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Completed suicides in psychiatric patients: identifying health care-related factors through clinical practice reviews

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Abstract

Objective

To identify health care-related factors associated with death by suicide in psychiatric patients and to gain insight into clinician views on how to deal with suicidality.

Method

The study material derived from a clinician committee in a psychiatric department reviewing every outpatient and inpatient suicide in a standardized way. Reports' conclusions and corresponding plenary discussion minutes regarding 94 suicides were analysed using inductive thematic content analysis.

Results

Health care-related factors were categorized into four themes: patient evaluation, patient management, clinician training, and involvement of relevant non-clinical partners. Clinician views on the themes were expressed through statements (i) promoting or restricting an aspect of care (here called recommendations), which mainly followed existing guidelines and were consensual and (ii) without precise indication (here called comments), which departed from mainstream opinions or addressed topics not covered by existing policy.

Conclusions

Involvement of non-clinical partners emerged as a new key issue for suicide prevention in psychiatric departments and should be openly discussed with patients. Clinicians preferred balanced conclusions when they reviewed suicide cases.

1. Introduction

Suicide is a major public health issue with an estimated annual number of 800,000 suicide deaths worldwide (WHO). Suicide prevention relies on interventions towards the individuals, the population and/or the health care system (WHO; Zalsman et al., 2016), and studying completed suicides is one way to target such interventions. Numerous psychological autopsy studies have been conducted in the general population to identify individual risk factors for suicide (Arsenault-Lapierre, Kim, & Turecki, 2004), but less is known regarding contributing factors related to health care. National data on patient suicides can help identify such factors. Two well-developed systems are the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in the UK (Swinson et al., 2007), based on questionnaires to the responding physician, and the Joint Commission in the US (Commission, 2016), based on voluntary and nonsystematic report of sentinel events. Also of interest are three studies on US veterans, using root cause analysis (RCA1) (Resources & Staff, 2005). One explored contributing factors associated with 96 suicides in a general hospital and revealed the following major themes: management of known suicide risk; decision-making to monitor suicide risk; and patient engagement in treatment (Riblet, Shiner, Mills, et al., 2017). Another study reviewed suicides within 7 days after discharge from a psychiatric unit and identified problems in the processes of care and in communication as potential contributing factors to suicide (Riblet, Shiner, Watts, et al., 2017). Finally, a study

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[1] Root Cause Analysis consists of case review by multidisciplinary teams, interviewing of the staff, determining underlying systematic (root) causes, and recommendations for future improvement.

specifically examined the method of suicide in inpatients mental health units and showed hanging as the most frequent (Mills, King, Watts, & Hemphill, 2013). The literature, however, does not specifically address the suicides of all-comers psychiatric patients (i.e. in- or outpatients with any type of diagnosis followed by mental health professionals), who are by far more at risk than the general population (Walsh, Sara, Ryan, & Large, 2015). To our knowledge, only one study reported on this population (Burgess, Pirkis, Morton, & Croke, 2000): An analysis of 629 psychiatric patients' suicides was conducted in Australia by three clinicians, who identified key factors associated with suicide preventability including staff-patient relationships, assessment and treatment of depression and psychological problems, and continuity of care (Burgess et al., 2000). The present study was based on a qualitative analysis of reports of the Departmental Committee of Clinical Practice Review (DCCPR) of the Psychiatric Department of Lausanne University Hospital (Switzerland). This committee reviews and discusses every suicide among inpatients and outpatients of the department, identifies potential problems in their clinical management with a "RCA philosophy". To put it differently, the goal of the DCCPR is to identify root causes possibly contributing to adverse events and to formulate recommendations for future, further, improvement. This study's first aim was to identify health care-related factors associated with death by suicide in psychiatric patients, and ultimately potential targets for prevention. The second aim was to gain insight into clinician views on these factors, and on how to deal with suicidality; a field which is constantly evolving. Clinical assessment focusing on individual risk factors has for long been a cornerstone of suicide prevention and still has supporters (Wortzel, Nazem, Bahraini, & Matarazzo, 2017), but a growing body of evidence challenges the clinical relevance of actuarial approaches (Carter et al., 2017; Chan et al., 2016; Matthew Michael Large,

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Ryan, Carter, & Kapur, 2017; Quinlivan et al., 2017) and warns against potential pernicious effects (e.g., more coercive treatment for "high-risk" patients and false reassurance for "low-risk" patients) (Mulder, Newton-Howes, & Coid, 2016; Sashidharan & Saraceno, 2017).

