Intellectual disability,
Autism,
Suicide

Clinical Suicide Prevention Process with People Presenting an ID or ASD

A collection of clinical tools to support interventions with people presenting ID or ASD and displaying suicidal behaviours

Version translated by the research team
October 2020

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Research projects and partners

- 2018-2021 - « Valider empiriquement le concept opérationnel de « l'option suicide » pour comprendre les comportements suicidaires chez les personnes ayant une déficience intellectuelle ou un trouble du spectre de l'autisme » Bardon C., Morin D., Saïas T., Project funded by SSHRC Insight Development grant.

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- 2018-2020 - « Stratégie innovante de mobilisation des connaissances en prévention du suicide chez les personnes ayant une DI ou un TSA : Collaborer avec le réseau pour améliorer les services » Bardon C., Morin D. Grant: « Les déterminants à la participation sociale des personnes ayant une déficience intellectuelle ou un trouble du spectre de l'autisme » Research Grant: CNRIS-OPHQ.

- 2016-2017 - « Développer des stratégies d'intervention auprès des personnes suicidaires présentant une déficience intellectuelle (DI) ou un trouble du spectre de l'autisme (TSA) », Projet de stage postdoctoral. Bardon C., Lanovaz M., Morin D. Bourse de stage postdoctoral CNRIS

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- 2014-2017 - « Comprendre et estimer le risque suicidaire chez les personnes présentant une déficience intellectuelle (DI) ou un trouble du spectre de l'autisme (TSA) » Bardon C., Mishara B., Morin D., Weiss J., Grant: CIHR.

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- 2013-2014 - « Consensus d'experts sur l'estimation du risque suicidaire chez les personnes ayant une Déficience intellectuelle ou un trouble du spectre de l'autisme » Bardon C., Morin D., Ouimet AM, Financement démarrage de projet CRISE.

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Projects have received the scientific support of:

- DI-TC Research Chair, UQAM: https://www.chaireditc.ca
- Lanovaz Lab, École de Psychoéducation, Université de Montréal: https://lanovazlab.com/
- Centre for Research and Intervention on Suicide, Ethical Issues and End-of-Life Practices (CRISE), UQAM: https://crise.ca/
- Institut universitaire en DI et en TSA: http://institutditsa.ca/

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The following organisations have participated in the projects that have led to the development of the IDAS Process:

Directions DI-TSA-DP of CISSS and CIUSSS	
Bas-Saint-Laurent	Centre-Sud-de-l'Île-de-Montréal
Chaudière-Appalaches	Outaouais
Côte-Nord	Québec
Estrie	Saguenay—Lac-Saint-Jean
Laurentides (Centre du Florès)	Est-de-l'Île-de-Montréal
Laval	
Mauricie—Centre-du-Québec	
Montérégie-Ouest	
Hospitals	
Rivière-des-Prairies Hospital	Institut universitaire en santé mentale de Montréal (IUSMM)
Louis-H.-Lafontaine Hospital	
Suicide Prevention Centres and Crisis Services	
Suicide Action Montréal	Tel-Jeunes
Institut universitaire de gériatrie de Sherbrooke	Regroupement des centres de prévention du suicide du Québec (RCPSQ)
Settings related to intellectual disability and Autism Spectrum Disorder	
RENTED	Société québécoise d'excellence en troubles graves du comportement (SQETGC)

How to cite this document

Bardon, C., Morin, D. (2015-2020) IDAS Process – Clinical Suicide Prevention Process with people presenting an ID or ASD. CRISE, Chaire DI-TC, Montréal, QC.

UQÀM Chaire de déficience intellectuelle et troubles du comportement
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CRISE
Centre de recherche et d'intervention sur le suicide, enjeux éthiques et pratiques de fin de vie
Centre for Research and Intervention on Suicide, Ethical Issues and End-of-Life Practices

Translated version- 2020

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Section 1 – Practical foundations of the IDAS Process and general structure

The IDAS process aims to support the clinical judgement of those working in suicide prevention with people with intellectual disability (ID) or autism spectrum disorder (ASD) and presenting suicidal behaviours (ideations, plans, attempts) and associated manifestations (cognitive, emotional, psychiatric, behavioural, physiological, social). Together these behaviours and manifestations associated to suicide are referred to as MAAS in the IDAS process.

The IDAS Process is intended for professionals working in the field of intellectual and developmental disability rehabilitation, in community organisations or in suicide prevention.

Any clinical decision always depends on the judgment and interpretation of the professionals present at the time when the suicidal behaviours occur, but also on the processes and tools used during the evaluations, on the way in which information is gathered and on the perceptions and interpretations of the people consulted (other therapists, relatives). Clinical judgment must be based on the best possible knowledge and practices but will always remain at the heart of suicide prevention assessment and intervention work. No tool will replace it.

As shown in Figure 1, the IDAS Process includes:

- A dynamic model of suicide in people with ID or ASD
- A process to support clinical decision-making regarding the suicide risk in people with ID or ASD *(Identification of people at risk (screening), Danger assessment and analysis of the suicidal episode, Long-term risk assessment)*
- A set of suicide prevention intervention tools *(management of the suicidal episode, risk reduction)* adapted to the different needs of the client/user and to the intervention practices of ID-ASD settings

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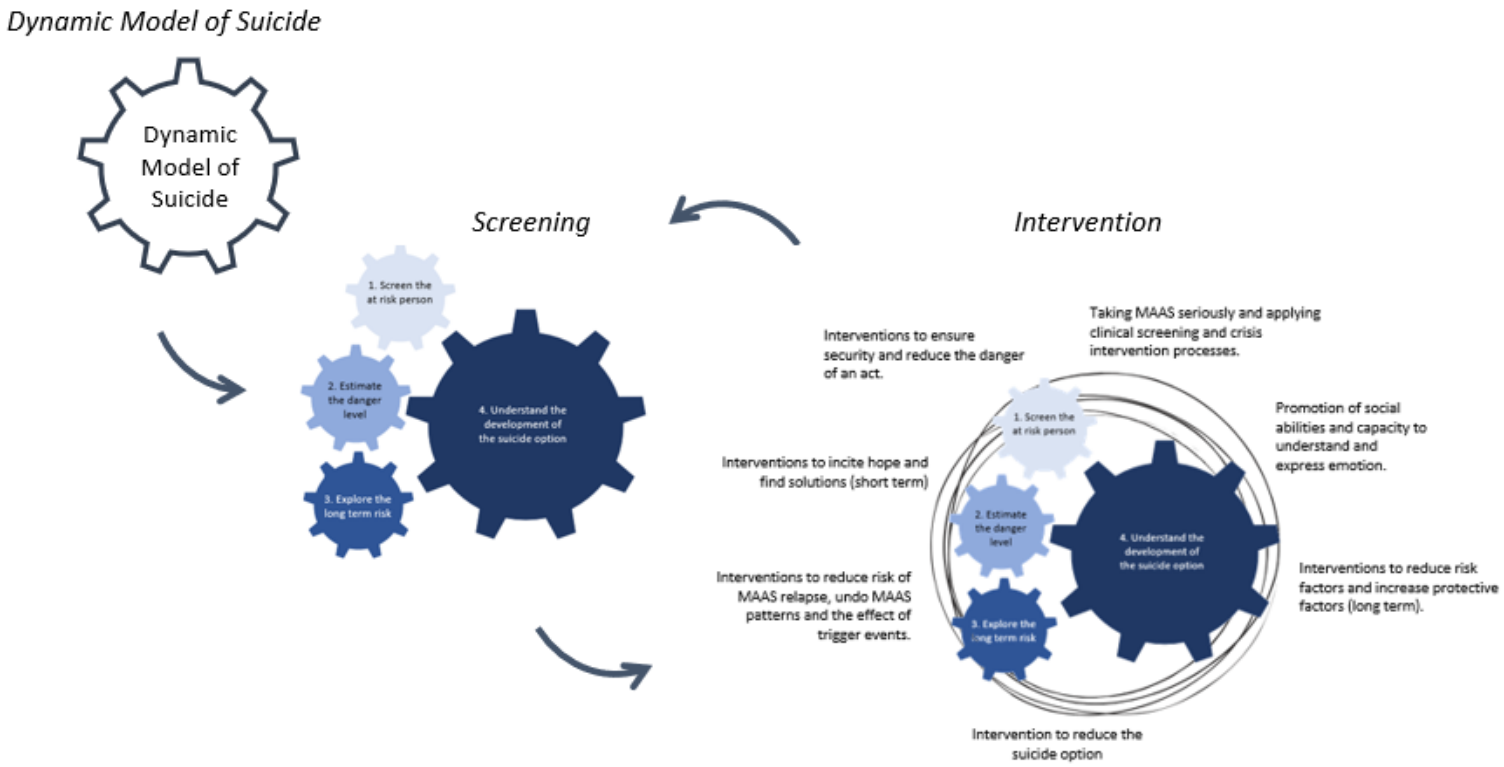
Figure 1 - IDAS Process overview



The IDAS Process addresses three complementary levels of suicide prevention. These levels have been broken down so that different actors can apply them according to the needs of the clientele and the characteristics of their environments:

- Screening: Identifying a person at risk of suicide
- Managing a suicidal episode (assessing level of danger, analyzing the episode, and acting to reduce the level of danger and distress associated with the current situation)
- Reducing the long-term suicide risk (risk and protective factors, suicide option, MAAS patterns).

The clinical tools are therefore described according to these three steps throughout this document.

Understanding Suicide Risk - A Dynamic Model of Suicide in People with ID or ASD

The dynamic model of suicide illustrated in Figure 2 was developed from a study conducted between 2015 and 2017 among 100 ID-ASD clients from the specialized services of 12 CIUSSS and CISSS in Quebec. It is the subject of a validation study, the results of which will be incorporated in 2021.

