External review of suicide at St. Joseph's Healthcare Hamilton
Reviewers: Dr. Paul Links and Dr. Craig Muir

Overview and Contextual Perspective

The Mental Health and Addiction Program at St. Joseph's Healthcare Hamilton (SJHH) provides multiple services for clients across the South Central Ontario Region. In addition to emergency and in-patient services (338 total psychiatry inpatient beds), the organization also focuses on early intervention, outreach services, rehabilitation, recovery and integration into the community.

In 2016-17, the Mental Health Emergency Department and Psychiatric Emergency Service had 6,416 visits, with 51% of those visits related to "risk of self-harm". During the same time, there were 2,138 Mental Health Inpatient Admissions with 61% of the acute general psychiatry admissions due to "threat or danger to self".

The Service's Quality Assurance Program identified that a number of suicides had occurred in 2016. There were five in-patient deaths (two on day passes) and four out-patient deaths. In order to ensure that the appropriate policies, practices and culture were in place to provide the safest care possible to their patients, an external review was commissioned to assess the programme and make recommendations as necessary to the hospital and its Mental Health team. The review was conducted by Dr. Paul Links and Dr. Craig Muir.

Dr. Links is a psychiatrist and Professor of Psychiatry, Department of Psychiatry and Behavioural Neurosciences, McMaster University. Dr. Links was the first holder of the Arthur Sommer Rotenberg Chair in Suicide Studies, University of Toronto. This Chair was the first in North America dedicated to suicide research. Dr. Muir served with the Office of the Chief Coroner as a Regional Supervising Coroner and with the Chief Coroner's Patient Safety Review Committee.

Suicide has emerged as a major public health issue in Canada leading to 3926 deaths in 2012, yielding a suicide rate of 11.3/100,000 (Statistics Canada). In 2014, 1,327 Ontarians died by suicide (Statistics Canada). Previous studies have reported that most people who die by suicide have a mental disorder at the time of death, most frequently mood disorders and/or substance-related disorders (Bertolote & Fleischmann, 2002; While et al., 2012). Longitudinal studies demonstrated nearly all individuals who died by suicide received health care in the year prior to death (83 %) (Ahmedani et al., 2014). These findings indicate that health and mental health services are well placed to improve efforts to prevent suicides.

Patients whose illness necessitates psychiatric hospitalization are at an increased risk of suicide (Pirkola et al., 2005). Studies show that suicides cluster in the period after discharge from a psychiatric inpatient service (Troister et al., 2008) and that 57 to 100% of psychiatric patients who die by suicide have been in [i]contact with inpatient psychiatric services within one year of their death (Yim et al., 2004). Therefore, Mental Health Services within hospitals can adopt quality improvement strategies to identify contributory systemic factors leading to suicide. These quality improvements in mental health care can lead to reductions in the rates of suicide in individuals in care (Kapur et al., 2016).

There is no database which allows a meaningful comparison between the deaths by suicide under review at SJHH and other similar programmes. The events were nonetheless sufficiently disconcerting to the organization and their healthcare providers that they requested and facilitated a critical examination of their practices.

The report was prepared after review of the relevant hospital policies and procedures, the health records, internal review documents and death investigation reports of the individuals. An on-site visit of the facility was conducted in addition to interviews with hospital and programme leadership, physicians and front line healthcare providers. A "Recommendations Summary" is attached.

It is to be noted that the reviewer's formed the clear impression that all those responsible for providing care to this very challenging population are, at every level, exceptionally engaged and deeply committed to providing the safest care possible. It is hoped that this report and its recommendations will be useful in helping them move toward a zero suicide objective (Pisani et al., 2016).

Recommendations Summary

1. System Improvement and Learning

SJHH should continue to take a system improvement approach by learning from every suicide incident and working with families to identify opportunities to improve care.

- Continue to take a quality improvement approach to devise, implement and disseminate system changes that provide the safest care possible to patients at risk of suicide (major action).

- Continue to develop greater consistency in the approach to Critical Incident Reviews of suicides (major action).

- The Critical Incident Reports should specify the patient's voluntary/involuntary status and observation level at the time of the critical event.

- Leadership should determine and then communicate whether any further steps can be taken to make the environment safer in the context of previous inpatient attempts and deaths by suicide.

2. Screening, Assessment and Formulating Risk

All patients should be screened for suicide risk at their first contact with SJH and at every subsequent contact.

- Adopt an approach to suicide risk screening, assessment and management that ensures that these actions are "always" events. For example, several suicide prevention groups, including the Suicide Prevention Resource Centre, the National Action Alliance for Suicide Prevention, and the Columbia Lighthouse Project, have recommended universal screening for all patients at every encounter.

- Patients with a mental health history should be screened for suicide risk in the Emergency Department (ED).

- Specific criteria should be developed regarding patients that need to have a psychiatric assessment after presenting to the Emergency Department as being at risk for suicide.

- The Psychiatric Emergency Service (PES) Risk Assessment tool should be revised.

- The PES Assessment is not saved with the rest of the record and this may explain our concerns about capturing the details of the management plan arising from the PES Assessment. The document includes a crisis plan; however, it could be made more

collaborative by indicating that copies are to be given to patient, family physician and family/significant others.

