Saskatchewan Health Authority periodically inspects the safety of inpatient facilities in northwest Saskatchewan providing services to patients at risk of suicide.

In July 2022, the Authority developed an environmental and safety checklist to appropriately guide inspections at the inpatient mental health unit in the northwest region (i.e., Battlefords Union Hospital). The purpose of the inspections is to identify any hazards patients could use to harm themselves or others.

Using the checklist, staff inspect numerous areas in a facility (e.g., walls; closets, shelves, and racks; furniture; bathrooms; patient rooms; nursing stations) and answer various questions about each area. For example, when inspecting patient rooms, staff assess things such as:

- Over-the-door alarms work properly
- Shatter-resistant mirrors have no anchor points
- Pillows and mattresses are free of plastic, vinyl, or materials that could be removed for suffocation/strangulation

The Authority expects staff to document issues found during inspections, along with required action, rationale, or any other comments.

Management expects to complete an annual inspection at the Authority's inpatient mental health unit in northwest Saskatchewan (i.e., Battlefords Union Hospital).

We found the Authority completed its first inspection of the unit, using the checklist, in July 2022. The inspection found deficiencies such as:

- Vinyl baseboards not secured to the wall and easily pulled off (potential weapon)
- A metal grate attached to ceiling vents which could be used as an anchor point
- Bathroom mirrors are not shatter-proof

Management indicated it shared the inspection results with maintenance and building staff to facilitate action plans to address the deficiencies.

In addition to the annual inspections, mental health and addictions inpatient staff conduct quick visual reviews of all inpatient rooms to identify any obvious safety risks during their regular check in with patients (i.e., every 15–30 minutes). The scope of these reviews are narrower than the checklist, as they mainly look for glaring issues (e.g., plastic bags left with patient, cords exposed).

Emergency departments do not conduct annual inspections of the safety of facilities in relation to patients at risk of suicide. Instead, the Authority provides emergency department staff with guidance to regularly monitor patients at risk of suicide and to remove all items (e.g., intravenous pole, call-bell cord, bedside table) from the emergency room that a patient could use to attempt suicide.

Preparing rooms to be safe for patient use and periodically inspecting facilities providing services to patients at risk of suicide decreases the risk of a patient committing self-harm while in the Authority's care.