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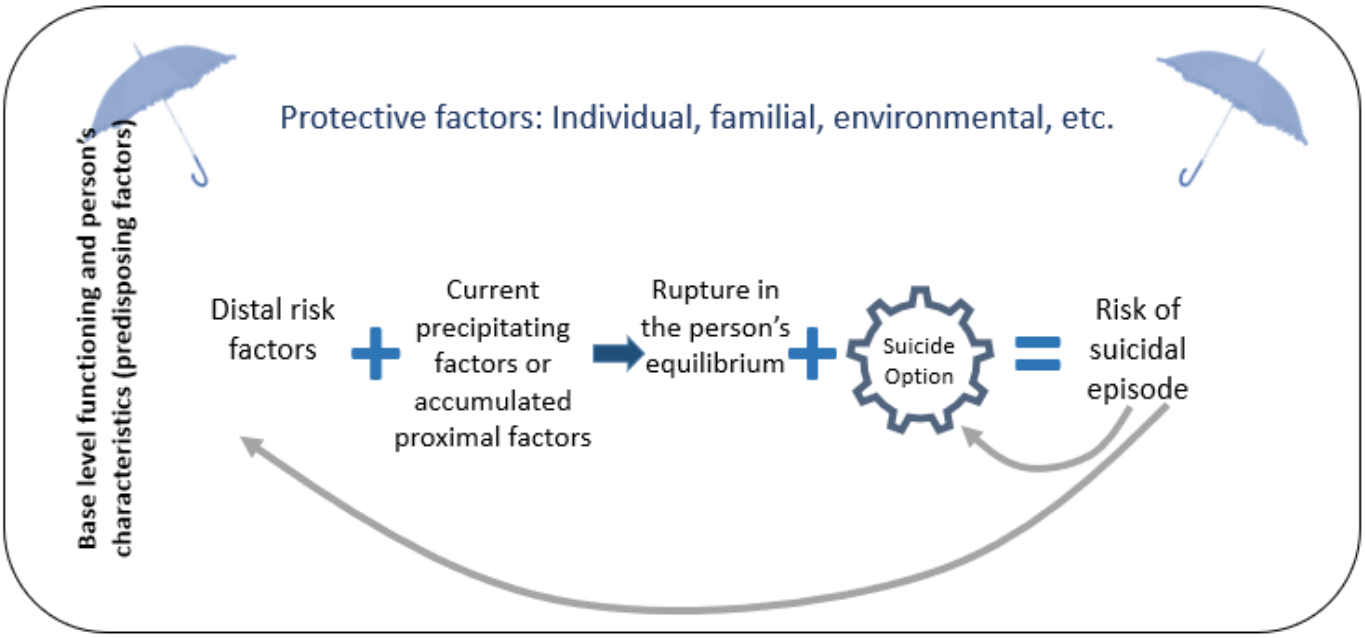

Figure 2 - IDAS Process Model – A dynamic model of suicide in people with ID or ASD

This model serves as the basis for the suicide risk analysis indicators proposed in the IDAS Process.

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Manifestations associées au suicide (MAAS)

The term “Manifestations associées au suicide” (MAAS) – or suicide-related manifestations – was chosen to reflect the variety of verbal, non-verbal, direct and indirect behaviours that can express suicidality in people with ID or ASD. Table 1describes several of these MAAS. It is not exhaustive, and people may have different MAAS. It was determined this term would not be translated from French in order to preserve the subtleties of the word “Manifestations”, which is very wide and can encompass many different direct and non direct behaviours.

Table 1 - Types of suicide-related manifestations (MAAS) observable in people with ID or ASD

Type of MAAS	Examples
Thoughts (unobservable or not communicated)	▪ Thinking about their own death when they are sad ▪ Thinking about hiding a knife in their room ▪ Having suicidal flashes or seeing themselves dead ▪ Thinking about the reaction of loved ones if they were dead or missing
Direct verbal communications	▪ ‘’I want to die’’; ‘’I want to kill myself’’; ‘’I have dark thoughts’’
Indirect verbal communications	▪ "I want to join my grandmother at the cemetery"; "I would like to be dead"; "You would be better off without me"; "I want to go far and not come back"; "I want to go with the birds"; "I want to act like ... (the person who killed himself)"
Direct or indirect verbal communications by text or social media	▪ In the form of sentences (statements, questions), images, ‘’likes’’ on posts about death or suicide, etc…
Non-verbal communications	▪ Drawings representing a violent act or a suicidal gesture, graves, suffering, objects to commit suicide ▪ Miming strangling themselves, cutting themselves
Self-aggressive behaviours without injury	▪ Trying to push a non-cutting object (a branch) through the skin (in the stomach, arm or leg) ▪ Swallowing pills or non-toxic substances (without knowing the level of danger) ▪ Trying to strangle themselves with their hands or holding their breath
Self-aggressive behaviours with injury or death	▪ Swallowing pills or substances with toxic potential (drugs) ▪ Injuring themselves with a sharp object ▪ Strangling or hanging themselves with a belt, towel, or rope ▪ Jumping from a window or from a high place ▪ Jumping in front of a vehicle ▪ Jumping into the water (without knowing how to swim, without looking) ▪ Crossing the street on a red light or a metro rail

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Signs associated with MAAS These clues can help identify a person at risk who does not verbally express distress and suicidal ideation	▪ **Cognitive:** confusion, difficulty concentrating, indecision ▪ **Emotional:** mood swings, manifestations of sadness, anger, irritability, increased anxiety about upcoming events, anxiety, increased aggressiveness, dissatisfaction, disappointment, fears or insecurity in the face of a situation, feeling of incompetence ▪ **Psychiatric:** increased symptoms ▪ **Losses in acquired capabilities and adaptation difficulties in the current situation:** stagnation or regression ▪ **Behavioural:** behaviour changes (worse or better, agitation or prostration, amplification of usual challenging behaviours, increased substance use or compulsive behaviour, isolation, increased request for help, absenteeism) ▪ **Somatic:** emergence or worsening of physical and digestive disorders, back pain, headaches, etc. ▪ **Neuro-vegetative:** deterioration of sleep, appetite, energy level ▪ **Signs of hopelessness:** negative discourse about the future, discouragement, resignation, self-deprecation, cessation of treatment, refusal of follow-up or absences, refusal of the help offered

General considerations on the IDAS Process

General approach

The IDAS Process integrates common clinical approaches used in ID and ASD intervention current practices (particularly functional behaviour analysis). In addition, it is compatible with the tools developed for the general population. This approach promotes exchanges between professionals from different backgrounds and intervention environments.

The IDAS process does not replace clinical judgment, it complements and supports it. It provides a framework for identifying relevant information and guiding clinical decisions on the level of danger, the type of risk and identifying the necessary interventions. It constitutes a means of retaining the information and knowledge acquired during the management of suicidal episodes to transfer information, work in a team, put in place Suicide Prevention Plans – Suicidal Episode (SPP-E, suicidal episode management) and Suicide Prevention Plans – Risk Reduction (SPP-R, reducing suicide risk, understanding and reducing the suicide option, understanding and reducing recurrence of suicidal behaviour).

The IDAS Process is not a standardized grid producing a hazard score, a substitute for expertise and clinical judgment, or an after-the-fact form to compile information unnecessary to the intervention. The screening tools are not intended to establish a danger or risk score. Rather, they constitute a process to support clinical decision-making regarding the risk of suicide in people with ID or ASD.

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Suicide risk management is a collaborative process involving people and professionals who know the user well and professionals who are familiar with the assessment process.

The principles that have guided the development of these tools are as follows:

- The assessment of the danger and the risk of suicide must be done as a team.
- Suicidality fluctuates rapidly over time and assessment of intentionality is not necessarily an effective indicator of suicide risk, particularly in people with ID or ASD.
- Once the risk of acting out has been assessed and the intervention to reduce the suicidal crisis is completed, it is important to understand the distal risk factors as well as the circumstances underlying the suicidal episode. A medium- and long-term risk assessment is therefore an integral part of the screening process and should support the deployment of long-term interventions aimed at reducing distress and limiting the risk of recurrence.

Target clienteles

The IDAS – Screening process can therefore be used with all people with an ID or an ASD for whom the workers or relatives have concerns about the presence of MAAS. The way to approach the topics varies according to the cognitive and communicational capacities of the person. In the current state of knowledge (2020), it is impossible to know whether specificities should be made for children versus adults or for people with ASD without ID.

Several people can collect information at different times depending on the person's abilities, the bond of trust, the availability of workers and relatives and the time available. A longitudinal perspective of danger and risk assessment also requires regular data collection. Note taking is therefore an integral part of the assessment and communication between stakeholders involved with this person.

Note-taking in the documents associated with the *IDAS – Screening* process can be made after the intervention to keep a transmissible record of what happened. Obviously, note taking is not done during an acute suicidal episode, during an emergency or crisis intervention. The tools of the IDAS-Screening process are above all a guide for remembering the relevant points to explore with the person to estimate the danger (when it is not clearly low or high) and to assess the risk (during usual interventions, therefore in a calm context). Much of the information used in the *IDAS – Screening* process is already available in the person's file or from stakeholders and relatives. It is possible to refer to the taking of progress notes in the *IDAS – Screening* process, so as not to copy the notes taken elsewhere.

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Clinical suicide prevention process with people with ID or ASD

The IDAS Process has the following objectives:

- **Understand**: The suicide-related manifestations (Manifestations associées au suicide, MAAS) are part of a dynamic process fueled by a person's history, vulnerabilities, current situation and a cognitive and interactional construction of suicidality. Suicidality is a complex process that must be understood in order to intervene properly.
- **Identify a person at risk**: This first crucial step in suicide risk management aims to adequately screen a person experiencing distress **and** displaying suicidal behaviour in order to take them seriously and develop an intervention adapted to their needs.
- **Managing a suicidal episode:** This step consists of analyzing the situation and estimating the danger, then intervening in the event of a suicidal episode. More precisely, the danger assessment aims to qualify the danger of a suicidal act, identify the presence / nature / intensity of suicidal ideation, identify the proximal risk and protective factors, identify the triggers of MAAS, document the history of individual and family suicidal behaviour, describe the level of hopelessness, understand the impulsiveness of the person, understand what is happening to the person without a priori, but above all it aims to **guide the intervention (allocate the right services at the right time with the right intensity)**. The intervention, for its part, aims to ensure safety, prevent suicide attempt, increase hope, reduce the risk of suicide attempt in the future, strengthen protective factors, reduce risk factors.
- **Reduce the risk of suicide:** This last step aims to understand the construction of the suicide process and intervene in the long term. More precisely, it aims to complete the information gathered (identify the more distal risk factors, the vulnerability factors and the protective factors acting in the long term in the construction of the suicide risk), understand the suicidal process of the person, take decisions on suicide risk, determine interventions aimed at reducing risk factors, strengthening protective factors and modifying the suicidal process (identifying and implementing avenues of intervention aimed at improving the person's well-being and reducing distress)

The assessment and intervention phases are interdependent at all levels of suicide risk management. From this perspective the clinical process is based on the sequence observe-decide-act (illustrated in Figure 3), which is found at all its levels.

