

Strengthening Suicide Prevention in Ontario Hospitals

A Report from the OHA Task Force on Suicide Prevention
August 2017





"I never thought about suicide when I started nursing more than 20 years ago. It was not something anyone talked about in nursing school or even in my personal life. But not long after I started my first nursing position on an inpatient mental health unit, a colleague told me that a patient who was recently discharged had 'committed suicide.' I was in shock. Those words (which I consider to be inappropriate and stigmatizing) echoed in my mind as I remembered her and her family. And now she was gone. I found out later she returned to the emergency department 'in crisis' the day after discharge. She was sent home since she had a follow-up appointment scheduled for the next week. But that appointment did not come soon enough for her.

I attended a workshop a few years later where the speaker stated 25 per cent of individuals with serious mental illness would die by suicide. This information was provided to prepare clinicians for this inevitable outcome. To me, it felt like I was being told suicide was an acceptable prognosis. This startling statistic provided little hope that existing services or those providing those services could do much to change that outcome.

In other sectors of health care, there are campaigns to raise awareness and conquer a particular disease. It is time for a campaign to raise awareness about suicide prevention to save lives."

- JENNIFER BERGER RN, MSC
MEMBER OF OHA TASK FORCE ON SUICIDE PREVENTION



TABLE OF CONTENTS

Executive summary	4
Introduction: Suicide in Ontario	5
The task force	6
Considerations	8
Current hospital requirements and protocols	9
The challenge of stigma	11
Recommendation 1: Implement the zero suicide model in Ontario	12
Recommendation 2: Ensure that hospitals have the support needed to review and improve the physical environment	17
Recommendation 3: Improve data collection in Ontario	18
Conclusion	21
Appendix A: Summary of recommendations	22
Appendix B: The zero suicide model	23
Appendix C: Other strategies	25
Appendix D: News release	26
Appendix E: Critical incident review and disclosure requirements in Ontario	27
Appendix F: Definitions	28
References	29

EXECUTIVE SUMMARY

In 2015, the Ministry of Health and Long-Term Care asked the Ontario Hospital Association (OHA) to create a Task Force to recommend safe medical practices for patients at-risk of suicide. The OHA Task Force on Suicide Prevention (Task Force) met regularly throughout the 2015-16 year, examined current hospital policies and protocols for suicide prevention and assessment, and reviewed practices and emerging evidence from other jurisdictions.

After careful consideration, the Task Force has made three central recommendations for the Ontario government to consider in its approach to preventing suicide. While these recommendations may reduce the number of deaths by suicide among patients under hospital care, all components of the health care system need to be part of suicide prevention initiatives moving forward. Primary care, community care services and hospitals need to work collaboratively to improve transitions between care settings. While implementation considerations were not part of the scope of this Task Force, financial resources must also be allocated in order for these recommendations to be successfully implemented by all hospitals.

Key Recommendations

1. Implement the Zero Suicide Model, which is a comprehensive, leadership-driven approach within hospitals that includes a commitment to dramatically reducing suicide and to collaborating with all partners on care transitions.
2. Ensure that hospitals have the support needed to review and improve the physical environment; and
3. Improve data collection in Ontario to accurately determine the number of deaths by suicide (including those that occur in persons under hospital care).

INTRODUCTION: SUICIDE IN ONTARIO



GLOBALLY, more than **800,000** people die from suicide each year



Within CANADA, **3,926** people died by suicide in 2012



In ONTARIO, **1,327** people died by suicide in 2014



HIGHEST rate of suicide ages **50-54**



MALES **3x** more likely to die by suicide than females



2ND LEADING CAUSE of death for persons aged **15-34**



INDIVIDUALS with **mental illnesses**, including depression, schizophrenia and bipolar disorder, are also at risk.

SPECIFIC GROUPS of people have **↑ elevated** rates of suicide



Suicide is a preventable and premature form of death that is a significant public health challenge. Globally, more than 800,000 people die from suicide each year (World Health Organization). Within Canada, 3,926 people died by suicide in 2012, and in Ontario, 1,327 people died by suicide in 2014 (Statistics Canada).

Although suicide deaths affect almost all age groups, those aged 50 to 54 have the highest rates, and it is the second-leading cause of death for persons aged 15 to 34 (Statistics Canada). Males are three times more likely to die by suicide than females (Statistics Canada), and specific groups of people have elevated rates of suicide, including First Nations, Inuit and Métis peoples living in northern Canada, newcomers, inmates in correctional facilities, lesbian, gay, bisexual, trans and queer (LGBTQ) individuals with substance-abuse disorders, young people, and the elderly (Canadian Mental Health Association). Individuals with mental illnesses, including depression, schizophrenia and bipolar disorder, are also at risk. Despite efforts to reduce the risk of suicide, the suicide rate has not varied in Ontario over the last 15 years.

While clear data exists on the prevalence of suicide within each province, and within sub-sections of the population, it is difficult to determine how many suicide deaths occur by patients under hospital care. As this report will later outline, there are a number of challenges related to the way suicide data is collected and reported in Ontario. These challenges include a delay in accessing mortality data, underreporting of deaths, and misclassification of deaths. As a result of these limitations, it is difficult to determine the number of deaths by suicide in Ontario hospitals – a challenge that must be addressed before determining the efficacy of the enclosed recommended prevention strategies.

THE TASK FORCE

Suicide is always a tragic issue, but it is particularly upsetting for families and hospital staff when a patient or client dies by suicide while under hospital care. In many cases, hospitals are the destination of last resort for patients contemplating suicide. Safety is a top priority for hospitals, and its staff is committed to providing the highest level of quality care. In early 2015, following the death of a patient at an Ontario hospital in the Greater Toronto Area, the Ministry asked the OHA if more could be done to prevent suicide. Shortly after, a Task Force was created to develop recommendations for preventing the number of deaths by suicide by patients and clients under hospital care (see Appendix D). In determining the membership of the Task Force, it was critically important that people with lived experience were involved.

“Ten years later, I feel my knowledge of suicide awareness and education has been an asset to those at risk and is comforting to those left behind. Providing support to others over the past eight years has helped me heal through my grief and loss. I cannot forget how my son needed help and got nothing because I was not suicide-aware. I have to live with that. I do that by educating myself and every person I come in contact with about risk. Do not misunderstand how critical suicide prevention is. It is a difference between life and death.”

– PENNY KNAPP
MEMBER OF OHA TASK FORCE ON SUICIDE PREVENTION

The OHA Task Force on Suicide Prevention:

- Dr. Ian Dawe, Program Chief and Medical Director, Mental Health Service, Trillium Health Partners (Task Force Chair)
- Dr. Jennifer Brasch, Associate Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University
- Jennifer Berger, Program Consultant – Rehabilitation and Mental Health Program, Canadian Institute for Health Information
- Beth Hamer, Clinical Educator, Waypoint Centre for Mental Health Care
- Dr. Simon Hatcher, Vice Chair Research, Department of Psychiatry, The University of Ottawa and The Royal Ottawa Health Care Group
- Mark Henick, National Director, Strategic Initiatives Canadian Mental Health Association
- Paivi Kattilakoski, Accreditation Specialist, Accreditation Canada
- Penny Knapp, Founder of Survivor of Suicide Loss - Canada and Globally
- Dr. David Kocerginski, Chief of Psychiatry, Medical Director, Mental Health and Addictions, William Osler Health System
- Dr. Paul Links, Chair/Chief, Department of Psychiatry, St. Joseph’s Health Care, London and London Health Sciences Centre
- Dr. Mary Ann Mountain, Director of Community Mental Health, St. Joseph’s Care Group, Thunder Bay
- Ann Pottinger, Director, Quality, Patient Safety and Risk, Centre for Addiction and Mental Health (CAMH)

In developing the recommendations, the Task Force engaged Health Quality Ontario, the Ministry of Health and Long-Term Care, the Ministry of Children and Youth Services, the Mental Health Commission of Canada, the Ontario Coroner's Office, and the Public Health Agency of Canada to ensure that recommendations aligned with other suicide prevention initiatives that are already underway.

After careful consideration, the Task Force has made three central recommendations for the Ontario government to consider in its approach to preventing suicide. Each central recommendation includes several sub-recommendations within (for a list of all recommendations, please see Appendix A).