2. Methods

The study design was a qualitative approach of reports and related material from a clinical practice review committee using inductive thematic content analysis.

Departmental Committee of Clinical Practice Review (DCCPR)

Created in 1998, the DCCPR originally aimed to examine situations of physical restraints. Its mission then evolved to review every critical incident involving patients from the Department (i.e., inpatients during their hospitalization or within 2 months after discharge, and outpatients followed in general or specialized consultations with their last consultation within 2 months): suicide and other deaths, major agitation and prolonged restraint (excluding suicide attempts) (Kaision & Gasser, 2016). Its primary goal is to identify potentially problematic factors related to the health care system and to provide both a general (e.g., a yearly newsletter summarizing some illustrative situations in an anonymous format) and a specific (e.g., meeting with clinicians involved in a situation) feedback. The DCCPR is part of the local suicide mental health policy (Kaision & Gasser, 2016), developed about ten years ago and including a two-day training for the assessment and management of suicidal patients (Séguin & Terra, 2004), a psychological distress helpline for the general public, and targeted interventions for suicide attempters (Brovelli et al., 2017). The 25 members of the committee meet ten times a year; their professional backgrounds are psychiatry (12 physicians and 12 nurses) and pharmacology (one member). All services of the department are represented (general psychiatry, consultation-liaison psychiatry, community

psychiatry, forensic psychiatry, child and adolescent psychiatry, geriatric psychiatry). All suicides (and other critical incidents) in the Department are reported by the teams to the DCCPR's president, who appoints two members (usually a physician and a nurse, excluding clinician directly involved in the case) to review the medical chart and draft a 2-4 page report. This report includes the following sections: context of the incident, past personal and psychiatric history, clinical observations, diagnosis, suicidal risk factors, suicidal risk assessment, medication, postvention, and conclusions (i.e., reviewers' synthesis, overall evaluation of the situation, and suggestions to the committee). The section content is not further formalized. Reports are individually discussed in a plenary session with all members present; it may happen that a suicide situation involves a clinician from the committee, who supervised the situation. The duration of the discussions is between 30 and 45 minutes and a summary is recorded in the minutes. The rules of the DCCPR state that one or two of the reviewers provide feedback to the concerned staff in presence of the DCCPR member of their service; feedback is provided in approximately half of the situations because of practicability (change of staff, geographic distance, and agendas) and reluctance among all protagonists (fear of confrontation with colleagues and of blame/being blamed).

Study material

The material consisted of (i) 131 incident reports and (ii) the minutes of the plenary discussion of these incidents, concerning a period between January 2007 and December 2015; the nine-section template was not in use before that period. The first author ([LM] a senior staff member and head of the psychiatric emergency of Lausanne University Hospital) and AMG (a medical student without psychiatric training) screened the material for incidents of suicide. Incomplete reports

and deaths unlikely related to suicide were excluded; the probability of suicide was based on reported death circumstances, independently evaluated by the two authors, who reached consensus in case of disagreement.

Of the 131 examined incident reports and corresponding minutes, 37 were excluded; three were too incomplete to allow an analysis, 12 addressed non-lethal incidents (major agitation, prolonged restraint), and 22 deaths were considered not to be due to suicide, most of them being drug overdoses with an uncertain suicidal intent. The final material then consisted of 94 suicide situations. Table 1 summarises the socio-demographic, diagnostic and clinical information of the deceased patients.