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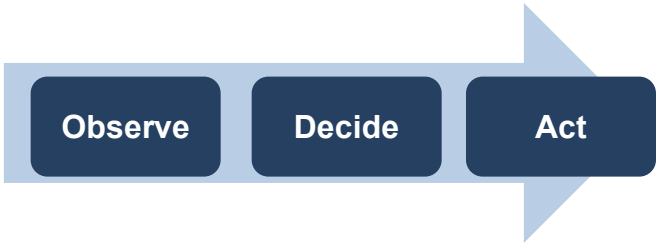

Figure 3 - Basis of the clinical process

Keeping this sequence in mind, the clinical process includes three complementary parts based on the dynamic model of suicide (see Table 2). The steps are: 1) screening, 2) management of the suicidal episode, and 3) risk reduction.

They have been distinguished so that they can be carried out by distinct people in the entourage and in the service structure accompanying the person with ID or ASD.

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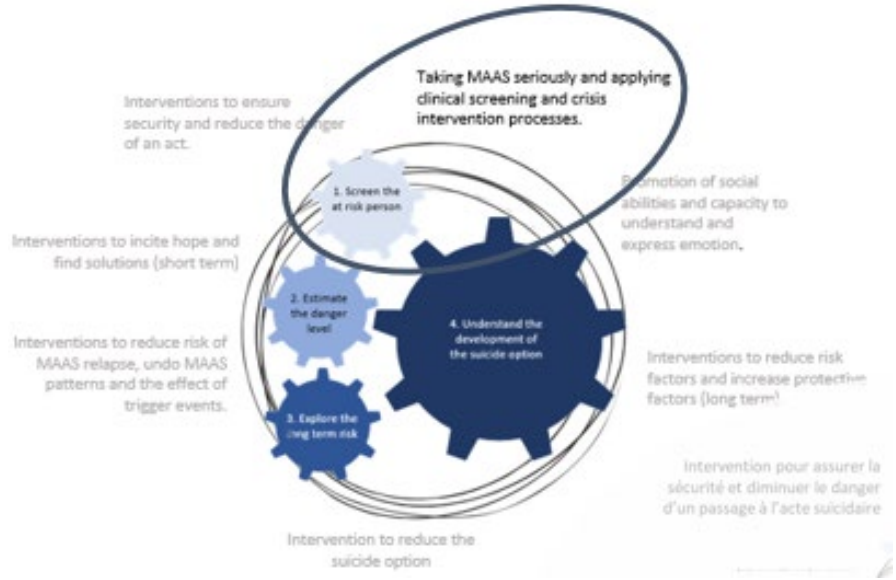
Table 2 - Suicide risk management steps as part of the IDAS Process

Steps	Structure	When?	Actors involved
1. Identification of people at risk (Screening).		When a person expresses distress or presents signs associated with MAAS	Caregivers, relatives, people in contact with the user in his daily interactions

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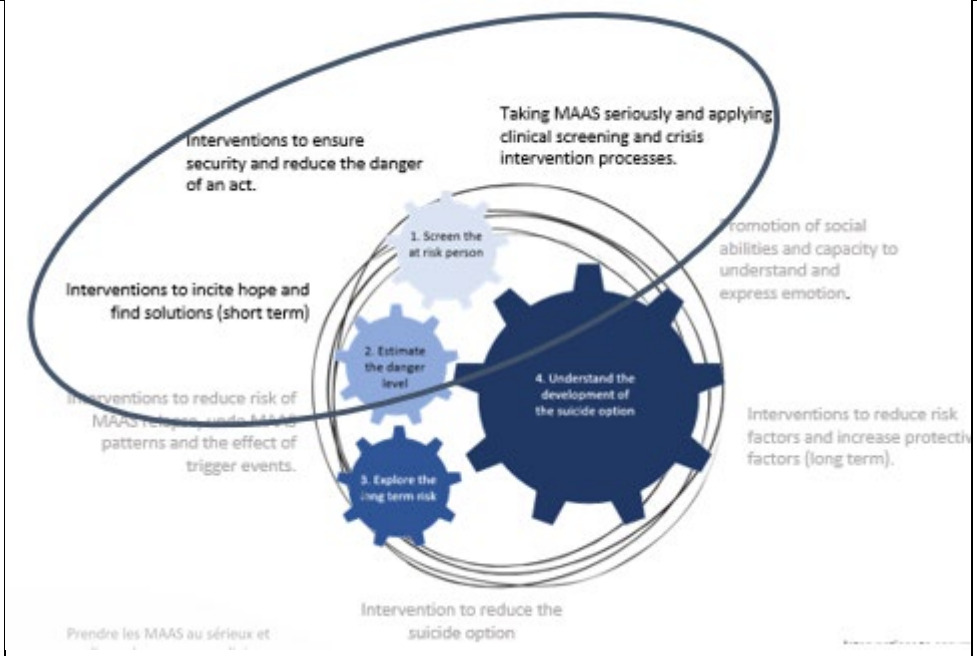
Steps	Structure	When?	Actors involved
2. Management of the suicidal episode Directly target MAAS		Assessment and intervention during the suicidal episode and in the following hours and days (for follow-up)	A worker trained in the use of the IDAS Process and in building a SPP-E, a suicide prevention worker

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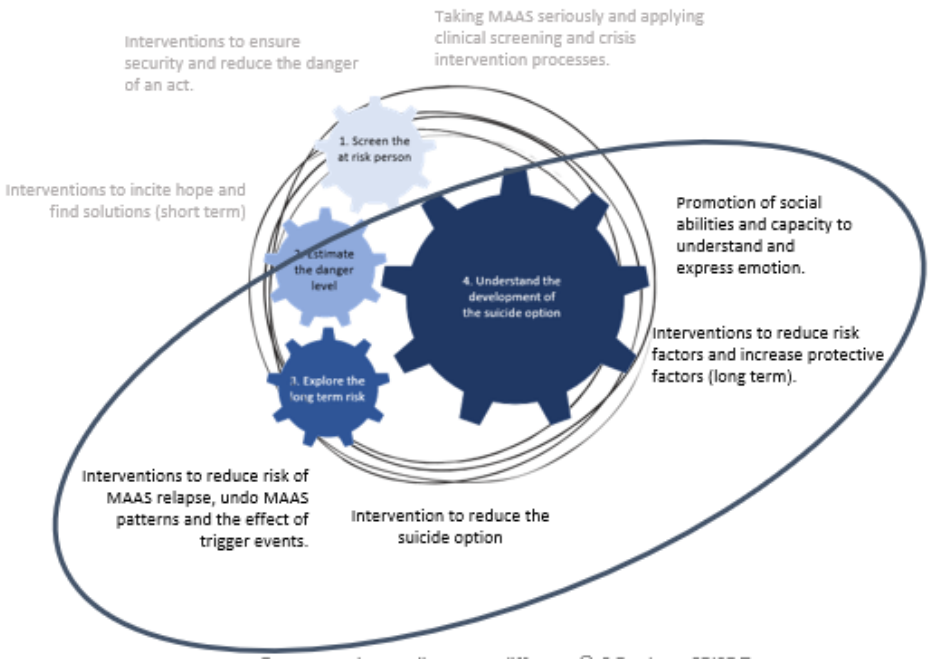
Steps	Structure	When?	Actors involved
3. Suicide risk reduction Assessment and intervention on risk factors and underlying cognitive, emotional and social processes (suicide option) and on MAAS patterns		During clinical follow-up, team meetings, apart from suicidal episodes	Clinical team usually intervening with the person, relatives, specialized professionals

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Integration of the IDAS Process in the suicide risk management protocols of establishments

Suicide prevention cannot be distinguished from general interventions carried out with the person. This is why the IDAS Process aims to fit into the usual clinical processes put in place to meet the needs of the person. As part of the approach described here, the emphasis is on the need to understand suicidality within the overall system of a person's life and functioning. For example, it may be pointless to work on a person's emotional expression skills when most of their distress comes from their lack of control over their daily life.

No intervention should be ad hoc, and no ad hoc intervention will solve the problem of a person's suicidality. **The strategies proposed in the IDAS-Intervention guide (Section 5) must be part of a systemic strategy based on a rigorous assessment of the person and their environment.**

At the same time, the IDAS Process follows a structure compatible with the usual practices in place in the rehabilitation network, namely Multimodal Analyses, intervention plans, action plans, active prevention sheets, etc. It is possible to integrate the suicide risk management into the clinical processes known and implemented with the person.

Finally, the integration of clinical and note-taking tools associated with the IDAS Process in the clinical-administrative files facilitates their use. It should be planned upstream of the implementation of tools in clinical teams.

General description of the screening and intervention tools offered

The three stages of suicide risk management have the same structure (observe - decide - act) and are based on tools aimed at supporting and documenting clinical judgment.

Screening

The screening tools include clues to be observed using various sources of information and questions to support clinical decision making as to:

- The presence of MAAS (1. Identify the person at risk);
- The danger during an episode (2. Assessing the level of danger);
- Understanding the risk of suicide and its development (3. Exploring the long-term risk, 4. Understanding the development of the suicide option).

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Figure 4 shows the interdependence of these different levels and times of screening. A complete understanding and analysis of the suicide risk can only be done longitudinally taking into account these four levels of assessment.

Figure 4 - Elements of screening

Intervention

All the interventions put in place must meet a clear objective determined by the evaluation in the process of observing - deciding - acting.