Key Recommendations

- 1 | Implement the Zero Suicide Initiative**, which is a comprehensive, leadership-driven approach within hospitals that includes a commitment to dramatically reducing suicide and to collaborating with all partners on care transitions.
- 2 | Support hospitals improve the safety of the physical environment; and**
- 3 | Improve data collection in Ontario to accurately determine the number of deaths by suicide (including those that occur in persons under hospital care).**

CONSIDERATIONS

While these recommendations are intended to reduce the number of deaths by suicide among patients under hospital care, all components of the health care system need to be part of suicide prevention initiatives moving forward. Primary care, community care services and hospitals need to work collaboratively to improve transitions between care settings. While implementation considerations were not part of the scope of this Task Force, financial resources must also be allocated in order for these recommendations to be successfully implemented by all hospitals.

Transitions between hospitals and the community must be seamless and connected in order for hospitals to be effective partners in suicide prevention. Suicide prevention efforts do not end when patients are discharged from inpatient units or emergency rooms.



Thus, the preventative strategies recommended in this report are targeted at all patients “under hospital care,” including up to 30 days post-discharge. For the Task Force’s definition of “under hospital care,” please see the definitions section of this report.

The Task Force recognizes that there are a number of populations in Ontario that are at elevated risk for suicide. Additional work is needed to explore effective suicide prevention strategies for these populations. For example, a distinct focus is needed to address needs of Indigenous populations, LGBTQ people, racialized populations, francophone populations and youth. Rather than focus on a specific sub-section of the population, the recommendations in this report are intended to prevent suicide among all patients and clients under hospital care.

The Task Force also acknowledged the importance of language in working to prevent suicide in Ontario. The term, “committed suicide” is still often used to describe a death by suicide. However, this Task Group (as well as many others in this field) agreed that this language is not accurate or appropriate as it implies an element of criminality and may perpetuate stigma. Altering the way we talk about suicide shows respect for those affected by suicide and creates a safe place for them to have conversations that may be helpful. Therefore, the Task Force will be using phrases such as “death by suicide,” “died by suicide” or “suicide death” throughout this report. It is suggested that this language be adopted universally, especially by all care providers, moving forward.

Finally, the recommendations in this report are not applicable to cases of medical assistance in dying. The Task Force recognizes the potential contradictions between initiatives to prevent suicide and protocols to support medical assistance in dying in Ontario. However, medical assistance in dying is not within the scope of the work by the Task Force.

CURRENT HOSPITAL REQUIREMENTS AND PROTOCOLS

“Preventing death by suicide is a core function of hospital mental health programs. Every day, dedicated professionals strive to engage with individuals on a journey of symptomatic and functional recovery with a goal of saving lives. The devastation of a life lost by suicide is heartbreaking for family, friends and community. It is only through a rigorous provincial focus on quality improvement and the sharing of best practice that we will continue to lessen stigma, learn from each other and achieve the aspirational goal of eliminating preventable death. For these reasons, I have been proud to be a part of the OHA Task Force on Suicide Prevention.”

- DR. DAVID KOCZERGINSKI
MEMBER OF OHA TASK FORCE ON SUICIDE PREVENTION

In 2011, the OHA and the Canadian Patient Safety Institute (CPSI) developed the Suicide Risk Assessment Guide ([Guide](#)) as a first step in standardizing the process of suicide risk assessment for health care professionals. In 2015, the Canadian Patient Safety Institute (CPSI) and Health Quality Ontario released a list of 15 “never events” for Canadian Hospitals. Never events are patient safety incidents that result in serious patient harm or death, and that can be prevented by using organizational checks and balances (Canadian Patient Safety Institute). Patient suicide, or attempted suicide that resulted in serious harm, is considered a “never event” in instances where suicide prevention protocols, including observation, were to be used.

In 2011, Accreditation Canada developed a Required Organizational Practice (ROP) for suicide prevention. Several steps are required for hospitals to ensure compliance: clients at-risk must be identified; risk must be assessed at regular intervals or as needs change; the immediate safety needs must be addressed; treatment and monitoring strategies must be identified; and implementation of the treatment and monitoring strategies must be documented in the client record. To ensure these standards remain effective, the Health Standards Organization (created in February 2017 under single leadership with Accreditation Canada) Mental Health and Addictions Technical Committee, will be reviewing the current literature and revising the standards accordingly. Alignment with recommendations being made by the Task Force will also be brought to the Technical Committee for consideration.

Hospitals with adult in-patient mental health beds also have their own mandated assessment systems. The Resident Assessment Instrument – Mental Health (RAI-MH)© assesses key domains of mental and physical health, social service use, and identifies individuals for further evaluation. Applications, including Clinical Assessment Protocols (CAPs) and Outcomes Scales, are embedded within the assessment and available at the point of care to support care planning and ongoing monitoring of clinical and functional status, including risk for self-harm. The Suicidality and Purposeful Self Harm CAP outlines clinical considerations for individuals at moderate to high risk of suicide or self-harm. The RAI Outcome Scale, Severity of Self-harm (SOS), provides a baseline measure of clinical status that can be used to monitor and evaluate interventions aimed at managing and reducing risk.

Non-mandated quality standards for patients with major depressive disorder and/or schizophrenia have also recently been developed by Health Quality Ontario (HQQ) to better identify suicidal ideation in clients.

HQQ recommends that people with major depression, who are at considerable risk to themselves or others or who show psychotic symptoms, receive immediate access to suicide risk assessment and preventive intervention, whether at a health care professional’s office or in an emergency department. The schizophrenia quality standard is intended to monitor suicide risk in relation to outcomes; however it does not include a suicide risk assessment.

Finally, there are legislative and regulatory requirements for all hospitals that ensure comprehensive systems are in place for reporting, disclosing, reviewing and taking action to reduce the risk of recurrence of patient safety incidents and “critical incidents”. As per Regulation 965 of the *Public Hospital Act*, Ontario hospitals are required to review and disclose “critical incidents” when they occur. Under this regulation, deaths by suicide as well as attempted death by suicide may be classified as critical incidents. While many hospitals already review every incident even if the criteria for a mandatory review are not met, on July 1, 2017, the regulation will be amended to require analysis of the incident and the development of a plan to avoid or reduce the risk of similar incidents from occurring (for more information, please see Appendix E).

THE CHALLENGE OF STIGMA

While risk assessment is an important tool for suicide prevention in hospitals, research shows that assessment tools are not always effective for preventing deaths (Sakinofsky, 2014). Appleby et al (1999) reviewed 10,000 cases of people who died by suicide and found that more than 90 per cent of these individuals were thought to have been at no or low risk of dying by suicide.

One of the biggest barriers to recognizing patients that are at risk of suicide is stigma (Patient Safety Institute). Stigma not only impacts ability to access care, but also the quality of care that patients receive. Stigma may be manifested by health care providers as an unwillingness to discuss suicide, by dismissing suicidal behaviour as an attention-seeking gesture, or by the language that is used.

As such, risk-assessment cannot be solely relied upon to predict outcome. Outcome scales should also not be used to determine allocation of resources. Assessment of client need (not risk) is equally important.

To reduce stigma, public health agencies must continue to provide ongoing education and awareness. Recognizing events, such as World Suicide Prevention Day, is one way that hospitals can enhance education and help reduce stigma within their organization.

People expect the emergency department to help someone in crisis with active suicidal thoughts. But most emergency rooms are ill-equipped to support someone who is actively suicidal. They are busy, chaotic places, often with no quiet or calming spaces. ER staff are often uncomfortable assessing patients with suicidal thoughts as they have little training in suicide risk assessment and de-escalation. If hospitals are going to be more effective at preventing suicide, changes need to start in the emergency room, with a safe place for distressed patients, and staff trained and confident in assessing and helping patients with suicidal thoughts. We need to reduce the stigma about suicide, so that staff will value having the skills to help suicidal patients.

- DR. JENNIFER BRASCH
MEMBER OF OHA TASK FORCE ON SUICIDE PREVENTION

RECOMMENDATION 1: IMPLEMENT THE ZERO SUICIDE MODEL IN ONTARIO

According to the World Health Organization's 2014 inaugural report on suicide prevention, there are three general approaches to addressing suicide risk factors: universal prevention strategies, selective prevention strategies, and indicated strategies (World Health Organization).