Data analysis

The analysis focused on report conclusions and corresponding minutes. The data material was analysed by means of a thematic content analysis (Green & Thorogood, 2018; Harper & Thompson, 2011). This method shows themes that are important in the description of the explored phenomenon. A theme is defined as a specific pattern of meaning found in the data (Harper & Thompson, 2011). Two authors, LM and AMG, moved across the data to develop a coding scheme (coding frame). The degree of concordance between them when applying the codes being high (around 75% of same codes), the coding scheme was considered reliable. They separately categorized the data but constantly compared and discussed their coding. A third author, YD (a psychiatric nurse), participated with LM and AMG to the classification of common themes, examining their interconnections and prevalence. In addition to examining the content of the data, specific attention was paid to their form (second study aim).

The analysis process, different professional background of team members examining the data set, and thorough discussions between them and the other authors (two social scientists [CB and DM] and a liaison psychiatrist [FS]) contributed to limit the influence of preconceived ideas that researchers may bring to the research. Thus, our approach was inductive, meaning that the findings are grounded in the data.

The study was approved by the cantonal ethic committee on human research of Vaud, Switzerland (Approval number: 414/2015).

3. Results

With respect to the first aim of the study, health care-related factors identified through thematic content analysis can be categorized into four themes: (1) **patient evaluation**, (2) **patient management,** (3) **clinician training**, and (4) **involvement of relevant non-clinical partners**. Furthermore, regarding the second aim, which was to explore how clinicians viewed these factors, the analysis showed that they used two types of statements: (i) statements promoting or restricting an aspect of care in order to address identified factors associated with death by suicide (e.g., "Patients should always be searched for dangerous objects before admission in a psychiatric ward"), which we called **recommendations,** and (ii) specific or general statements without precise indication and just mentioning potentially problematic areas (e.g., "The time before the first appointment following discharge was quite long"), which we called **comments** (see Table 2). Two analytic themes – **patient evaluation** and **patient management** – were "generic", meaning the committee produced both recommendations and comments related to them, while the two other themes were "specific", meaning the committee produced only recommendations – **clinician training** – or only comments – **involvement of relevant non-clinical partners** – on

these themes. Accordingly, it was decided to report on recommendations and comments together for the generic themes and separately for the specific ones. Table 2 shows the distribution and frequency of *recommendations* and *comments* according to the themes.

Patient evaluation

Many recommendations and a few comments underlined the importance of *suicidal risk assessment*. The DCCPR formulated several recommendations on this topic: e.g., to formalise assessments by using the *R-E-D* concept (epidemiological *Risk*, degree of *Emergency* and *Danger* (access to lethal methods)) as advocated by the local two-day training relies, or to explore more in-depth suicidal ideas and monitor them more regularly. Related comments questioned the way suicidal risk assessment should be conducted.

> *Unplanned suicidal ideas should not be considered as precluding suicidal risk; they*
> *are very challenging because the clinician may suspect that the patient has a plan he*
> *does not share, and it raises the question of if and how to discuss that.*

The relevance of formalised risk assessments to guide clinical decisions and the long delays for participating in the training were also addressed. For patients who died by suicide and who previously denied any intent, the issue of "false negative" answers, possibly related to a weak working alliance, was raised.

> *Working alliance is especially important to evaluate because its absence hampers*
> *any proper suicidal risk assessment.*

Finally, the DCCPR recommended *evaluating patient-specific dimensions*, such as the patient's resources, the cognitive capacities, and the absence of personal projects and positive outlook for the future.

Patient management

Patient management included a variety of therapeutic actions and interventions such as consultations, drug prescriptions, surveillance, decisions concerning an in/outpatient treatment, and written notes. The DCCPR identified numerous omissions in the *reporting of information* and repeatedly recommended improvement in the readability and structure of medical records, especially regarding drug prescriptions and care setting (e.g., open or closed doors on psychiatric wards). The related comments underlined the relevance of the patient's history and of a psychological understanding of the situation.

> *There is no consideration of the personal and family life of the patient. The absence of a documented hypothesis on a patient's crisis precludes the understanding of the reasons to complete suicide.*

Recommendations for *transmissions* focused on fostering the coordination between teams before and after discharge, and comments addressing *transitions* stressed, for example, the risk of referral during holidays (see below) or delays for outpatient post-discharge consultation.