The interventions proposed within the framework of the IDAS Process are suggestions. They can be modified and adapted to the needs of clients and stakeholders. For example, a story can be transformed, accompanied by pictures or summarily staged using a role play. Objects can also be used to illustrate a concept (for example, using a weighing pan to help understand the concept of ambivalence). The option of individual or group activity can always be considered. Many interventions have also already been developed and can be adapted to work on different aspects of suicidality. It is important to share the existing interventions in the community. However, before using them, **it is necessary to clearly identify the clinical objective of the intervention and to discuss as a team the suitability of this intervention to the person's needs and his or her ability to understand.**

Figure 5 illustrates the different areas of intervention responding to the objectives identified during the assessment of the danger and the analysis of the person’s suicidality.

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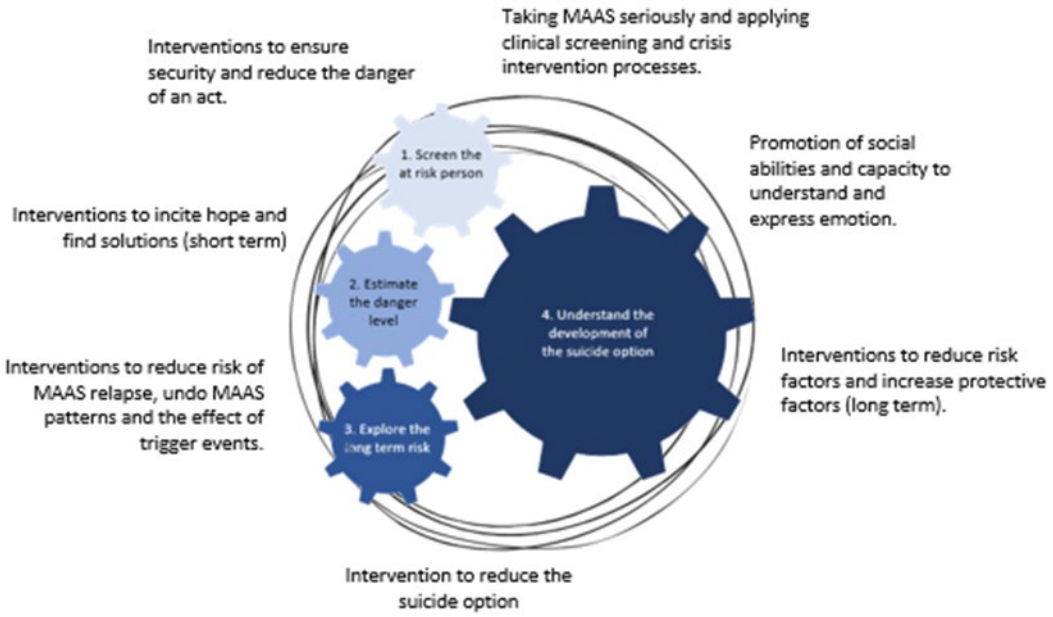

Figure 5 - Intervention strategies adapted to the objectives identified during the screening

The intervention strategies fall into three areas depending on their objective and timing:

- **Following the screening**: Take the MAAS seriously and apply the clinical assessment and crisis intervention processes.
- **Following the assessment of the level of danger during a suicidal episode**: intervene to ensure safety and reduce the danger of suicide attempt, intervene to foster hope and find solutions to the situation.
- **Following the assessment of risk factors and the suicide option after the end of a suicidal episode**: Intervene to reduce the risk of recurrence of MAAS in the short term, undo the patterns of MAAS and the effect of triggers, intervene to reduce the suicide option, intervene to reduce risk factors and increase protective factors (long term), promote social skills, the ability to understand and express emotions.

As part of the IDAS Process, interventions targeting each of these suicide risk management objectives are proposed and described in detail based on the structure below:

1. **Objectives:** presents the reasons why the intervention can be useful.

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2. **Rationale / explanations**: a) presents the theoretical foundations, if any, to support the intervention; or b) describes the process by which the intervention is likely to help reduce the risk of suicide.
3. **Process:** describes how to use the intervention. This section may also contain examples.
4. **Presentation of intervention tools, if applicable**: When the intervention uses written or drawn material, the intervention tools are included in the notebook.

Structure of clinical decision support documents

Each step of the clinical process is presented in a table such as Table 3. Colored areas present information to guide the clinical decision process. The blank areas are intended to take notes on the observations, decisions and actions taken.

Table 3 - Typical structure of the steps in the IDAS process

Information to collect: Indicators on which to base your **clinical judgment** as to the appropriate stage of the process (screening, management of suicidal episode, long-term risk reduction) Clues and elements to observe in order to make a clinical decision on the person's suicidal process	Observe Decide Act	**Observe**: collected information Source: Questions to the person, observations, questions to professionals, friends or relatives, person's clinical file	
		Decide: Decisions resulting from the screening / episode management / risk reduction process	
		Decision criteria in the form of questions	
		Act: intervene to prevent suicide	
		Possible intervention strategies at this stage and to be adapted according to the decision taken from the observations made.	

The clinical decision support tools consist of four pages reflecting the steps in the suicide risk management process.

These first three stages complement each other with each suicidal episode:

- Identifying the person at risk – IDAS Screening Process
- Managing the suicidal episode - Suicide Prevention Plan - Episode (SPP-E)-

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- Post suicidal episode follow-up – Suicide Prevention Plan – Follow-up (SPP-F)

The following stage is completed longitudinally, apart from the suicidal episodes, by enriching the information for each suicidal episode.

- Reducing the risk of suicide - Suicide Prevention Plan - Risk (SPP-R)

Gathering information on suicide and its prevention

This section brings together some suggestions for addressing questions related to the exploration of suicidality with people with ID or ASD, verbally, directly, indirectly, using pictograms and drawings, social scenario proposals or other various activities. You will find suggestions further in this section. It is also important to vary the sources of information and not to overlook the direct observation of the person and his behaviour, attitude, body expressions and emotions, as well as noticeable changes in these expressions.

Importantly, it is preferable to seek to clarify ambiguous information in order to make an informed decision, even if this can be stressful.

In this context, the question often arises of the validity of the person's answers. When a person says they want to kill themselves, what is a valid answer? What are valid statements? The IDAS Process attempts to address these concerns through different methods. The triangulation of information sources helps to validate the information (relatives, workers, person). In addition, combining information gathering strategies can enhance the quality of information (observe and question). Asking others about the behaviour of the person and the changes observed in the person's functioning in a short period of time is a good strategy, but it should not be used alone, as relatives often have a biased perception of the emotions of the person. Knowing the person's usual functioning styles is an important asset since MAAS often represent a change from this functioning. Finally, the IDAS Process indicates the elements to be explored in order to establish the nature and extent of the danger and risk of suicide. The exploration can be done by different means (direct, open or closed questions, observation, use of pictograms, questioning of friends and family members, etc.). Various exploration strategies are presented in the section below.

Approaches to obtaining the necessary information from users presenting MAAS

Different approaches can be used to explore MAAS in people with ID or ASD, even in people whose primary means of communication is verbal (direct questions, indirect questions, use of visual aids, observation, activities). The best strategy is the combination of different methods.

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Attitude of the practitioner towards the user

More than specific methods of questioning and exploration, it is the practitioner's general attitude that has the biggest impact on the suicide risk management process. Here are some key elements that can help you adopt an attitude conducive to risk exploration and suicide prevention intervention.

Supportive attitudes

- A caring, warm, reassuring, patient, welcoming attitude is essential
- Showing that you are available to hear and understand is crucial (welcoming and establishing a relationship of trust)
- It is important to be fairly directive with the person (e.g., "This is important, we will sit down and take the time to talk about it.")
- Adapt to the person's emotional level, taking into account their understanding of their emotions and their level of disorganization
- The ideal person to do the assessment is a familiar stakeholder with whom the person has good contact (this may mean that the meeting is done by two people: the assessment specialist and the person specialist).
- Start from what the person says / understands, without putting words in his mouth, especially not at the beginning. Take into account the person's cognitive and social abilities while asking unequivocal questions.
- Note the terms used by the person to talk about their distress and their MAAS, then reuse them (eg: "When you [term used by the person], come and tell me.")
- Use a neutral tone in questions
- Pay attention to the non-verbal (that of the speaker and that of the user)
- Start with the person's speech, his own words. If you rephrase, use simple terms
- Reassure the person that the aim is not to punish them, but to understand to better help them
- Stay open in order to understand well without diverting the person's thinking by too many questions
- Tolerate silences, be patient
- Encourage the expression of suffering which leads to suicidal thoughts, listen to the story of the person according to their perception, whatever your analysis of the situation
- Use the means of communication that are familiar to the person.

Behaviours to avoid

- Avoid putting words in the person's mouth
- Avoid suggesting answers (e.g., “have you thought about suicide to stop suffering?”) or expressing disapproval of suicidal thoughts (e.g., “I hope you are not thinking about suicide?”)

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- Avoid inducing answers (e.g., “Did you hide this knife to kill yourself?”)
- Avoid cutting the person's line of thought by asking too many questions
- Take care not to direct the questions too much with interpretation, the person may have difficulty finding what they wanted to say
- Avoid stigmatization and guilt (e.g., “Have you thought about the pain you would cause if you committed suicide?”)
- Avoid questions about suicidal intent (this is not a reliable indicator of risk and it can change very quickly)
- Avoid giving privileges because of the MAAS, or conversely, depriving the person of an activity (this could be perceived as a punishment and hinder the expression of his needs in the future)
- Avoid questioning the person's response (e.g., “Are you sure?”). This can increase the potential for acquiescence and can hinder, rather than help or clarify a problem.

Validation of the request for assistance

This is the first necessary step in any suicide risk management process (assessment and intervention). It is important to always validate the request for help (e.g., “You did well to tell me that you want to talk to me. It is important to say it when things are not going well.”).

Collaboration of the person

The collaboration of the person who had MAAS is important to understand what happened, to clarify the MAAS and the triggers. On the other hand, in some cases the person, once calm has returned and the crisis has dissipated, refuses to go back on what happened and will not easily collaborate in the assessment of danger and risk in the long term.

Multiplying the sources of information is therefore a useful strategy. However, we must remain cautious with the perceptions and analyzes of relatives and stakeholders. Indeed, studies show that parents do not perceive the MAAS of their children in the same way as practitioners do, which may put practitioners at risk of misinterpreting the MAAS they observe.