Universal strategies are designed to reach the entire population (e.g., a provincial or national strategy towards suicide prevention), whereas both selective and indicated prevention strategies target vulnerable populations (e.g., abused persons). Selective strategies focus on training gatekeepers to assist with the vulnerable population, whereas indicated strategies focus on providing community support, such as educating health care professionals and providing follow-up for those leaving health-care facilities.

Universal strategies are both in development (e.g., the Government of Canada's federal framework) or have been implemented (e.g., Mental Health Commission of Canada's "Changing Directions, Changing Lives") across Canada to address suicide prevention. Furthermore, a multi-pronged strategy (i.e., one that is comprised of universal, selective, and indicated strategies) has been implemented in Quebec.

In 1999, the province of Quebec's Ministère de la Santé et des Services Sociaux implemented 'Help for Life' – a multi-pronged suicide prevention strategy that included establishing a provincial hotline, suicide prevention centres

in every region, better mental health treatment, follow-up for people who attempt suicide, barriers on bridges and railway trestles, as well as improved training for staff at youth protection agencies and improved coordination and collaboration between service providers. Before implementing the strategy, in the late 90s, the suicide rate in Quebec was one of the highest in the industrialized world at 25.5 deaths by suicide per 100,000. By 2009, the rate had fallen to 14.6 per 100,000. It is estimated that Quebec's strategy has saved nearly 3,000 lives, especially young lives.

As part of the multi-pronged effort to address suicide prevention in Ontario, Ontario's hospitals require an indicated strategy to target the risk factors of suicidal behaviour.

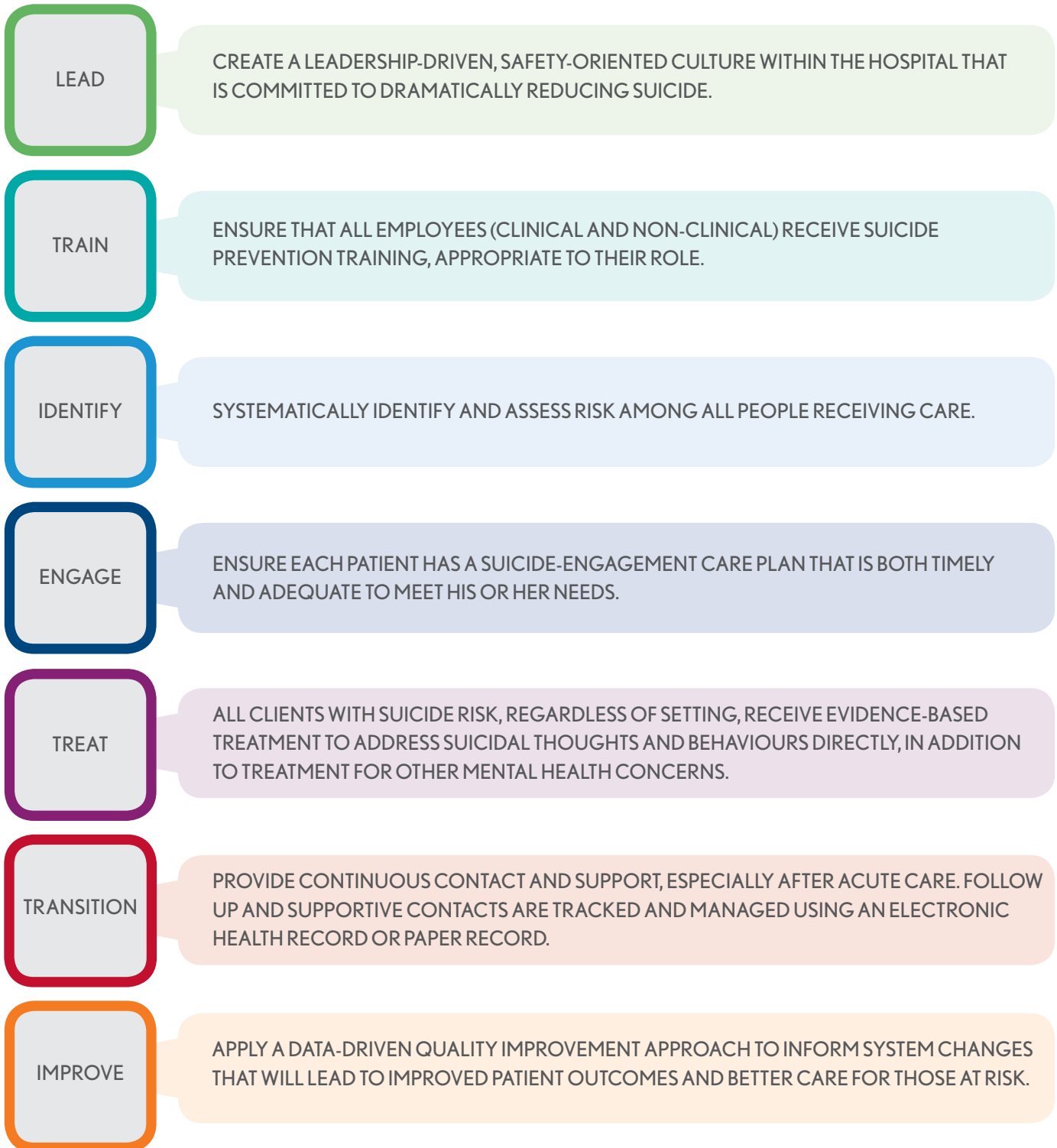
A prevalent indicated strategy throughout the health care literature is the Perfect Depression Care initiative (now known as the Zero Suicide Model). It was created within the Henry Ford Health System in Detroit, Michigan (Coffey, 2007 and Institute of Medicine).

While the Task Force examined other strategies (see Appendix C), in reviewing the merits of each model, the Task Force determined that the Zero Suicide Model would be most appropriate for hospitals in Ontario.

The Zero Suicide Model includes a suite of comprehensive clinical tools and strategies for improving suicide prevention, which are available online. More specifically, the zero suicide initiative incorporates seven elements in

its approach (see Appendix B). The model has been well-developed and includes a comprehensive guide and suite of tools for hospitals to get started by creating a work plan and setting priorities.

The seven steps for hospitals to follow in implementing the Zero Suicide Model include:



While each of the seven elements are critical to success, the Task Force recommends that hospitals determine which elements can be implemented immediately and which ones can be implemented later. For example, hospitals may choose to focus on better discharge planning or improving the transition of at-risk patients to the community as they may be less resource-intensive than training all staff. Moving forward, the Task Force suggests that the Ministry convene a second Task Force to assist with implementation and resource-allocation.

The goal of “zero suicide” is aspirational. Its core proposition is that suicide deaths are preventable, and it is based on the realization that many individuals fall through the multiple cracks in a fragmented health system. While some have argued that the goal of “zero” is unrealistic, Thomas Priselac, President and CEO of Cedars-Sinai Medical Center said: “it is critically important to design for zero – even when it may not be theoretically possible.”

The Zero Suicide Model originated as a suicide prevention protocol for both inpatient and outpatient service delivery (Coffey, 2007). The initiative was based on the aims and rules highlighted in the Institute of Medicine’s (IOM’s) landmark 2001 report on delivering quality care in health systems (Coffey, 2007). Theoretically based on Donabedian’s classic Structure-Process-Outcome Framework, this report highlights six aims for health systems to deliver quality care: Safety, Effectiveness, Patient-Centeredness, Timeliness, Efficiency, and Equity (Institute of Medicine). Following the publication of this IOM 2001 report, the Robert Wood Johnson Foundation held a competition for funding health system initiatives with a goal of “pursuing perfect care,” as per the framework outlined by the IOM. The Perfect Depression Care Initiative (now Zero Suicide Model) was fortunate enough to be one of 12 funded initiatives (Coffey). Its vision and strategic goals were developed by a steering committee consisting of senior hospital executives, clinicians and managers, and when possible front line service providers. In order to meet the concept of “perfect care,” the performance goal tied to IOM’s “effectiveness” aim and implemented by the steering

committee was “zero defects”, including zero suicides. Although the notion of zero suicide as the operationalized definition of effectiveness of care was heavily debated within the steering committee, it was ultimately chosen as a performance goal since nobody could answer the question “if not zero, how many?” (Institute of Medicine and Pursuing Perfect Depression Care).

The outcomes achieved through implementing the Zero Suicide Model have been very promising to date.