> *An important point is to know how the referral to another outpatient clinic in the middle of summer holidays was decided, as it may have contributed to loneliness and abandonment feelings in the patient.*

Security was another key theme: the DCCPR recommended respecting existing procedures on the detection of dangerous items, such as checking personal belongings and body searches.

Clinical decisions and procedures were a frequent theme identified in the comments. The content of the comments, however, was sometimes contradictory. For example, the DCCPR stressed the risk of undermining the therapeutic alliance and of worsening, through coercion, an existing

experience of failure when admitting a patient on a non-voluntary basis to the hospital, but the committee, at the same time, valued the protective function of the hospital.

> *This patient could have been admitted against his will in order to protect him, but the risk of suicide associated with coercion has to be considered.*

> *The most important question is whether this patient* [deceased after an outpatient consultation] *should have been admitted despite his refusal*

A similar debate existed in the Committee on locked intensive care rooms, which were considered to influence suicides both during and after discharge from intensive care rooms and to have deleterious effects.

> *The patient viewed the intensive care rooms as a punishment; we question its utilisation.*

Finally, the DCCPR also commented on *medication*, most often regarding the potential effect of selective serotonin recapture inhibitors (SSRI) on suicide (e.g., SSRI introduction or dose increased preceding suicide).

Clinician training

The DCCPR repeatedly recommended that all clinicians participate in the abovementioned two-day training on suicidal patient evaluation and management to increase their knowledge and to enhance the quality of *Risk-Emergency-Danger* formalised risk assessment.

> *Residents must be strongly encouraged to participate in the suicide risk assessment training.*

Involvement of relevant non-clinical partners

The involvement of non-clinical partners, be they the patient's significant others, the police, the justice system or prison, was the subject of comments on collaboration, communication and confidentiality issues. First, how to include significant others in the patient management (e.g., phone contacts, family meetings), and when to disclose them worrying information on patient acute suicidal risk was addressed several times. The potential risks (e.g., breaking confidentiality and harming working alliance, being confused by information from patients' family or friends) or benefits (e.g., gaining a comprehensive view, opening discussion on difficult interpersonal issues between patient and his/her significant others) were much debated and comments on this topic were nuanced:

> [Non-involvement of family is discussed] *while it was important for this patient to have his own space in the treatment, he was in conflict with his spouse, and it would have been interesting to schedule a consultation for the couple.*

In addition, comments were formulated on the issues of communication and collaboration between police and medical teams in emergency interventions for suicidal patients within the hospital, or on the pros and cons of sharing information regarding suicidal risk with the justice system or the prison authority,

> [In the case of a prisoner who completed suicide immediately after being isolated in a dedicated cell for disciplinary reasons without the medical team being consulted]*, the committee wonders how medical contraindications of disciplinary actions are considered by prison authorities.*

4. Discussion

Principal findings and meaning

The following discussion first addresses the results related to our first aim, which was to identify health-care related factors associated with death by suicide in psychiatric patients that could become targets for prevention. Foremost among the identified themes was the **patient evaluation** and especially the issue of suicidal risk assessment; many recommendations stressed the need for a careful and in-depth suicidal risk assessment, and only some comments questioned the clinical value of its use. This may mirror the previously mentioned debate between mainstream views on the importance of suicide risk assessment (Jacobs et al., 2010; Royal College of Psychiatrists, 2010) and more critical opinions (Hawgood & De Leo, 2016; Konrad Michel, Valach, & Gysin-Maillart, 2017), based on recent research (Carter et al., 2017; Chan et al., 2016; Mulder et al., 2016; Quinlivan et al., 2017; Sashidharan & Saraceno, 2017), which has called for a shift from clinician experience-based risk assessment to patient experience-based collaborative and compassionate evaluation (Hawgood & De Leo, 2016; Konrad Michel et al., 2017). These somehow "challenging" comments reveal themselves as meaningful in light of the difference between the psychiatric assessment and the building of a therapeutic alliance (K. Michel et al., 2002). Based on our own observations in teaching, clinics and supervisions, clinicians who assess suicidal patients tend to either favour the one or the other. In this regard, recent qualitative studies shed light on the differences between "duty and control" and "connection and care" and suggested that suicidal risk assessment impairs clinicians' ability to connect with suicidal patients (Hagen, Hjelmeland, & Knizek, 2017). Thus, training in the management of the suicidal patient should include a discussion of this complex issue.