The analysis of certain components of the suicide risk can be done without the direct collaboration of the person (observation of the person in his environment, collection of information from relatives, caregivers, file, etc.), but others require access to the inner life, behaviours and emotions of the person.

Approaching and establishing the right context is then important for confidence and acceptance to talk about the suicidal episode.

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Feedback or follow-up

It may help to wait until the person is calm and safe to come back to the situation. You can also start the discussion by talking about your perceptions and needs in relation to the situation that arose.

Ex.: "*I know you don't want to talk about what happened (during the crisis). I would like us to see together how you are doing now, what happened that helped you get better. I would also like us to see what we can do so that this does not happen again.*"

Obtain information on the presence of MAAS during the danger assessment

This section provides some options and suggestions for exploring suicidal thoughts with people with ID or ASD. These are options that everyone can adapt according to their needs and the capabilities of the person.

Ask questions to gather information from a user on the presence of suicidal ideation

Asking questions about suicidal behaviour can be scary or uncomfortable. However, it is essential to be clear and precise in this area in order to ensure a good analysis and interventions adapted to the needs and to the level of danger and risk of the person.

1. The user presented direct suicidal communications

In this case, the suicidal elements must be approached in a frank and direct manner, without judgment and without detours, preferably using the same terms as the person, to begin with.

2. The user has not presented any obvious or direct suicidal communications

In this case, explore the distress and the thoughts in order to find ways to address the issue of suicide. When asking questions about suicide, mention that questions like this are asked of all people who are going through difficult situations, to ensure their well-being and their safety.

Reassure the user: when you think of something, it does not mean that you are going to do it.

Exploring the presence of MAAS takes place in continual dialogue.

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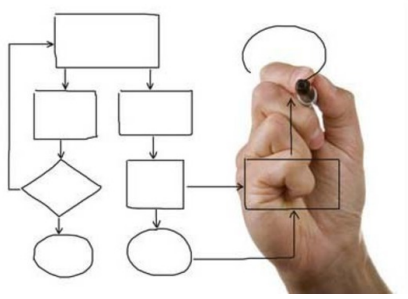
Use of clinical vignettes

As with other subjects and if this means is known to the person, it is possible to construct and use simple vignettes addressing different aspects of MAAS. Some examples are given below.

Presence of suicidal thoughts		
Image  	Text: (Alex) is very frustrated. He/she no longer knows what to do to change that. He/she would like to die to stop being frustrated. He/she thinks of finding a way to kill himself/herself.	Questions: - Do you feel like (Alex)? - What are your thoughts? - Why do you feel like (Alex)? - Why don't you feel the same as (Alex)? - Do you still feel like this?

Suicidal planning	
Image  Text: (Alex) thinks about dying, like you. He/she found a way to kill (or hurt) himself/herself.	Questions: - Have you also thought of a way to kill / hurt yourself, like (Alex)? - And you, how did you think of killing yourself or hurting yourself? - Do you think you're going to die if you do that? - What made you think of that?

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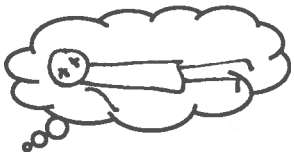
Suicide attempt	
Image  Text: (Alex) is very sad. He/she is so sad that he/she tried to hurt himself/herself, to kill himself/herself.	Questions: - Do you feel like (Alex)? - Did you try to kill yourself or hurt yourself? - How did you do it? - Did you think you were going to die while doing…? - Do you want to do it again? - Why would you do it again?

Use of simple questions with choice of answers

The person can point out what matches how they are feeling and what happened or fill in on their own in writing. Explain that all of the answers are correct and that there is no wrong answer. Some examples are described below.

Exploring of the purpose of the gesture			
When you did (description of the suicidal act), what did you want to happen?			
Did you want to hurt yourself? Did you want to die? Did you want help? Did you want me to know you were sad (or angry)?	Yes	I don't know	No

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Exploring ideations			
Do you sometimes think of being dead? Do you think of being dead right now?	Yes	I don't know	No

Exploring ambivalence			
Are you happy to be alive right now? Are you angry you're alive right now?	Yes	I don't know	No
You tried to kill yourself and you are alive now. How do you feel to be alive?	Happy	Neutral	Sad

Integration of the exploration of MAAS in a non-verbal expression activity

The objective here is to promote the expression of emotions and behaviours in a way that emphasizes the non-verbal, for people who have difficulty expressing their experiences orally.

Examples:

- *"I would like us to discuss what happened, because I want to understand to help you better if you feel bad again like when you did (resume a brief description of the event)"*
- *Sit down with the person and draw a picture*
  - *"It's difficult and if you don't manage it is okay, but can you draw a picture of how you felt when...''*
  - *"Draw what you did when you were angry, sad..."*
  - *"I will draw what I understand you are telling me. You will tell me if I'm wrong."*
  - *"Show me how it goes in your body when you feel bad and you want to die."*
  - *"Show me how you want to hurt yourself or kill yourself."*
  - *"When you put a knife in your room, why was that? What did you want to happen? What did you want to do with this knife?"*

Suggested direct and indirect questions

The IDAS process does not include specific items and questions to ask users since the questions must all be adapted to the person's level of communication. However, we offer some examples in Table 4.

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Table 4 - Examples of questions and formulations for the exploration of suicide risk

	The user presented direct suicidal communications	The user has not presented any obvious or direct suicidal communications
Field of exploration	**Intervention**	
Expression of distress and thoughts	Use gestures, images representing emotions and other pictograms familiar to the user that represent his/her environment to get him/her to express his/her distress, suffering, the things that create discomfort at the moment, his/her wishes, desires.	
Recognition, validation, and acceptance of distress, whatever its form expression (frustration, anger, aggressiveness, crying, sadness, etc.)	- I see you have a lot on your heart. You said (…), you did (…). Usually you do this when things are not going well. Is that correct? It's okay, it has to come out. I'm listening to you.	

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	The user presented direct suicidal communications	The user has not presented any obvious or direct suicidal communications
Search for signs of the presence of suicidal thoughts and exploration of suicidal thoughts	- You told (...) that you wanted (to kill yourself, to die, etc.), does that mean that you are thinking (of suicide, of taking your life? - When you think about dying, what is it like? How is it going in your head? (open question, exploration) - Do you mean that you are thinking of killing yourself? (closed question) - What is it like when you think about dying? What do you think you are doing? Check the planning by telling the story: tell me what it is like when you think about taking your life, what are your ideas? Where did you find these ideas (suicide option)? What else, continue. - When the answer is yes, check the suicidal planning directly.	- Normalization question: It can sometimes happen that people who live [name the difficult situation experienced by the user]. think about killing themselves. Do you think about it? Have you ever thought about it before? - When it feels really bad the way you feel now, you can have all kinds of ideas in your head, I understand that. - Sometimes you may want to hurt when you are angry or in pain. Sometimes we want to hurt ourselves. These are ideas that people can have when things are going too badly. You can tell me about it. - Are you in so much pain that you think about dying? Take your life? (closed question). - When you feel (reflect) do you sometimes think about dying? I see you feel very bad - confused - lost - discouraged - etc. - I would love to know how you feel inside, what ideas you have when you feel like this (exploration of suffering and suicidal thoughts). Do you feel so frustrated - angry - sad - angry - that you want to die - disappear - kill yourself?

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	The user presented direct suicidal communications	The user has not presented any obvious or direct suicidal communications
Validation of elements observed	- I noticed that you do not seem to be having fun (doing this activity) like before, you said life is not worth it, you don't seem to feel good, I would like to check things with you. When you say life is not worth it, what exactly do you mean? Do you mean that you are thinking of dying? Do you mean you're thinking about killing yourself?	- I noticed that you do not seem to be having fun (doing such activity) like before, you don't seem to feel good, I would like to check things with you. It sometimes happens that when things are not going well, people think about dying. You, do you think about it?
Inclusion of the elements of validation of the comprehension of the speech and the behaviour of the person. Using reflection and rephrasing before asking the next question	- You looked very angry and you told (...) that you wanted (kill yourself, die, etc.). Sometimes there are people who say that when things are bad. Are things bad for you? Tell me what's wrong? (...) is that what made you say that (use his/her words, or name what he/she drew). What does this mean to you? (...) Does that mean that you are thinking (about suicide, taking your life), or does it mean something else?	- You looked very angry and you told (...) that you wanted this to stop. Sometimes people say that when things are bad. Are things bad for you? Tell me what's wrong? (...) is that what made you say that (use his/her words, or name what he/she drew). What does this mean to you? (...) Does that mean that you are thinking (about suicide, taking your life), or does it mean something else?
Towards solutions and the action plan: openness to action aimed at working with the person to promote collaboration and begin to reduce his/her distress	- You will see, we will talk about it, think about it, and together, we will find solutions - so that you feel better (when we cannot change the situation) - to improve this situation (when we can change the situation). - What did you think that made your thoughts of dying decrease - increase?	
Post-crisis follow-up (a few hours or days): reassessment of the presence of suicidal thoughts and distress.	- How are your thoughts of dying – suicidal thoughts - compared to the last time? Less strong, stronger, the same (use image of scale, of thermometer)? - What made them decrease /increase?	- How do you feel today? Compared to the other time? Do you remember when I asked you about suicidal thoughts? Have you thought about that or not? - How did you feel when you thought about it? - You have not you thought about it? That's good, (move on to another topic).

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Construction of a social scenario of the development of the user's distress, the situation which brings about suffering.

Social scenarios are tools commonly used with people with ID or ASD. They can also be applied to the exploration of danger and risk of suicide. The social scenario can be written, drawn or illustrated. It can be used to describe with the person the process that led them to think about suicide or to have suicidal behaviours. It also makes it possible to identify the moments in the process when we can intervene to interrupt it. On the other hand, you should avoid drawing or describing the suicidal gesture in the social scenario, and instead use a symbol of the distress of the person or the effects of the suicidal gesture (such as pain, grief) if possible. Another social scenario can describe the intervention and how the suicidal process was interrupted with actions carried out in collaboration with the person.