- Access to means is included in the PES assessment but should be built into inpatient assessments particularly prior to discharge.

- Processes should be adopted that require a re- assessment of suicide risk be completed and documented with each change in the patient's level of observation.

3. Clinical Services, Care Management and Safety Planning

SJHH should take the approach that most suicides are preventable, recognizing that suicide prevention requires a collaborative approach that involves patients, families and care teams.

- Complete a needs assessment survey regarding staff's educational needs to ensure that they feel confident and competent to deal with patients at risk for suicide (major action).

- Concurrent Disorders Program should develop and implement an algorithm for decision making and intervention for patients with a specific risk profile related to suicide e.g. the algorithm should include risk profiles, substance use, care pathways, family engagement, observation levels, an environmental evaluation and rapid responses related to emerging information (major action).

- Expand on collaborative approaches that include families and significant others in suicide prevention such as fostering collaborative safety planning, joint interventions to remove access to means and clear procedures to respond to a family's concerns about the patient's risk for suicide (major action).

- Staff should continue to focus on developing therapeutic alliances and support the patient in telling their story.

- Policies regarding passes – The program may consider creating a policy about allowing passes to patients on Forms 1, 3 and 4.

- Clinical Monitoring Policy: Within the policy, the section on documentation should specifically indicate that a new assessment of suicide risk should be documented with any change in the level of monitoring for patients considered at risk of suicide.

- Suicide Risk Assessment and Monitoring Policy: The Guiding Principles should include that most suicides are preventable; suicide prevention requires a collaborative approach involving patient, family etc. Although the document is quite complete, the policy should include doing safety planning with each patient at risk and documenting that removing access to means has been addressed.

- Contracting for safety is not an effective suicide prevention method and focusing primarily on the presence or absence of suicide ideation is not an adequate means to determine suicide risk. Both these approaches should not be used to replace a well-documented suicide risk assessment, management plan and pathway of care.

- Patients seen in ED because of the risk of suicide should have follow-up contact.

- Leadership action should be taken on search and seizure policies to prevent patients from having access to means.

4. Leadership

St. Joes should undertake a review of its leadership structure in the Mental Health and Addiction Program that positions the organization to be a regional leader in suicide prevention and Concurrent Disorders. Leadership should work to encourage increased engagement of psychiatric staff in the leadership of the Concurrent Disorders Program.

- Review the medical leadership structure of the "General Psychiatry and Addictions Services" and the Concurrent Disorders Inpatient Program (major action).

- The Medical Leadership structure should encourage more engagement of the psychiatric staff in the operations of the Concurrent Disorders Inpatient Service (major action).

- It is suggested that the organization and its healthcare professionals consider sharing relevant issues arising from this review with other psychiatric facilities and professionals in the province and the Ontario Hospital Association (as it relates to the Suicide Prevention Standards Task Force) with the specific goal of creating an appropriate means of collecting data to refine the most effective policies, procedures and practices in order to approach the zero suicide objective.

References

1. Statistics Canada - http://www.statcan.gc.ca/eng/help/bb/info/suicide

2. Bertolote, J. M., & Fleischmann, A. (2002). Suicide and psychiatric diagnosis: a worldwide perspective. *World Psychiatry, 1*(3), 181-185. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/16946849

3. While, D., Bickley, H., Roscoe, A., Windfuhr, K., Rahman, S., Shaw, J., . . . Kapur, N. (2012). Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross-sectional and before-and-after observational study. *Lancet, 379*(9820), 1005-1012. doi:10.1016/S0140-6736(11)61712-1

4. Ahmedani BK, Simon GE, Stewart C, Beck A, Waitzfelder BE, Rossom R, et al. Health care contacts in the year before suicide death. J Gen Intern Med. 2014;29(6):870-7. doi: 10.1007/s11606-014-2767-3. PubMed PMID: 24567199; PubMed Central PMCID: PMCPMC4026491.

5. Pirkola S, Sohlman B & Wahlbeck K. The characteristics of suicides within a week of discharge after psychiatric hospitalization: A nationwide register study. BioMed Central Psychiatry 2005;5(32).

6. Troister T, Links P & Cutcliffe JR. Review of predictors of suicide within 1 year of discharge from a psychiatric hospital. Current Psychiatry Reports 2008;10:60-5.

7. Yim PHW, Yip PSF, Li RHY, Dunn ELW, Yeung WS & Miao YK**.** Suicide after discharge from psychiatric inpatient care: A case-control study in Hong Kong. Australian and New Zealand Journal of Psychiatry 2004;38(1-2):65-72.

8. Kapur, N., Ibrahim, S., While, D., Baird, A., Rodway, C., Hunt, I. M., ... & Appleby, L. (2016).Mental health service changes, organizational factors, and patient suicide in England in 1997–2012: a before-and-after study. The Lancet Psychiatry, 3(6), 526-534.

9. Pisani AR, Murrie DC, Silverman MM. (2016) Reformulating suicide risk formulation: From prediction to prevention. Academic Psychiatry, 40:623-629.