With respect to **patient management**, the DCCPR paid particular attention to the recording of information, to transmission and to transitions of care, especially psychiatric hospital discharge. In fact, transfers between services, discontinuity of care (Riblet, Shiner, Mills, et al., 2017), and the number of outpatient consultations after discharge (Vasiliadis, Ngamini-Ngui, & Lesage, 2015) have been associated with inpatient suicide. In this context, it must be noted that psychiatric hospitals are under high pressure with a decrease in beds and an increase in psychiatric admissions (Heggestad, 2001) and that teams are repeatedly invited to identify patients who are not in an absolute need of hospitalisation and could be discharged, thus "emptying beds" (Rhodes, 1995). This need implies rapid and at times, abrupt transition of care, which is not only associated with a potential loss of information but also of relationships, which are at the heart of therapeutic and preventive interventions. Solutions for limiting loss of information and enhancing transitions have thus to be developed (Bonsack et al., 2016).

The importance of the theme of **training** may have been influenced by the involvement of several DCCPR members in the local training. The training of clinicians has been shown to increase intermediate outcomes of suicidality, such as knowledge and attitudes, consultations for mental health issues or prescription of antidepressants, but its direct effect on suicide rate remains uncertain (Zalsman et al., 2016). We nevertheless assume, based on these study findings and our experiences, that training should be promoted to increase security and coordination of care and to guarantee an optimal flow of information. Moreover, training has the potential to reduce the tension between the abovementioned approaches, either structured guidelines-based or more patient-centred**.**

Involvement of relevant non-clinical partners was the fourth theme identified. First, communicating with patients' significant others is of utmost importance (Royal College of Psychiatrists, 2017), especially when suicidality is associated with relational difficulties or in regard to assessing suicidal risk. However, our results show that clinicians were ambivalent on this topic. In fact, involvement of significant others may be challenging when the patient is reluctant to share with them personal concerns or information and even refuses any contact. Clinicians should use their understanding of the situation to elaborate on the patient's refusal; thereafter, they should carefully consider risks, such as feelings of betrayal in patients who need a private and confidential environment, and benefits, such as patient safety and support from loved ones. Ultimately, breaches of confidentiality have to be proportionate and minimal and, as stated by a Royal College of Psychiatrists' report (Royal College of Psychiatrists, 2017), "[Clinicians] should use their professional judgement to determine what is in the person's best interest". Moreover, interactions with the police and the justice system also raise confidentiality issues and require a careful balance between therapeutic alliance and security/protection concerns. A recent study stressed the risk of paternalistic breaches of confidentiality from clinicians working with prisoners (Elger, Handtke, & Wangmo, 2015), but our results suggest a potential need and benefit of an increased communication between clinicians and prison authorities. Current policies on confidentiality-related issues are mainly based on experts opinions (Royal College of Psychiatrists, 2017) or clinicians views (Elger et al., 2015; Jacobs et al., 2010), and further research is necessary to explore the views of patients and relatives or friends and to comprehend how keeping or breaking confidentiality might be linked to suicide. It has been demonstrated in other fields that medical secrecy might evolve over time as exemplified by a study examining it

in relation to mass murders throughout history. This study showed that "despite a constant recognition of the importance of the notion of medical secrecy through time, in practice, attitudes were adapted to both social, economic, political, medical values and historical contexts" (Rieder, Louis-Courvoisier, & Huber, 2016). This should be specifically investigated in suicide prevention. Pending such findings and by analogy with shared decision-making, which also has a "limitation" (Coulter, 1999), we consider that clinicians sometimes have to take a strong stance in favour of life, even against the will of their patient, especially in regard to suicidality.