Coffey (2007) describes the results of this initiative with a time-series analysis of suicide incidence per 100,000 persons in the Henry Ford Health System. From baseline in the year 2000 to follow-up interval of 2002-2005, the rate of suicides decreased from 89 per 100,000 persons to 22 per 100,000 persons. Despite these promising preliminary numbers, the limitations of time-series analysis (appropriately acknowledged by Coffey (2007)) suggest that these results should be interpreted with caution. Nevertheless, the Perfect Depression Care Initiative was awarded the 2006 American Psychiatry Association’s Gold Achievement Award for its use of the IOM framework to create and implement a mental health quality improvement initiative, as well as for its decreased suicide rate and increased patient satisfaction rate (as measured by a patient survey).

In 2013, Coffey provided an update on the results of the initiative with a letter to the editor in the journal of *Psychiatric Services* (Coffey, 2013). Coffey explains the validation of clinical suicide data with the most recent Michigan State mortality records. This validation resulted in a suicide rate of 97 per 100,000 for the baseline years prior to the Perfect Depression Care initiative (1999-2000), and a rate of 19 per 100,000 for the follow-up years during the initiative (2002-2009). These results suggest that clinical suicide data can be a valid measure, and that the Perfect Depression Care initiative appears to decrease suicides. More recently in 2015, Coffey and colleagues published a research letter in the *Journal of the American Medical Association (JAMA) Psychiatry* with the purpose of characterizing suicide within the entirety of the Henry Ford

Health System, including participants and non-participants in the Perfect Depression Care initiative (Coffey, 2015). He concluded that the demography of the Henry Ford Health System was representative of Southeast Michigan, and that those who participated in the initiative had decreased suicide rate compared to those who did not.

Due to these preliminary analyses as well as the novelty of the Perfect Depression Care initiative, widespread dissemination of this model has occurred in recent years. The United States 2012 National Strategy for Suicide Prevention included the initiative as a key concept; it was promoted as a priority of the National Action Alliance for Suicide Prevention; became a project of the Suicide Prevention Resource Center; and is supported by the Substance Abuse and Mental Health Services Administration. It has been implemented in hospitals across the United States and is currently being piloted by St. Joseph's Health Care in London, Ontario for ambulatory care. The pilot project is being funded by the hospital foundation at St. Joseph's. Once an evaluation based on process outcomes is done, the goal is for the model to be implemented within the inpatient units.

The quantitative measures of success discussed above have been published primarily as letters to the editor and commentaries (i.e., not peer-reviewed literature) by the leadership team at Henry Ford Health System, which has drawn some criticism, as highlighted by Dr. James Coyne in his October 2016 PLOS Blog post (Coyne, 2016).

Despite this critique, the Task Force recommends the implementation of this initiative in Ontario hospitals for the following reasons:

1. The model is grounded by the IOM framework for delivery of quality care, which is considered theoretically sound and has widespread use across health systems worldwide (Institute of Medicine).
2. The lack of comprehensive evaluation of the Perfect Depression Care Initiative (now known as the Zero Suicide Model) is not uncommon in the world of quality improvement. Rigorous evaluation of programs,

Suicide is a rare event, but suicidal ideation and thoughts of suicide are common. Zero Suicide initiatives don't just prevent suicide—they improve care for all patients with thoughts of suicide, so that they get better and their thoughts do not intensify to the stage where they make a suicide attempt.

- DR. JENNIFER BRASCH
MEMBER OF OHA TASK FORCE ON SUICIDE PREVENTION

such as realist evaluation, requires extensive investment in both time and human resources (e.g., this type of evaluation typically requires an evaluation specialist to properly lead). Furthermore, this lack of rigorous evaluation has not stopped the National Institute of Mental Health in the United States invest in a grant competition (from August 2016 to August 2019) focused on projects that will improve the integration of IT systems into health systems with the Perfect Depression Care Initiative (The Department of Health and Human Services Part 1).

3. Although a comprehensive evaluation of the model is lacking, most components of the model (five out of seven) are based on peer-reviewed literature, as summarized by Hogan and Grumet (2016) (please see Appendix B for model components). Briefly, the lead component is based on Chassin and Loeb's 2011 and 2013 work, which is focused on bringing the concept of high reliability from other sectors into health care, and that leadership must take an approach of zero harm. The need to train health care professionals (i.e., the 'train' component of the initiative) about suicide prevention is discussed throughout the literature, including Schmitz et al. (2012) study on how to improve suicide training, and the WHO's landmark suicide report discussed above. A lack of screening (i.e., the 'identify' component of the initiative) in health care systems for suicidal risk factors has been linked to poor outcomes, and current evidence suggests the use of standardized tools to identify suicidal risk factors

is more accurate than solely using clinical judgement (Posner, et al. 2011). Current evidence also suggests that the receipt of evidence-based treatment for suicide directly (i.e., the ‘treat’ component of the initiative) should occur, as opposed to focusing only on any underlying mental health conditions (Brown, et al. 2005). As reviewed by Luxton et al. (2013), in some studies, provision of support during care transition (e.g., discharge from inpatient setting to home) via in-person visits or telephone calls have resulted in decreased suicidal behavior.



RECOMMENDATION

1. Implement the Zero Suicide Initiative which is a comprehensive, leadership-driven approach within hospitals that includes a commitment to dramatically reducing suicide and to collaborating with all partners on care transitions.

RECOMMENDATION 2: ENSURE THAT HOSPITALS HAVE THE SUPPORT NEEDED TO REVIEW AND IMPROVE THE PHYSICAL ENVIRONMENT

One of the most important steps that hospitals can take to prevent suicide is to ensure that the physical environment is safe for patients, while balancing the need to protect patient dignity.

The ideal design for an inpatient setting is one that allows patients to be under direct supervision or observation at all times together with the absence of physical hazards (Sakinofksy, 2014).

The purpose of observation is to keep patients safe and to reduce the risk of harm to themselves or other people (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2015). However, evidence is mixed on whether observation alone is an effective method for suicide prevention. A study from the United Kingdom acknowledged that deaths may occur when staff is distracted, during busy periods, when there are staff shortages, and when ward design impedes observation (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2015). As such, the Task Force felt strongly that hospitals conduct regular audits of the physical environment to identify and remove potential safety risks. For example, approximately three-quarters of patients who die by suicide on psychiatric wards do so by hanging/strangulation (Hunt, et al, 2012). Therefore, as a starting point, any ligature points should be removed.

Physical plant standards already exist to guide Canadian health care facilities in the development of a safe care environment for patients at risk of suicide (Canadian Standards Association, Standards for Canadian Health Care Facilities). As per the CSA Z8000 standards, mental health safety and risk-mitigation guidelines exist that should be applied to all aspects of the design of mental health and addiction services, both inpatient and outpatient as well as other areas where mental health patients receive care and treatment. The Ministry of Health and Long-Term Care incorporates these standards and other best practice design standards into the review of new mental health spaces in hospital and other community based care environments.

The Task Force determined that it is unclear whether all organizations are fully aware of these guidelines and the need to adhere to them in all areas of all hospitals, beyond mental health units.

Other jurisdictions have developed checklists and/or auditing tools to ensure a systematic and standardized approach to reviewing the physical environment of mental health units, emergency departments and mental health outpatient clinics. The Task Force reviewed many of these tools – including checklists created by Veteran Affairs in the United States, the National Patient Safety Agency in the United Kingdom, and the Saskatchewan Ministry of Health. The Task Force recommends that the Ontario government develop a checklist for hospitals, based on these existing tools. Each hospital will need to undertake a detailed assessment of the physical environment to create a report of potential deficiencies and to establish a plan for improvement. Again, resources will need to be identified that will allow hospitals to perform regular, detail assessments or audits of potential deficiencies.

RECOMMENDATIONS



1. The Ontario government should develop or adopt an existing checklist to assist hospitals in reviewing the physical environment to reduce the risk of suicide.
2. Every hospital needs to undertake a detailed assessment of the physical environment to create a report of potential deficiencies and a plan for improvement.
3. Hospitals need to complete the checklist developed on a routine basis.

RECOMMENDATION 3: IMPROVE DATA COLLECTION IN ONTARIO

It is very difficult to accurately determine how many patients die by suicide in Ontario hospitals due to the delay in accessing mortality data, underreporting of suicides, and misclassification of deaths. Accurate data on suicide attempts is also lacking because of a lack of standardization in reporting of suicide attempts. As a result of these limitations, it is difficult to quantify the number of deaths by suicide in Ontario hospitals – and to determine the efficacy of prevention strategies.

