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POSTER ABSTRACT

# Profiles of quality of care among individuals with suicidal behaviors

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Suicide is an important cause of mortality worldwide. For each individual dying by suicide, it is estimated that 20 others have attempted suicide at least once. Providing quality care that's adapted to the individual's needs and factors in suicidal behavior severity is a key issue in several countries – including Canada, where access to care is particularly poor.

Individuals with suicidal behaviors are quite vulnerable, but not necessary an homogenous group. This study is original in identifying profiles of individuals with suicidal behaviors (ideations, plans, attempts) and quality of outpatient care received before their suicidal behaviors, associated these profiles to the respondents' sociodemographic and clinical characteristics, and measured succedent outcomes.

**Methods**: Using a representative population-based 2015-2016 survey from Quebec (Canada) merged with the province's health registry (1996-2017), cluster analysis and multinomial logistic regressions were conducted on 569 respondents experiencing suicidal behaviors.

**Results**: Among the four identified profiles, 63% had suicidal ideations only (Profile 1, 40% of the cohort; Profile 2, 23%), while 37% reported suicidal plans (mostly Profile 4, 15%) or attempts (mainly Profile 3, 22%) – of Profiles 3 and 4 about one-third reported suicide attempts over their lifetime. Before exhibiting suicidal behaviors, 56% had received low quality of outpatient care – mainly Profiles 1 and 4.

Those with the worst social and health conditions, including more serious mental disorders, received the best MH care: Profile 2 patients (suicidal ideations only) received high continuity and regularity of recovery-oriented care; those of Profile 3 (more suicide attempts and unmet needs) received more intensive care.

Being older with higher rates of suicidal plans or attempts – and with over 50% of them having mental disorders –, Profile 4 patients received low quality of care and showed the worst outcomes (acute care use, lower quality of life, bad or poor physical/mental health conditions), followed by Profiles 3, 2 and 1. Profile 1 patients also received low quality of care, but showed the best

outcomes, probably because of better social and clinical conditions and the fact all of them only had suicidal ideations.

**Conclusion**: Quality of care was higher in patients with worse social and health conditions (Profiles 2 and 3), which may indicate good care equity throughout the system. However, findings showed that services could be substantially improved to prevent suicidal behaviors, with outreach interventions significantly strengthened for Profiles 1 and 4. Services could protect patients better against suicidal behaviors and adverse outcomes if they more closely matched their needs and the severity of their conditions.

In this sense, Profile 3 and 4 patients would benefit from more continuous follow-up care over time. A greater integration of researchers, decision makers, clinical teams and experts on suicidal behaviors might also be recommended to facilitate the deployment of the care strategies suggested in this study, this in order to adequately respond to the diversified needs of patients with suicidal behaviors.