Our second aim was to explore clinician views on identified factors and thus to get an idea on how to deal with suicidality. Our results showed that the DCCPR produced different output depending on the subject. Recommendations mostly focused on topics already addressed by the institution: Recommendations on suicidal risk assessment and training favoured a suitable and in-depth evaluation process – in line with the institutionalised training focusing on the *Risk-Emergency-Danger* (Kaision & Gasser, 2016) – and repeated recommendations were made on the reporting of information in the medical file, as internal guidelines have recommended for many years. On the other hand, comments either addressed topics not treated by existing institutional policy and highly dependent on the clinician's opinion (therapeutic options or confidentiality issues) or issued midstream or challenging opinions on otherwise consensual topics, then taking a critical stance, for instance on suicidal risk assessment. In addition, while recommendations usually pointed in the same directions, comments exhibited different and sometimes antagonistic views. For example, the relevance of non-voluntary psychiatric hospitalisation or the use of locked intensive care rooms resulted in antagonistic comments, ultimately reflecting the current debate on these topics. Hospitalisation is generally viewed as protective, as confirmed by several

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studies (Bastiampillai, Sharfstein, & Allison, 2016; Kapur et al., 2016); however, some authors stressed that the hospital can be experienced as traumatic and stigmatising by patients (Matthew M Large & Ryan, 2014). The recent literature also reconsiders current institutional policy, which includes locked rooms (Huber et al., 2016), while advocating a primacy of the therapeutic relationship. To put it differently, the DCCPR seemed not inclined to move beyond the institutional policy and remained in the role of reminding the clinicians that existing guidelines and procedures are relevant. This result calls for two comments. First, the DCCPR appears to be reluctant to extend existing guidelines to other issues, thus resisting the current trend of promoting a growing number of guidelines and procedures, given that many subjects cannot be approached from a "one size fits all" perspective, especially with regard to suicide prevention (Hawgood & De Leo, 2016; Konrad Michel et al., 2017). Second, the high number of comments of the DCCPR may be explained by its double mission. Indeed, the DCCPR has, on the one hand, the explicit task of reviewing every suicide in the institution and to produce recommendations to improve the quality of care and suicide prevention. On the other hand, the implicit task of the DCCPR is to provide fair and quality feedback to the staff who has been involved in the fatal and distressing event. Moreover, the DCCPR may fear creating a "blame culture", in which individuals rather than the system are blamed for critical incidents. A recent study showed, indeed, that general practitioners were reluctant to share with peers their uncertainty and concerns about their potential errors (Kendall & Wiles, 2010), because they feared being blamed; a similar phenomenon may exist within the Committee, along with concerns about possible legal claims. A more constructive and systemic perspective on errors, focusing on work conditions (Reason, 2000) rather than on individuals, has already been advocated after a patient's suicide (Alexander,

Klein, Gray, Dewar, & Eagles, 2000). Many of the conclusions of the DCCPR consist of comments, which could be worrisome since unlike recommendations, comments are not easily translated into guidelines. This aspect raises the issue of how to fulfil one major DCCPR objective, which is to improve suicide prevention. A first stance would be to consider that such a committee should, rather, be external to the institution, such as the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness or the Joint Commission, which may benefit from more freedom. However, their external nature could accentuate the fear of blame within the institution, and they would lack knowledge of the specific context of the health care institution. An alternative would be to transfer these insights to clinicians through teaching to improve suicide prevention. Furthermore, other options could be considered: collective feedback by means of newsletters was, for instance, recently launched by the DCCPR and appears to be a promising way of reviewing suicide cases. However, a newsletter should not replace feedback to involved clinicians and in-depth discussion followed by a common identification of what could be done differently. This issue implies a need to counteract the institution's tendency not to talk about suicide, which mirrors the stance of individuals and professionals.