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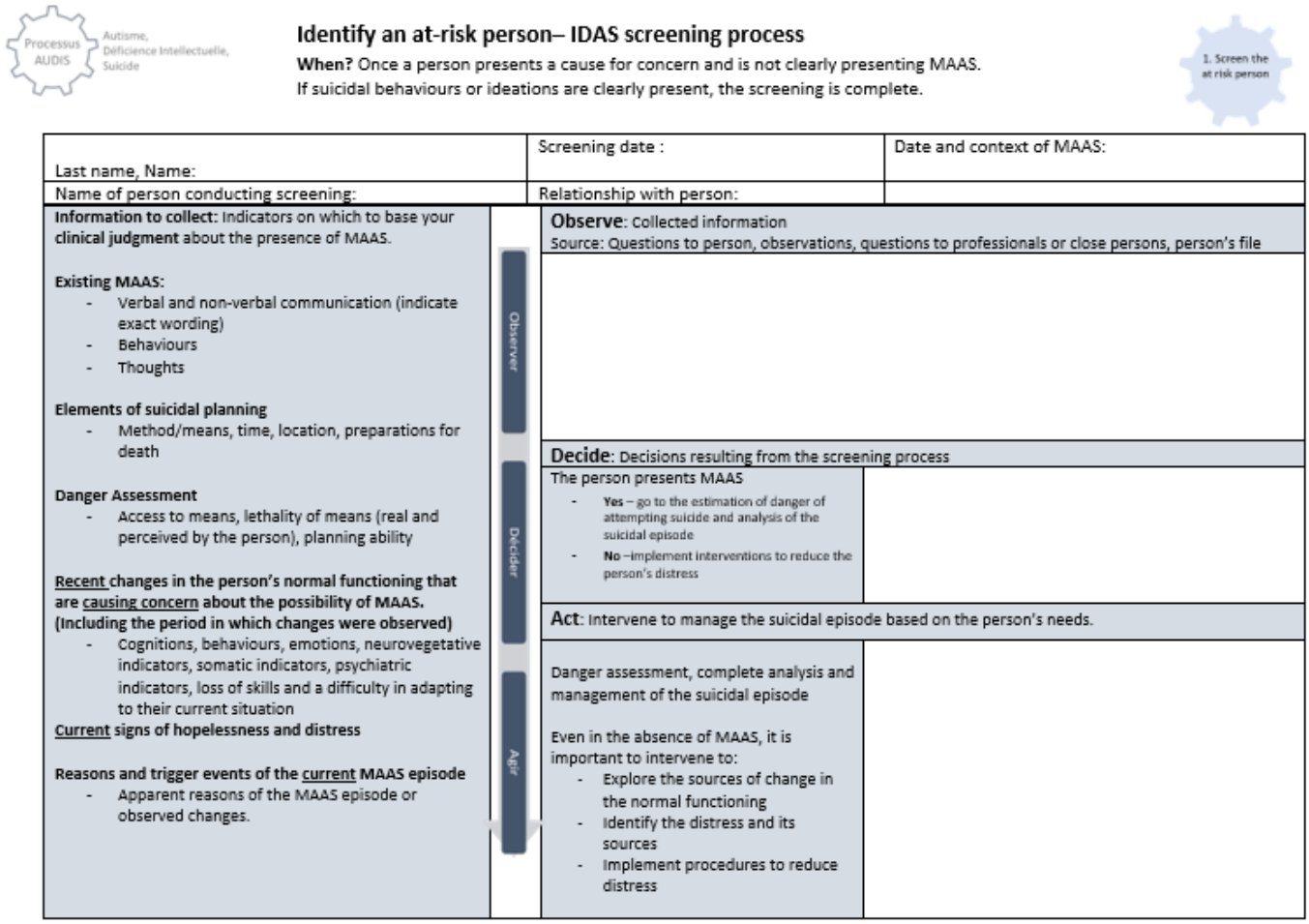
Section 2 – Identifying the person at risk - IDAS Screening Process

The first area of suicide risk management is to identify people at risk through their contact with adults who can help identify distress.

General structure of the screening process

The identification/screening step goes as follows in the Clinical Decision Support Process:



Processus AUDIS — Autisme, Déficience Intellectuelle, Suicide

Identify an at-risk person– IDAS screening process

When? Once a person presents a cause for concern and is not clearly presenting MAAS.
If suicidal behaviours or ideations are clearly present, the screening is complete.

1. Screen the at risk person

Last name, Name:	Screening date :	Date and context of MAAS:
Name of person conducting screening:	Relationship with person:	

Information to collect: Indicators on which to base your **clinical judgment** about the presence of MAAS. **Existing MAAS:** - Verbal and non-verbal communication (indicate exact wording) - Behaviours - Thoughts **Elements of suicidal planning** - Method/means, time, location, preparations for death **Danger Assessment** - Access to means, lethality of means (real and perceived by the person), planning ability **Recent changes in the person's normal functioning that are causing concern about the possibility of MAAS. (Including the period in which changes were observed)** - Cognitions, behaviours, emotions, neurovegetative indicators, somatic indicators, psychiatric indicators, loss of skills and a difficulty in adapting to their current situation **Current signs of hopelessness and distress** **Reasons and trigger events of the current MAAS episode** - Apparent reasons of the MAAS episode or observed changes.	Observer Decider Agir	**Observe**: Collected information Source: Questions to person, observations, questions to professionals or close persons, person's file **Decide**: Decisions resulting from the screening process The person presents MAAS - **Yes** – go to the estimation of danger of attempting suicide and analysis of the suicidal episode - **No** –implement interventions to reduce the person's distress **Act**: Intervene to manage the suicidal episode based on the person's needs. Danger assessment, complete analysis and management of the suicidal episode Even in the absence of MAAS, it is important to intervene to: - Explore the sources of change in the normal functioning - Identify the distress and its sources - Implement procedures to reduce distress

Objectives of screening

The screening process aims to answer the following questions:

- Does the person have suicidal manifestations?
- What should I do to go further in my analysis of the suicide risk and the actions to be taken?

The screening can be done independently or in combination with the assessment. Different people may be in charge of screening and assessing level of danger depending on the context and work environment. For example, people in the living, working or leisure environments can be trained in screening so as to be able to refer users in distress to the professionals with whom they collaborate. At the same time, those trained in the management of the suicidal episode can perform danger assessment in the context of a comprehensive suicide prevention assessment and intervention.

This step identifies the presence of suicidal ideation and danger in the very short term and cannot be used to categorize a person as suicidal or not suicidal in the medium or long term.

In-depth screening is unnecessary when the person clearly and directly says they want to kill themselves or when someone is attempting suicide or has access to a means immediately and indicates that they want to use it. In addition, screening is unnecessary when the person is well at the moment. The screening is not intended to identify past MAAS, but only current ones.

Screening is very useful in less clear situations, when the person uses ambiguous words, makes ambiguous gestures or experiences a rapid change in their usual functioning. It is used to clarify the presence of MAAS before performing a more comprehensive danger assessment process.

A person who, following screening, does not present MAAS may still be in difficulty or in distress. This distress must be explored, understood, recognized and an appropriate intervention must be made.

Observe: Sources of information and indicators of MAAS

Several sources of information can be used to do a screening. The person's behaviour and comments are the main source of relevant information, but it can be supplemented by observations, questions to practitioners or relatives, a reading of the user's file, etc.

The following table offers clues to observe in the person in order to complete the screening process.

Information to collect	Description and instructions
Manifestations associés au suicide (MAAS)	
Types of MAAS	Direct and indirect verbalizations, communications by various means, observed changes in behaviour, preparations for departure, letters, obtaining or finding means, etc. (see details in Table 1). Any type of MAAS should be considered from the outset as posing a suicide risk. When making ambiguous or indirect comments, it is important to clarify them with the person. Describe the words and behaviours in a precise way so that you can reuse the words that the person used during subsequent interventions.
Suicide planning	Even an incomplete planning can remain dangerous. The fact that the planning is not complete does not indicate a lesser danger in people with ID or ASD, contrary to what is observed in the general population. Planning includes having thought of a means (however lethal) and a way to use or implement it.
Danger	Access to the means, lethality of the means, perceived lethality of the means. The inability to plan a suicide or identify a lethal means does not take away the suffering of the person with ID or ASD. An intervention is still necessary. In addition, there is always a risk of underestimating the ability to kill oneself or sustain serious injury.
Recent changes in the following areas	
Cognitions	Confusion, difficulty concentrating, indecision, state of intoxication, perception of a suffered dependency, dissatisfaction / frustration, inability to adapt to a situation, catastrophic thoughts, loss of restricted interests, rigidity or fixations increased on object, person or idea.
Behaviours	Behaviour changes (worse or better), restlessness or prostration, amplification of usual behaviours, increased substance use or compulsive behaviours, isolation, absenteeism, increased or new request for help, attention seeking, aggressive behaviour towards others or objects
Emotions	Changing mood, mood swings, manifestations of sadness, anger, irritability, increased worry about upcoming events, anxiety, increased aggressiveness, dissatisfaction, disappointment, fears or insecurity in a situation, loss of self-esteem, feeling of abandonment, feeling of incompetence, of being in a dead end, mourning the loss or impossibility of having a “normal life”, etc.
Neurovegetative symptoms	Degradation of sleep, appetite, energy level, pain, fatigue, worsening of psychiatric symptoms, loss of interest in restricted interest
Somatic symptoms	Appearance or worsening of physical or digestive disorders, of back pain, headaches, etc.
Psychiatric symptoms	Aggravation or worsening of symptoms
Associated context	
Loss of previously acquired skills	Stagnation or regression, difficulties in adapting to the current situation

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Information to collect	Description and instructions
Despair	Negative speech about the future, discouragement, resignation, self-deprecation, discontinuation of treatment, refusal of follow-up or absences, refusal of the help offered
Apparent reason for MAAS or observed changes	The reason identified may differ depending on the source of the information. This is one of the tools for assessing behavioural function. The actual pattern may not be the one that appears first. It can help to understand the function of the behaviour but is not enough. It complements itself in the exploration of the situation and provides avenues of solutions to defuse the crisis and for the action plan.
This information is not exhaustive. Please write down anything that seems relevant to the situation of the person in distress.	