The major data sources for monitoring deaths by suicide and self-inflicted injuries includes Vital Statistics – Death Database, Canadian Coroner and Medical Examiner Database (CCMED), mental health records - Ontario Mental Health Reporting System (OMHRS), and self-inflicted injuries for ED data, and surveys (e.g., The Canadian Community Health Survey, which includes questions about suicide ideation and attempts).

Within a hospital, there are multiple reporting and assessment systems that are used to capture data about suicide deaths and attempts:

1. The Distract Abstract Database (DAD), which is used when a patient is in a medical bed;
2. The Ontario Mental Health Reporting System records, which uses data from the Resident Assessment Instrument-Mental Health (RAI-MH©); and
3. The National Ambulatory Care Reporting System (NACRS), which is used for patients in the ED.

The International Statistical Classification of Disease and Health Related Problems, 10th Revision (ICD-10-CA) is used by both DAD and NACRS to capture patient information related diseases, disorders, injuries and health related conditions. When a patient dies the death certificate includes information from both data sources to capture the medical cause of death (such as respiratory arrest or poisoning), and the external cause of injury which provides the mechanism and the intent (e.g., intentional self-inflicted poisoning). Death certificates are completed by an attending medical doctor, coroner or other certifier.

Recording a death as a suicide is a slightly different process if the patient is in a mental health bed. All deaths occurring in a psychiatric facility designated under the Mental Health Act are reported to the coroner (*Coroners Act*, 1990). Many coroners do not classify a death as a suicide unless they have absolute certainty or a high degree of probability that the death was by suicide. Deaths reported to Vital Statistics include information on the direct, antecedent and underlying cause of death, other significant conditions and manner of death (natural, accidental (or unintentional injuries), suicide, homicide, or events of undetermined intent. Coroners and medical examiners are required to investigate sudden and unexpected deaths, as stated in the *Coroner's Act*, 1990.

Although the RAI-MH© captures deaths due to suicide, it is not consistently coded as such because of the coroner's involvement. There is often a delay before the coroner confirms that a death is due to suicide, and it is rare for the hospital to update their records (and the RAI-MH) with the most accurate cause of death. As such, it is likely that deaths by suicide are underreported in OMHRS.

Additionally, when a patient dies post-discharge (within 30 days), there is no formal process for notifying the physician or the treating facility, which may remain unaware of the death, adding further inaccuracies to the data.

Therefore, Ontario must first work to mitigate the challenge in collecting and reporting data to determine whether the Zero Suicide approach is effective in reducing the number of deaths by suicide in Ontario hospitals. The Task Force has chosen not to include any statistics about the number of deaths by suicide in Ontario hospitals in this report due to the reporting challenges outlined here.

There is also an existing challenge in reporting the number of Canadians who attempt suicide. Currently, this number is calculated by measuring: the number of patients who present to ED for treatment, patients who are admitted to hospital for self-inflicted injury (which is a proxy for suicide attempts), as well as those who are captured through public health survey data – but each has its own set of limitations (recall bias, minimum age, and frequency of data collection). Stigma may also be a factor impacting what is reported. The RAI-MH© collects clinical and functional information, including recent self-injurious attempts and other details surrounding the attempt as well as any concern for the person expressed by others (family, friend, caregiver, and staff), but is only administered to patients who receive a mental health assessment in a hospital setting

While the RAI-MH© has a Severity of Self-Harm scale and Suicidality and Purposeful Self-Harm Clinical Assessment Protocol to identify high-risk issues, provide a measure of symptom severity, and to facilitate care planning, the use of these tools vary across the province related to organizations choosing whether or not to implement and optimize these aspects of the RAI-MH© assessment.

An additional challenge identified by the Task Force is the timeliness in which data on deaths by suicide is released. Both Statistics Canada mortality data and the Coroner’s data are not timely. While the Coroner’s data is more up-

to-date, it is difficult to assess current trends and respond in a timely fashion. To help address the timeliness of the data, the Task Force recommends the Coroner release data about confirmed suicides and probable suicides (still under investigation).

It is further recommended that one centralized body keep track of the data about deaths due to suicide, such as the Coroner’s Office, which already has the most up-to-date and accurate statistics related to the number of suicides in Ontario hospitals. The Coroner and Medical Examiners from across Canada should collaborate to establish standards and guidelines for investigating and classifying deaths due to suicide, giving consideration to identifying deaths as “definite” or “probable” suicide.

Improving the quality, accuracy and timely distribution of data is fundamental to driving continuous quality improvement efforts and reducing suicides.



Research has found that internally-collected mortality data is sufficient for driving quality improvement in the prevention of suicide. Hospitals should be focused on tracking their own data on deaths by suicide so that providers understand the prevalence of suicide within their own patient populations. For example, St. Joseph’s is working to gather data from every source available to them and is looking to validate this data with the Coroner’s Office through a research request.

Research suggests that an effective overall strategy for suicide prevention is to use internal real-time surveillance data for rapid cycles of learning while also using government-collected data (once available) to confirm or enhance learning (Ahmedani, Coffey and Coffey, 2013). This approach can help determine the efficacy of suicide prevention initiatives – and motivate employees to continue their efforts. Suicide prevention efforts can and should be guided by multiple sources of data – including real-time, internally-collected results (Ahmedani, Coffey and Coffey, 2013).

Finally, the Task Force recommends that the province establish a Suicide and Mental Health Death Review Committee. This would be structured similarly to the Paediatric Death Review Committee and would investigate and review all suicides and all deaths of patients under mental health care in Ontario.

Similar to other Death Review Committees, it would evaluate patient suicides that occur within 12 months of hospital contact, make recommendations to help prevent deaths in similar circumstances, and identify systemic issues that contribute to suicides and deaths of persons receiving mental health care.



RECOMMENDATIONS

1. Improve central data collection in Ontario to accurately determine the number of deaths by suicide that occurs in Ontario.
2. Address the timeliness of the data by having the Coroner release data about deaths confirmed as suicides and probable suicides (still under investigation).
3. Appoint one centralized body, such as the Coroner, to keep track of all data about deaths by suicide in Ontario.
4. The Coroner and Medical Examiners from across Canada should establish standards and guidelines for investigating and classifying deaths that are definite and probably attributed to suicide.
5. Improve hospital-level data collection in Ontario to enable hospitals to track their own data, monitor for trends and make adjustments to suicide prevention initiatives, as needed.
6. Implement a Provincial Suicide and Mental Health Death Review Committee to help prevent deaths due to suicide and to identify systemic issues that contribute to deaths by suicide and other causes of death by persons in mental health care.



CONCLUSION

To effectively reduce the number of deaths by suicide in Ontario hospitals, the Task Force recommends implementing the Zero Suicide model, reviewing and improving the physical environment, and altering the way that data related to suicide deaths is collected and shared in Ontario. Adoption of the recommendations would require a long-term, multi-year commitment to immediate action and additional resources.

The Task Force recognizes that the implementation of the three recommendations will be a major undertaking and is potentially controversial. However, the citizens of Ontario want their hospitals to be leaders in suicide prevention. It's time to take action and save lives.



APPENDIX A: SUMMARY OF RECOMMENDATIONS

1. Implement the Zero Suicide Model

- A. Lead: Create a leadership-driven, safety-oriented culture within the hospital that is committed to dramatically reducing suicide
- B. Train: Ensure that all employees (clinical and non-clinical) receive suicide prevention training, appropriate to their role.
- C. Identify: Systematically identify and assess risk among all people receiving care.
- D. Engage: Ensure each patient has a suicide-engagement care plan that is both timely and adequate to meet his or her needs.
- E. Treat: All clients with suicide risk, regardless of setting, receive evidence-based treatment to address suicidal thoughts and behaviours directly, in addition to treatment for other mental health concerns.
- F. Transition: Provide continuous contact and support, especially after acute care. Follow up and supportive contacts are tracked and managed using an electronic health record or paper record.
- G. Improve: Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

2. Ensure that hospitals have the support needed to review and improve the physical environment

- A. The Ontario government should develop or adopt an existing checklist to assist hospitals in reviewing the physical environment to reduce the risk of suicide
- B. Every hospital needs to undertake a detailed assessment of the physical environment to create a report of potential deficiencies and a plan for improvement.
- C. Hospitals need to complete the checklist developed by the Ontario government for mental health units on a routine basis.