Strengths and limitations

To our knowledge, this study is the first to rely on conclusions of members of an ad hoc committee to identify health care-related factors for suicide in psychiatric patients. Strengths and limitations of the study are mostly in connection with the organization and functioning of the DCCPR, from which the analysed data were derived. In this regard, the assessment by clinicians of the work of their colleagues is of high clinical relevance but also represents a major limitation. In fact, the material may be somewhat biased as the clinicians are treating suicidal patients – and

may even be directly involved in a reviewed suicide – and can censor themselves by adopting a lenient view and avoiding adverse opinions. In addition, some suicides of inpatients after discharge or of outpatients may have been missed by the committee (e.g., when no further appointment was planned and staff was not notified of the suicide by the family, friends or newspapers). Finally, it must be noted that DCCPR's members base their reports on clinical charts without the opportunity to speak with involved clinicians. Future research on these topics should include direct contact with the staff in charge of the deceased patients to understand their clinical appreciation of the situation.

Implications for practice

A new finding is that the **involvement of relevant non-clinical partners** is an important issue for suicide prevention in psychiatric patients. Depending on the situation, the lack of involvement of such partners as well as any inadequate breach of confidentiality may carry a noteworthy risk on suicidality. In this regard, clinicians should be aware that a thorough and open discussion with suicidal patients about the significant others they want to include in the care provide an opportunity to disclose core relational issues and to address them. Furthermore, the results show that as in other populations, patient evaluation and management is a cornerstone of suicide prevention for psychiatric patients; however, the question to what extent the approach must rely on a standardised method remains open, with standardisation considered as bearing the potential to negatively impact the therapeutic alliance but at the same time, increase comprehensive assessment. The study also highlighted the need for training to promote a patient-centred approach and to avoid standardised, depersonalized care. With respect to the clinicians of the committee, they appear to favour nuanced conclusions of their reports. This preference may be

explained by their stakeholder stance, but it also underlines the complexity of suicide prevention in psychiatric institutions and advocates for a clinical *and* patient-centred approach in suicide prevention and against actuarial or predictive models. Finally, tensions become apparent between institutional directives, produced to establish quality assessment and management of suicidal patients but also to prevent legal claims, and the potential risks of what can be considered as a standardisation of the clinic.

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Table 1 Sample sociodemographic characteristics

Variables		Total patients (*N* = 94)
Age (years)	M (SD)	44.1 (16.2)
Gender (% male)	% (n)	63 (59)
Citizenship:		
Switzerland	% (n)	63 (59)
EU	% (n)	18 (17)
Other	% (n)	14 (13)
Unknown	% (n)	5(5)
Primary diagnosis:		
Alcohol or Drug addiction	% (n)	13 (12)
Schizophrenia and other psychotic disorders	% (n)	21 (20)
Affective disorders	% (n)	56 (53)
Other diagnosis	% (n)	6 (6)
Unknown	% (n)	3 (3)
Type of follow-up when committing suicide:		
Outpatient	% (n)	45 (42)
Inpatient	% (n)	50 (47)
Prison – health professional	% (n)	5 (5)

Table 2 Results of the analysis of reports' conclusions and corresponding minutes

Type of statement	Analytic themes			
	Patient evaluation	Patient management	Clinician training	Involvement of relevant non-clinical partners
Recommendations	— Suicidal risk assessment *[29 occurrences*]* — Specific evaluations *[4 occurrences]*	— Reporting of information *[28 occurrences]* — Transitions and transmissions *[11 occurrences]* — Security *[4 occurrences]*	— Improvement and participation in the training *[5 occurrences]*	
Comments	— Suicidal risk assessment *[5 occurrences]* — Specific evaluation *[1 occurrence]*	— Clinical decisions and procedures *[15 occurrences]* — Medication *[8 occurrences]* — Transitions *[4 occurrences]*		— Collaboration with the police *[2 occurrences]* — Collaboration with the justice *[2 occurrences]* — Collaboration with the prison *[1 occurrence]* — Involvement of significant others *[3 occurrences]*

* Occurrences refer to the number of concerned situations

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