Decide: Decision resulting from the screening

The person has suicide-related manifestations (MAAS):

- **Yes** – Proceed with danger assessment and the analysis of the suicidal episode
- **No** – Implement interventions to reduce the person's distress

Act: Intervention to be put in place following the screening process

If the person has MAAS, it is important to continue assessing and managing the suicidal episode. However, even in the absence of MAAS, it is important to intervene since the person was showing signs of distress. Interventions then aim to:

- Explore the sources of change in usual functioning
- Identify the sources of distress
- Reduce distress

Section 3 - Managing the Suicidal Episode - Suicide Prevention Plan-Episode (SPP-E)

Once the screening process is completed and it is recognized that the person is experiencing distress with MAAS, a full analysis of the current situation, including an assessment of the danger of attempting suicide, and intervention to manage the suicidal episode can be made. This management of the suicidal episode can be completed by the same person who did the screening if properly trained and equipped, or by a different professional. However, it must be done very quickly after the screening in order to ensure the safety of the person and his or her family and friends, and because the intensity of the distress and of the suicidality can vary very quickly.

General structure of the suicidal episode management process

The process for managing the suicidal episode is based on the structure below:

Processus AUDIS — Autisme, Déficience Intellectuelle, Suicide

Managing the suicidal episode- Suicide prevention plan -Episode (PPS-E)

When? Once a person raises concern regarding a suicidal risk

2. Estimate the danger level

Name, last name :	PPS-E date :
Name of the person managing the suicidal episode:	Relationship with person :

Information to collect: Indicators on which to base your **clinical judgment** about the suicidal episode and risk of an attempt.
Proximal factors that may increase danger or be protective in the current situation

Episode risk factors:

- History of MAAS (which ones? When?), suicidal behaviours or death, by suicide or otherwise, in the environment (less than 1 year), level of impulsivity/aggressiveness, mental health disorders and associated issues (**behavioural disorders**, ADHD, etc..), type and level of ID and ASD, negative interpersonal relationships or isolation, risk-taking behaviours or injury proneness, current state of disorganization, current state of intoxication, hopelessness, exasperation, discouragement (short, mid-term), planning ability (generally and in relation to suicide behaviour)

Episode protective factors:

- Varied options for expression (needs, emotions, frustrations, asking for help), and problem solving, presence of support during predictable or stressful events, reasons for living, ambivalence in relation to suicide, social support

Critical moments/ trigger events related to the current MAAS episode:

- Recurring situation of powerlessness, accumulation of apparently minor events, major predictable events, major unpredictable emotional events

Environmental demands

- Mismatch between the person's current capacities and the environmental demands

Consequences of the MAAS episode on relationships, activities, emotions, cognitions, entourage, etc.

Observer — Décider — Agir

Observe: Collected information
Source: Questions to person, observations, questions to professionals or close persons, person's file

Decide: Decisions resulting from the danger assessment process

- Is there a foreseeable danger of an attempt if the person is left alone?
- Is there a foreseeable danger of an attempt within the next few days?
- Does the person have serious suicidal ideations?
- Could the situation change quickly for the person?

Act: Intervene to manage the suicidal episode based on the person's needs.

Ensure security
Reduce risk of an attempt
Close monitoring
Increase hope
Find solutions to current problems
Take (MAAS) seriously, do not trivialise or minimise

Concluding the process of managing the suicidal episode:
Ensuring that the person understands and feels comfortable with the conclusions reached by the intervention process
Check with the person on how they feel about their suicidal ideations, on the changes made and with the action plan
-The person's ease with the action plan (including the solutions), their willingness and engagement with the action plan, their ability to put the plan into action, help them to put the plan into action (how to help, who will do what? When?), critical moments to monitor in the next hours, days, weeks, status of suicidal ideations and suicide plan
Verify the potential effects of having addressed the subject of MAAS
-Check how the person feels after having talked about their MAAS, explore what was helpful and what made them uncomfortable, support and **intervene with** the person if they are having difficulties with the discussion on suicide, reinforce protective factors, emphasize effective coping strategies, validate help seeking, emphasize strengths and qualities, remind of reasons for living, indicate that you are happy that the person no longer thinks (or less so) of suicide in this moment, that this is positive for them.

Objectives of managing the suicidal episode

As described in Table 5, the objectives are twofold and complementary: to assess and to intervene.

Table 5 - Objectives of suicidal episode management

Assessing the danger of suicide (danger assessment)	Intervening during the suicidal episode
▪ Qualifying the danger of a suicidal act ▪ Identifying the presence/nature/intensity of suicidal ideations ▪ Identifying risk and protective factors ▪ Identifying triggers ▪ Documenting individual and family history of suicidal behaviour ▪ Describing the level of despair ▪ Understanding the person's impulsivity ▪ Understanding what is happening to the person with preconceived ideas ▪ **Directing the intervention (allocating the right servi the right time with the right intensity)**	▪ Ensuring security ▪ Preventing the act ▪ Strengthening hope ▪ Decreasing the risk of future suicidal act ▪ Strengthening protective factors ▪ Reducing risk factors

Observe: Sources of information and indicators for assessing danger during a suicidal episode (danger assessment)

The relative weight of the various factors observed varies according to the level of ID or ASD, the individual's life history, his or her cognitive, social and emotional abilities, and his or her living environment. This relative weight is established by the counsellor making the assessment based on his or her clinical judgement and knowledge of the person's usual functioning. The suicidal episode management process is intended to support the exploration of factors associated with the development of suicidal ideation and danger in order to make an intervention of adequate intensity to ensure the person's safety.

In addition, it is important to take into account that the decision made about the danger is valid in the shorter or longer term, depending on the situation. A danger assessment made at a given time is no longer valid when conditions change for the person, for example, or after an intervention has been put in place.

Beyond the short-term danger of attempting suicide, this stage also allows for an assessment of the form and intensity of suicidal ideation. It is important to understand what may cause suicidal thoughts and to implement appropriate interventions. Suicide

prevention is not limited to preventing the transition to the suicidal act. Reducing suicidal thought and distress must be part of the goals of intervention.

We suggest some clues to observe in order to carry out the danger assessment and the analysis of the suicidal episode.

Information to be collected	Description and instructions
Risk Factors	
▪ History of MAAS (which ones? When?) ▪ Suicidal behaviour or death, by suicide or not, in the entourage (less than 1 year) ▪ Level of impulsivity/aggressiveness ▪ Mental disorders and associated disorders (SBD, ADHD, etc.) ▪ Type and levels of ID and ASD ▪ Negative interpersonal relationships or isolation. ▪ Risk-taking or injuries behaviours. ▪ Current state of disorganization. ▪ Current state of intoxication ▪ Hopelessness, exasperation, discouragement (short, medium term) ▪ Ability to plan (in general and the suicidal gesture)	These risk factors are used to supplement the information gathered during the identification process. They are essential for estimating dangerousness and supplement the information on elements of suicide planning, which are important but insufficient for clinical decision-making, especially since planning is often very vague for people with IDs or ASDs. They make it possible to target the areas of vulnerability to be considered for establishing an action plan, ensuring safety, and for short-, medium-, and long-term follow up
Protective Factors	
▪ Varied options for expression (needs, emotions, frustrations, asking for help), and problem solving. ▪ Presence of support during foreseeable events or events that lead to increased stress. ▪ Reasons for living ▪ Ambivalence about suicide ▪ Social support	Protective factors are levers of intervention. The absence of protective factors increases risk. The absence of certain risk factors can be considered protective, but there must also be positive protective factors, such as the presence of reasons for living clearly identified by the person, the bond of trust, the presence of a responsible person who is aware of suicidal ideation. Protective factors are built into the plan of short-term action.
Triggers and critical moments	
Chronicisation of a situation of powerlessness: increased reactivity to a situation in which the person has an emotional stake, autonomy or self-esteem.	This type of critical moment was identified in the study as being more often present during suicidal episodes in individuals with ID or ASD. They may or may not be present in a particular case. A critical moment observed once in a suicidal episode may not be present during a subsequent episode. Critical moments can be identified and anticipated for prevention purposes. There are other types of critical moments than those mentioned here.
Accumulation of events (even seemingly minor ones): failures in socialization, hindrance to freedom, mourning or loss of objects.	
Foreseeable major events: Changes, annual recurring events.	
Unexpected major emotional events (bereavement, conflict, rejection episode)	

Information to be collected	Description and instructions
Inadequacy between the person's current abilities and the demands of the environment.	Note here the changes in the person's functioning in relation to the demands of the environments he or she frequents: either 1) he or she is no longer able to do things that he or she could do before, or 2) he or she is bored or experiences lower self-esteem because the requirements are too low.
Episode impact	
Impact of the suicidal episode or MAAS on the person's activities, cognitions, environment, loved ones and relationships.	Note here what has changed in the person's life routine or relationships as a result of MAAS, either positively or negatively. From a functional behavioural assessment perspective, the "consequence" component of the ABC sequence is explored here.

Decide: Decision following danger assessment

The analysis of the episode and the assessment of the danger of suicide is based on all the information gathered in steps 1 and 2. It is based on the clinical judgment of the practitioners, taking into account the person's abilities, their level of cooperation to ensure their safety and the abilities of their environment to protect them.

The clinical decision may be based on the following questions:

- Is there a danger that the person will attempt suicide if left alone?
- Is there a danger of suicide attempt in the next few days?
- Does the person have serious suicidal thoughts?
- Can the situation change quickly for the person?

Act: Intervention to be implemented following the assessment to manage the suicidal episode.

Answers to the assessment questions above make it possible to evaluate the person's needs and to decide on an intervention plan whose intensity is adapted to the person's needs and characteristics. The general objectives of intervention at this stage are described in Figure 6.