3. Improve data collection in Ontario

- A. Improve central data collection in Ontario to accurately determine the number of deaths by suicide that occurs in Ontario.
- B. Address the timeliness of the data by having the Coroner release data about deaths confirmed as suicides and probable suicides (still under investigation).
- C. Appoint one centralized body, such as the Coroner, to keep track of all data about deaths by suicide in Ontario.
- D. The Coroner and Medical Examiners from across Canada should establish standards and guidelines for investigating and classifying deaths that are definite and probably attributed to suicide.
- E. Improve hospital-level data collection in Ontario to enable hospitals to track their own data, monitor for trends and make adjustments to suicide prevention initiatives, as needed.
- F. Implement a Provincial Suicide and Mental Health Death Review Committee to help prevent deaths due to suicide and to identify systemic issues that contribute to deaths by suicide and other causes of death by persons in mental health care.

APPENDIX B: THE ZERO SUICIDE MODEL

The following has been taken from the Zero Suicide Initiative, which is a priority of the National Action Alliance for Suicide Prevention and a project of the Suicide Prevention Resource Center (SPRC) in the United States.

LEAD

Leading involves making an explicit commitment to reducing suicide deaths by mobilizing staff to believe that suicide can be prevented: “Leadership must both convince staff to see and believe that suicide can be prevented, and provide tangible supports in a safe and blame-free environment”. Under this approach, the organization would develop a policy specific to suicide care. The policy emphasizes the importance of the core components of safer suicide care (which are outlined in the other six elements of this approach), and the organization’s policy specifies a program for preventing compassion fatigue among all staff who interact with patients at risk of suicide.

TRAIN

Training involves developing a competent, confident, caring workforce. Everyone must understand that safe care and suicide prevention begins when the patient walks through the door. All staff members must have the necessary skills to provide excellent care. The Zero Suicide approach ensures that employees are assessed for the beliefs, training and skills needed, and ensures that all employees (clinical and non-clinical) receive suicide prevention training, appropriate to their role. Staff training must be repeated at least every three years, and training must contain the following elements: the fundamentals of the zero suicide philosophy, policies and protocols relevant to the staff member’s role, best practice training on suicide identification for all staff, additional training to all clinical staff to ensure a basic level of skills in assessing, and engaging and treating patients so that they feel validated and a sense of hope and caring.

IDENTIFY

Under this approach, all persons who receive care are screened, and when a patient screens positive for suicide risk, a full risk assessment is completed. Policies and procedures clearly describe screening patients for suicide risk, including the frequency of screening, documenting risk screenings, screening and identification workflows, and how staff will be alerted. A standardized screening measure is used by all staff. Staff receives formal training on suicide screening and documentation. A written policy and procedure specifies that patients are provided timely access to clinically trained staff after screening (Barker and Barker, 2005). Findings of the risk assessment will help inform the goals of the Suicide Engagement Plan of Care that will guide the person’s journey to recovery.

ENGAGE

Each patient who has been identified as being at risk of suicide must be engaged in a Suicide Engagement Plan of Care (plan). The plan must support the person’s recovery process and should outline many elements, including requirements and protocols for safety planning, crisis support planning, the frequency of visits for a patient and action to be taken when the patient misses appointments; the process for communicating with a patient about diagnosis and treatment expectations; requirements for continued contact, especially during transitions in care; the referral process, documentation of progress and symptom reduction; and criteria and protocols for closing out a patient’s plan. Experience has shown that using an electronic health record is a key factor in consistently engaging patients in their plan.

TREAT

Clinicians have historically focused on treating mental health problems, such as depression and anxiety, with the assumption that a patient's suicidal thoughts and behaviours will cease once the depression or anxiety disorder is resolved. However, this model strongly encourages targeting and treating suicidal ideation and behaviours directly, independent of diagnosis. Under this approach, all clients with suicide risk, regardless of setting, receive evidence-based treatment to address suicidal thoughts and behaviours directly, in addition to treatment for other mental health concerns. Providing evidence-based interventions specific to suicide involves training staff in one or more suicide-specific interventions; creating standard patient education materials about expectations for specific treatments; and creating a process for charting patient progress with suicide specific treatment. The Zero Suicide Toolkit lists a number of specific interventions. Under this model, it is recommended to also provide care in the least restrictive setting. This may require working with community agencies and other partners to provide options for treatments.

TRANSITION

In a Zero Suicide approach, organizational policies provide guidance for successful care transitions and specify the contacts and supports needed throughout the process to manage any care transition. Follow-up and supportive contacts are tracked and managed using an electronic health record or paper record. Internal written policies and procedures must be developed: when the patient is referred to a provider or service both within or outside of the hospital; when the patient transitions to another organization or provider in the community; when the patient terminates services, either independently or in agreement with the care provider; when the patient repeatedly misses appointments; following a patient's contact with crisis services; or at discharge from an emergency department or a psychiatric hospital.

IMPROVE

Administrators must create a plan to assess the organization's commitment to the Zero Suicide Model, determining how closely the elements are being followed and helping identify opportunities for improvement.

APPENDIX C: OTHER STRATEGIES

England's National Suicide Prevention Strategy

The National Suicide Prevention Strategy, developed by England's Department of Health focuses on applying effective intervention to groups that are known to be at higher risk of suicide and ensuring that the resources needed are available. Policies, such as recommending follow-up within seven days and more rigorous discharge planning, have allowed for reductions in hospital admission for self-harm in the post-discharge period. Reducing access to means for at-risk inpatients has also helped reduce the number of deaths by suicide. Finally, it was shown that psychosocial assessments of people who have suicidal thoughts or who have self-harmed are helpful in preventing further suicidal behaviour.

The Nuremberg Alliance Against Depression

The Nuremberg Alliance Against Depression is a four-level community-based action plan developed to prevent depression and suicidality, conducted in the city of Nuremberg, Germany in 2001/2002. It initially included four key strategies: 1) improving the detection and management of depression in primary care; 2) an information and awareness campaign on depression for the broad public; 3) educational training for community leaders such as teachers, priests or pharmacists; and 4) improving care for high-risk populations. A fifth strategy of reducing access to the means of suicide was added more recently. After two years, the four-pronged strategy coincided with a reduction in suicidal behaviour by 24 per cent. Based on the positive results, 18 international partners, representing 16 different European countries, established the European Alliance Against Depression in 2004.

APPENDIX D: NEWS RELEASE

New Mental Health Initiatives to Provide Better Patient Care

May 6, 2015 9:30 A.M.

New suicide prevention standards for hospitals are being created to help improve care for Ontarians dealing with a mental illness crisis.

The province has asked the Ontario Hospital Association (OHA) to develop the new standards for hospitals across Ontario. A new OHA task force chaired by Dr. Ian Dawe, a leading expert on mental health, will focus on establishing safe medical practices for at-risk patients by looking at best practices and working with patients and those with lived-experience.

Ontario is also providing more education for health care providers to treat patients with mental illness. The Centre for Addiction and Mental Health (CAMH) and the University of Toronto are launching an ECHO (Extension for Community Healthcare Outcomes) mental health project that will use videoconferencing sessions to develop mental health expertise among health care providers. The project will foster a virtual community of practice that will be especially beneficial for northern, rural, Aboriginal and other underserved communities.

Improving services and care for people with mental health and addiction challenges is part of the government's plan to build a better Ontario through its Patients First: Action Plan for Health Care, which is providing patients with faster access to the right care, better home and community care, the information they need to stay healthy and a health care system that's sustainable for generations to come.

Quick Facts

- The OHA task force will examine current hospital policies and protocols for suicide prevention and assessment, and establish standards by 2016.
- Ontario is investing \$1.5 million over three years to support the ECHO mental health education program, which will begin in September 2015.
- Approximately 30 per cent of Ontarians will experience a mental health and/or substance abuse challenge at some point in their lifetime, with one out of 40 Ontarians experiencing a serious mental illness.
- This year, Mental Health Week runs from May 4 -10.

Additional Resources

- Find help for people experiencing mental health problems.
- Patients First: Action Plan for Health Care.
- The next phase of Ontario's comprehensive mental health and addictions strategy.
- Open Minds, Healthy Minds: Ontario's comprehensive mental health and addictions strategy.

APPENDIX E: CRITICAL INCIDENT REVIEW AND DISCLOSURE REQUIREMENTS IN ONTARIO

Ontario legislation and regulation, along with accrediting standards outline requirements for hospitals to have comprehensive systems in place for reporting, disclosing, reviewing, and taking action to reduce the risk of recurrence of patient safety incidents, and specifically “critical incidents”. The term critical incident is defined in the *Public Hospitals Act* (PHA) Regulation 965 to mean:

- any unintended event that occurs when a patient receives treatment in the hospital;

AND

- that results in death, or serious disability, injury or harm to the patient;

AND

- does not result primarily from the patient’s underlying medical condition or from a known risk inherent in providing the treatment.

Since 2008, the PHA Regulation 965 regulation has required mandatory disclosure of critical incidents to the patient; or if the patient was incapable, to their substitute decision-maker (SDM); or if the patient dies, to their estate of the:

- Material facts of what occurred with respect to the critical incident;
- Consequences for the patient of the critical incident; and
- Actions taken and recommended to be taken to address the consequences to the patient of the critical incident, including any health care or treatment that is advisable; and
- The systemic steps, if any, that a health facility is taking or has taken in order to avoid or reduce the risk of further similar incidents.

In July 2010, PHA Regulation 965 was expanded to include disclosure to the MAC and hospital administrator; and that the board ensure that following disclosure of a critical incident, a system was in place to analyze the critical

incident and develop system-wide plans to avoid or reduce the risk of recurrence, as well as outline further disclosure requirements to the patient. On January 1, 2011 further changes were made to PHA Regulation 965 to ensure that the administrator reports aggregate critical incident data to the board quality committee, established under ECFAA at least twice a year.

Effective **July 1, 2017** the PHA Regulation 965 will be amended to require additional items. A summary of all expectations are that the board shall ensure that the administrator establishes a system for ensuring that:

- A committee appointed by the hospital reviews every critical incident, as soon as is practicable after the critical incident occurs
- As part of each critical incident review, a person acting on behalf of the hospital must offer to interview the patient or their authorized representative
- A person designated by the hospital who has responsibility in the area of patient relations or someone providing patient perspectives to the hospital must participate in each review
- In addition to the patient or their authorized representative, disclosure to the MAC and administrator occurs as soon as is practicable after the critical incident occurs of:
 - Material facts of what occurred with respect to the critical incident;
 - The cause(s) of the critical incident, if known
 - Consequences for the patient of the critical incident; and
 - Actions taken and recommended to be taken to address the consequences to the patient of the critical incident, including any health care or treatment that is advisable.

Additionally, the amendments will enable reporting to an external body for the purposes of analyses and disseminating information to support quality improvement.

APPENDIX F: DEFINITIONS

Distract Abstract Database (DAD): Originally developed in 1963, the Discharge Abstract Database (DAD) captures administrative, clinical and demographic information on hospital discharges (including deaths, sign-outs and transfers) (District Abstract Database Metadata, CIHI).

Clinical Assessment Protocols (CAPs): Clinical Assessment Protocols, generally referred to as CAPs, are designed to assist the assessor to interpret systematically all the information recorded on an instrument. CAPs are not intended to automate care planning; rather, they help the clinician focus on key issues identified during the assessment process, so that decisions as to whether and how to intervene can be explored with the individual (Clinical Assessment Protocols, Interrai).

“Under Hospital Care”: Defined by the Task Force as all patients that are currently receiving hospital or who have been discharged in the last 30 days. This would include inpatients, outpatients and patients seen in the emergency departments.

Critical Incidents: The Public Hospitals Act Regulation 965 defines a critical incident as any unintended event that occurs when a patient receives treatment in the hospital and that results in death or serious disability, injury, or harm to the patient, and does not result from the patient’s underlying medical condition or from a known risk inherent in providing treatment.

Resident Assessment Instrument – Mental Health (RAI-MH): The interRAI Mental Health (MH) Assessment System is a comprehensive standardized instrument for evaluating the needs, strengths and preferences of adults with mental illness in in-patient psychiatric settings (Mental Health for Inpatient Psychiatry, Interrai)

Vital Statistics – Death Database: An administrative survey that collects demographic and medical (cause of death) information annually from all provincial and territorial vital statistics registries on all deaths in Canada (Vital Statistics, Statistics Canada).

Ontario Mental Health Reporting System (OMHRS): Ontario Mental Health Reporting System uses data from the Resident Assessment Instrument-Mental Health (RAI-MH©), which is a comprehensive assessment system mandated for inpatient mental health beds in Ontario. The OMHRS analyzes and reports on information submitted to CIHI about all individuals receiving adult mental health services in Ontario, as well as some individuals receiving services in youth inpatient beds and selected facilities in other provinces. OMHRS includes information about mental and physical health, social supports and service use, as well as care planning, outcome measurement, quality improvement and case-mix funding applications (Ontario Mental Health Reporting System, Resource Manual).

International Statistical Classification of Disease and Health Related Problems, 10th Revision ICD-10 – CA: An international standard for reporting clinical diagnoses developed by the World Health Organization. ICD-10-CA is an enhanced version of ICD-10 developed by CIHI for morbidity classification in Canada (ICD-10-CA, CIHI).

NACRS: The National Ambulatory Care Reporting System (NACRS) contains data for all hospital-based and community-based ambulatory care. This includes day surgery, outpatient and community-based clinics and emergency departments (NACRS Metadata, CIHI).

Stigma: Stigma refers to negative attitudes (prejudice) and negative behaviour (discrimination) toward people with substance use and mental health problems (Stigma, CAMH).

Suicide: According to the World Health Organization, suicide is the act of deliberately killing oneself, and risk factors may include mental illness or physical illness, like neurological disorders, cancer or HIV infection (Suicide, World Health Organization).

Self-injury: Self-injury is also called self-harm and self-abuse and refers to deliberate acts that cause harm to one’s body, mind and spirit (Canadian Standards Association, Standards for Canadian Health Care Facilities, CSA Z8000 standards).

REFERENCES

- “About Zero Suicide,” Suicide Prevention Resource Center, accessed September 26, 2016, <http://zerosuicide.sprc.org/about>.
- Ahmedani, B.K., Coffey, J. and Coffey, C.E., Collecting Mortality Data to Drive Real-Time Improvement in Suicide Prevention. *Am J Manage Care*, 2013; 19(11): e386-390.
- Appleby L., Shaw J., Amos T., et al. Suicide within 12 months of contact with mental health services: national clinic survey. *Br Med J*. 1993; 318 (7193): 1235-1239.
- Caring For Adult Patients with Suicide Risk, A Consensus Guide for Emergency Departments, Suicide Prevention Resource Centre, 2015
- Canadian Coroner and Medical Examiner Database: Annual Report. Statistics Canada, Public Health Agency of Canada.
- Chassin MR, Loeb JM. 2011. The ongoing quality improvement journey: next stop, high reliability. *Health Affairs* 30 (4): 559-568.
- Chassin MR, Loeb JM. 2013. High-reliability health care: getting there from here. *The Milbank Quarterly* 91 (3): 459-490.
- Clinical Assessment Protocols, Interrai, accessed January 23, 2017, <http://www.interrai.org/protocols.html>.
- Coffey C.E. Behavioral Health Services, Henry Ford Health System. *Jt Comm J Qual Patient Saf*. 2007; 33:193-199.
- Coffey 2007. Building a System of Perfect Depression Care in Behavioral Health. Joint Commission on Accreditation of Healthcare Organizations.
- Coffey MJ. 2013. An Update on Perfect Depression Care. Letter to the Editor. *Psychiatric Services* 64(4): 396.
- Coffey MJ, Coffey CE, Ahmedani BK. 2015. Suicide in a Health Maintenance Organization Population. *JAMA Psychiatry*. 72(3):294-296.
- Coyne, J. 2016. An open-minded, skeptical look at the success of “zero suicides”: Any evidence beyond the rhetoric?. *PloS Blog*. Accessed March 7th 2017 at: <http://blogs.plos.org/mindthebrain/2016/10/28/an-open-minded-skeptical-look-at-the-success-of-zero-suicides-any-evidence-beyond-the-rhetoric/>
- “CSA Z8000 Canadian Health Care Facilities - Planning, Design and Construction,” CSA Group (2015), accessed January 23, 2017, <http://shop.csa.ca/en/canada/landing-pages/canadian-health-care-facilities/page/z8000>
- “Depression Care Program Eliminates Suicide,” Henry Ford Health System, accessed September 26, 2016, <http://www.henryford.com/body.cfm?id=46335&action=detail&ref=1104>.
- “District Abstract Database (DAD) Metadata,” CIHI, accessed January 23, 2017, <https://www.cihi.ca/en/types-of-care/hospital-care/acute-care/dad-metadata>.
- EGgerston L. and Patrick K. Canada Needs a National Suicide Prevention Strategy. *Canadian Medical Association Journal*, accessed September 6, 2016, <http://www.cmaj.ca/content/early/2016/09/06/cmaj.160935.full.pdf>
- Emanuel LL, Taylor L, Hain A, Combes JR, Hatlie MJ, Karsh B, Lau DT, Shalowitz J, Shaw T, Walton M, eds. *The Patient Safety Education Program – Canada (PSEP – Canada) Curriculum*. PSEP-Canada, 2013
- Facility Checklists & Access to Means Auditing, Outcome Measures and Quality Assurance for Saskatchewan Health Care Providers, Framework for the Assessment and Management of People at Risk of Suicide, Appendix C, Saskatchewan Ministry of Health, March 2012, accessed January 16, 2017, <http://eenet.ca/wp-content/uploads/2013/08/SK-Suicide-Appendix-C-Audit-Tools.pdf>

Hegerl U., Schafer R. From the Nuremberg Alliance Against Depression to a European Network – Extending Community-Based Awareness Campaigns on a National and European Level. *Psychiatr Prax.* 2007; 34 Suppl 3: S261-5.

Hirdes, J, Curtin-Telegdi, N, Mathias, K, Perlman, C, Saarela, T, Kobeinsson, H, Valdimarsdottir, R, Morris, J, Fries, B, Rabinowitz, T, Martin, L, Barbaree, H, Brown, G, Stewart, S, Smith, T, Jones, R., Baas, R (2011). *interRAI Mental Health Clinical Assessment Protocols (CAPs). For Use with Community and Hospital-Based Assessment Instruments. Version 9.1.* Rockport, Massachusetts, interRAI publications.

Hunt IM, Windfuhr K, Shaw J, Appleby L, Kapur N; Ligature points and ligature types used by psychiatric inpatients who die by hanging: a national study. *National Confidential Inquiry into Suicide and Homicide. Crisis.* 2012 Jan 1;33(2):87-94.

Hogan MF, Grumet JG. 2016. Suicide prevention: an emerging priority for health care. *Health Affairs* 35(6):1084-1090.

“How we dramatically reduced suicide,” Case Study by M. Justin Coffee, MD & C. Edward Coffee MD, *New England Journal of Medicine*, accessed September 26, 2016, <http://catalyst.nejm.org/dramatically-reduced-suicide>.

“ICD-10-CA,” CIHI, accessed January 23, 2017, <https://www.cihi.ca/en/data-and-standards/standards/classification-and-coding/icd-10-ca>

Institute of Medicine. 2001. *Crossing the Quality Chasm: A new health system for the 21st century.* Washington, D.C.: National Academy Press.

Jacobs, D., Brewer, M., & Klein-Benheim, M. (1999). Suicide assessment: An overview and recommended protocol. In D. Jacobs (Ed.), *Harvard Medical School guide to suicide assessment and intervention* (pp. 3-39). San Francisco: Jossey-Bass.

Luxton D., June, J. and Comtois, K. Can postdischarge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, Vol 34(1), 2013, 32-41.

Mental Health Environment of Care Checklist, VA National Center for Patient Safety, U.S. Department of Veteran Affairs, December 2016, accessed January 16, 2017, <http://www.patientsafety.va.gov/professionals/onthejob/mentalhealth.asp>

“Mental Health for Inpatient Psychiatry,” Interrai, accessed January 23, 2017. <http://www.interrai.org/mental-health.html>

“National Ambulatory Care Reporting System (NACRS) Metadata,” accessed January 23, 2017, <https://www.cihi.ca/en/types-of-care/hospital-care/emergency-and-ambulatory-care/nacrs-metadata>

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). *In-patient Suicide Under Observation.* Manchester: University of Manchester 2015.

Neufeld, E., Hirdes, J. P., & Rabinowitz, T. (2011). Suicidality and Purposeful Self-harm Clinical Assessment Protocol. In Hirdes, Curtin-Telegdi, Mathias, Perlman, et. al. *interRAI Mental Health Clinical Assessment Protocols (CAPS) to be used with Community and Hospital Based Mental Health Assessment Instruments. Version 9.1 Canadian Edition.* Washington D.C.: interRAI.

Ontario Mental Health Reporting System, Resource Manual, 2016-2017. Published by CIHI.

Patient Safety Institute, “Never Events for Hospital Care in Canada,” *Safer Care for Patients*, September 2015.

Perlman CM, Neufeld E, Martin L, Goy M, & Hirdes JP. *Suicide Risk Assessment Inventory: A Resource Guide for Canadian Health care Organizations.* (Toronto, ON: Ontario Hospital Association and Canadian Patient Safety Institute, 2011).

“Preventing Suicide in England: A Cross-Government Outcomes Strategy to Save Lives,” Department of Health, England, accessed September 26, 2016, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

“Preventing suicide in England: One year on First annual report on the cross-government outcomes strategy to save lives,” Department of Health, England, accessed September 26, 2016,

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278119/Annual_Report_FINAL_revised.pdf

Preventing Suicide: A Global Imperative. World Health Organization (2014), accessed January 11, 2016, http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

Pursuing Perfect Depression Care. *Psychiatric Services* 57(10): 1524-1526.

Rudd, MD. (2008). Suicide warning signs in clinical practice. *Current Psychiatry Reports*, 10, 87-90.

Sakinofsky I. Preventing Suicide Among Inpatients. *Can J Psychiatry*. 2014; 59 (3): 131-140.

Schmitz WM, Allen MH, Feldman BN, Gutin NJ, Jahn DR, Kleespies PM, Quinnett P, Simpson S. 2012. Preventing suicide through improved training in suicide risk assessment and care: an American association of suicidology task for report addressing serious gaps in U.S. mental health training. *Suicide and Life-Threatening Behavior* 42(3):292-304.

“Stigma,” Centre for Addiction and Mental Health (CAMH), accessed January 23, 2017, https://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/stigma/Pages/stigma_brochure.aspx

Smetanin et al (2011). The life and economic impact of major mental illnesses in Canada: 2011-2041. Prepared for the Mental Health Commission of Canada. Toronto: RiskAnalytica.

“Suicide May Be Substantially Underreported in Ontario,” *Toronto Star*, accessed September 26, 2016, https://www.thestar.com/news/gta/2011/12/02/suicide_may_be_substantially_underreported_in_ontario.html

“Suicide,” Statistics Canada, accessed September 26, 2016, <http://www.statcan.gc.ca/eng/help/bb/info/suicide>

“Suicide,” World Health Organization, accessed September 26, 2016, www.who.int/topics/suicide/en/

“Suicide Statistics,” Canadian Mental Health Association, accessed September 26, 2016: http://toronto.cmha.ca/mental_health/suicide-statistics/#.V811nM53DN4

The Department of Health and Human Services Part 1. Overview Information. Accessed March 7th 2017 at: <https://grants.nih.gov/grants/guide/pa-files/PAR-16-185.html>.

“The Oxford Monitoring System for Attempted Suicide.” University of Oxford, Centre for Suicide Research, accessed September 26, 2016, <http://cebmh.warne.ox.ac.uk/csr/monitoring.html>

“Vital Statistics – Death Database,” Statistics Canada, accessed January 23, 2017 <https://www12.statcan.gc.ca/census-recensement/2006/consultation/92-135/surveys-enquetes/deathdb-bddeceng-eng.cfm>

World Health Organization. Preventing Suicide: A Global Imperative. 2014. Accessed March 8, 2017 at: http://www.who.int/mental_health/suicide-prevention/attempts_surveillance_systems/en/

“Zero Suicide,” St. Joseph’s Health Care Foundation, accessed September 26, 2016, <https://www.sjhcfoundation.org/zero-suicide>

“Zero Suicide Toolkit” Suicide Prevention Resource Center, accessed September 26, 2016, <http://zerosuicide.sprc.org/toolkit>

200 Front Street West, Suite 2800
Toronto, Ontario M5V 3L1
www.oha.com