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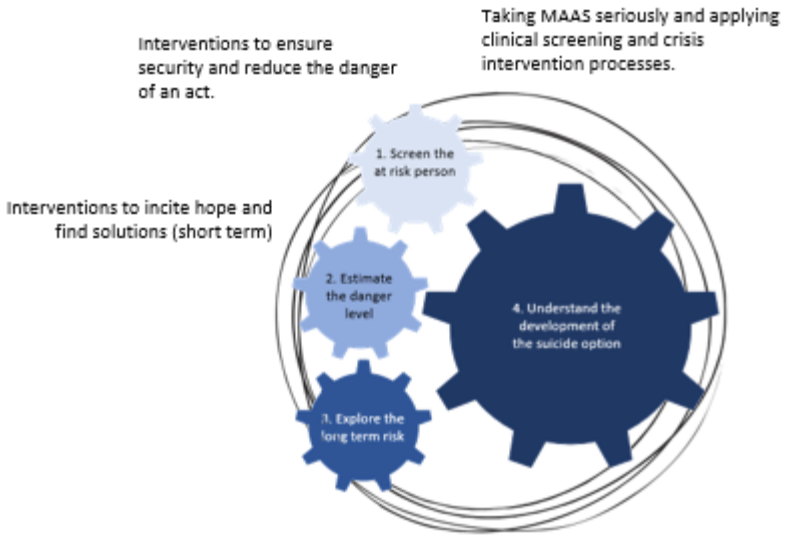

Figure 6 - Intervention objectives for managing the suicidal episode

Concrete tools for intervention are described in section Intervention Tools for Managing the Suicidal Episode.

Adequately conclude the process of managing the suicidal episode

The checklist described below can help adequately conclude the process of managing the episode (assessment and intervention).

- Make sure that the person understands and feels comfortable with the conclusions of the assessment and the action plan put in place. **Check with the person how he or she feels about his or her suicidal thoughts**, the changes that have taken place, the action plan, etc.

- Check: the person's comfort with the action plan (which includes solutions), the person's willingness and mobilization in relation to the action plan (collaboration), the person's ability to implement the action plan, the help to be given to the person to implement the action plan (how to help, who will do what? When?).

- Check: the critical moments to be monitored in the following hours, days, weeks, the status of suicidal ideation and the suicidal plan at the end of the assessment process. The danger of committing suicide should be re-evaluated at the end of the danger assessment process. The danger may have changed

during the encounter and it is important to keep track of this change so that future interventions can be informed.

- Finally, the following should be checked with the person:
  - Verify the potential effects of having addressed issues related to MAAS
  - Check how the person feels about talking about their MAAS.
  - Explore what helped and what may have made the person uncomfortable.
  - Reframe if the person is having difficulty with the suicide discussion.
  - Reinforce protective factors, highlight good coping strategies, validate the request for help, highlight strengths and qualities, remind the person of reasons for living.
  - Indicate that you are happy that the person is no longer (or less) thinking about suicide right now, that it is a good thing for him or her.

Intervention tools for managing the suicidal episode

The following intervention tools can be used as is or adapted according to the person's needs and abilities. They are presented in the order shown in Figure 7. Interventions in black are in the workbook and interventions in grey are generally available in the clinical settings. These intervention tools are suggestions. You can develop new ones according to your needs. However, it is important that each intervention clearly addresses a specific objective that is derived from the episode analysis and danger assessment.

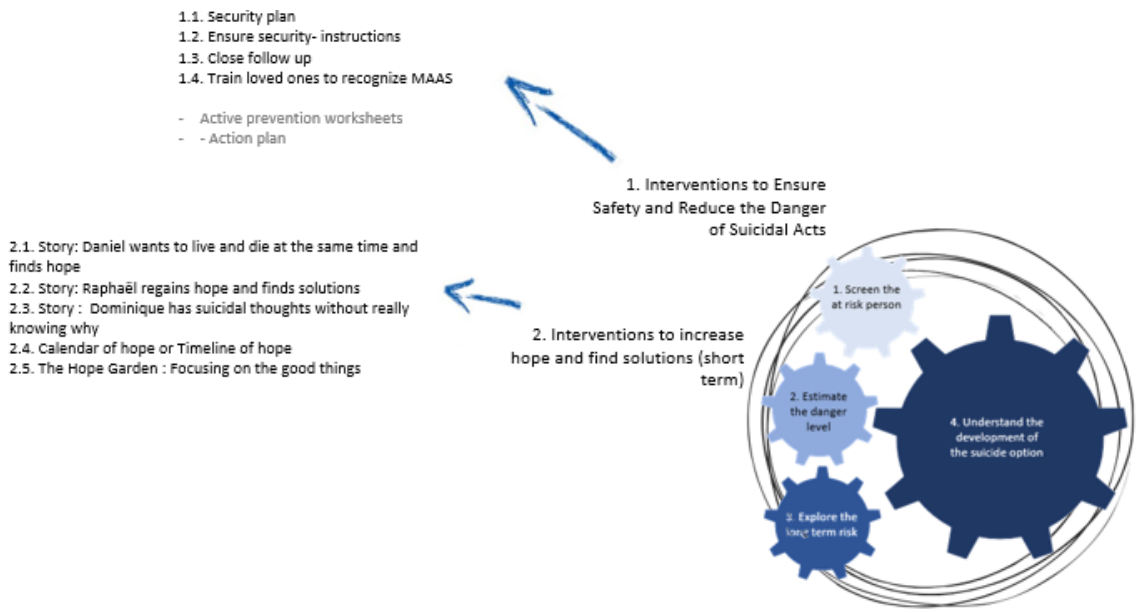

Figure 7 - Suicide Management Intervention

1. Interventions to Ensure Safety and Reduce the Danger of Suicidal Acts

This first series of interventions is used during a suicidal episode or when the person worries his or her loved ones or caregivers, following a screening and danger assessment.

1.1 Safety plan for a person with suicide-related manifestations (MAAS)

Objectives

- To ensure the safety of the person with MAAS to avoid a suicidal act during a suicidal episode;
- Empowering the person to take action and seek appropriate help during episodes of distress in order to reduce the onset of suicidal thoughts or the risk of attempting suicide.

Justifications/rationale

When a person is suicidal (ideas or behaviours), he or she may have difficulty using strategies to reduce tension or ease the crisis. A safety plan allows the person to use strategies that he or she knows will work for him or her to deal with the situation, without immediately resorting to high-intensity intervention. The safety plan can help the person regain control of the crisis process by giving them the opportunity to apply solutions pre-identified with them and within their reach.

A person with ID or ASD may, however, have more difficulty than another person in assessing his or her emotional state. He or she may not know *when* or *how* to use his or her safety plan alone.

The safety plan includes solutions developed in collaboration with the individual. This plan proposes actions that are graduated according to the intensity of support needed to defuse the crisis process. At one end of the continuum are actions that the person can do alone. If these actions are insufficient, we find at the other end of the continuum strategies such as calling on specialized services. The inclusion of this solution graduation strategy is particularly relevant for people who tend to call 9-1-1 immediately when they are in crisis. In a safety plan, the person is encouraged not to use a higher intensity strategy until they have tried the previous level. The goal is to help the person develop a sense of empowerment and confidence in themselves and their personal coping and problem-solving mechanisms, while reducing unnecessary use of emergency services.

The plan is implemented in collaboration with the stakeholders and services usually involved with the person. This plan requires good communication between the different actors involved in order to maintain its optimal use over time. For example, in Lea's plan, she must call her sister before communicating with her counsellor. If Lea has

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not called her sister, the counsellor can encourage her to do so, accompany her while she calls, and then intervene if her sister is not available at that time.

In its most classic form, the security plan is aimed at a relatively autonomous clientele, who may be able to recognize the intensity of a crisis or disorganization. The person can also be guided by the counsellor through the various stages of his or her safety plan. In the case of less autonomous people, each step of the safety plan can be deployed with the support of a counsellor or a relative.

The safety plan falls into the same category of tools as the active prevention sheets. These tools reflect a progression in the intensity of interventions and include a set of actions that the person can do alone in order to regain an acceptable level of well-being. The safety plan is specifically aimed at preventing MAAS, by applying interventions of increasing intensity to reduce the risk of MAAS.

Intervention Process

The security plan is developed with the individual and includes the identification of several components which are:

- The triggers of suicidal episodes and the type of MAAS that the person shows, along with the person's associated emotions and warning signs (e.g., level of agitation, disorganization or confusion).
- The actions the person can take on their own to reduce the effect of the trigger as well as the benefits of using the identified strategies to enhance the person's motivation.
- Actions involving others and the use of outside help (counsellors, family and friends) and key phrases enabling them to understand that the person has suicidal thoughts and needs their help as part of the safety plan.
- The people who will have a role to play in the safety plan. These people should be familiar with the plan and the key phrases that mean the plan is being implemented. They must be equipped to respond to the person and help the person explore the situation for distraction, defusing the crisis or calming down. Everyone's role must be well defined.

Each action identified must be feasible for the individual and clearly planned and described. It can be drawn in a social scenario, written or illustrated with gestures or objects.

It is also possible to include a reminder of what not to do, if the person is able to refer to it. For example, actions that the person has already done that are known to increase the risk of MAAS and reduce the person's ability to feel better can be recorded.

If suicidal episodes are frequent, the plan should be easily accessible, for example by hanging it on the wall or on the person's door.

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It may be important to conduct regular situational exercises with the person to allow them to become familiar with their safety plan and to practice the identified means in order to alleviate suffering.

Illustration of intervention tools

Here is Raphaël's plan (Table 6), an example of a safety plan that a person with an ID or ASD can use alone or with the support of an counsellor.

Table 6 - Raphaël's safety plan

Things that make me think about suicide or make me sad (emotional or behavioural warning indicator that can be linked to a MAAS episode): I'm fighting with someone at school and it makes me unhappy.		
	The actions I can do to stop thinking about suicide and why it is useful for me to do them.	The actions I have to avoid because they still make me think more of suicide.
		
By myself, all alone	• I take three deep breaths and then I do my relaxation exercise. • I draw how I feel. It helps me to feel stronger, to decide for myself. I can be proud of myself.	• Thinking about the fight alone in my room.
Ask my friend for help	I feel miserable. I have been trying to do my relaxation exercises on my own. I still feel unhappy. • I ask my friend for help by saying, “I'm unhappy, can I talk to you to distract myself?” • It makes my friend understand that I need help and he knows how to help me. I feel able to tell my friend what is wrong.	• Being angry because my friend cannot distract me. • Drinking alcohol • Staying alone
Asking for help from my sister who is not next to me. I call her on the phone	I feel miserable. I tried to talk to my friend. It did not work (he was not available because he was busy, or we played but I still feel unhappy). I still feel unhappy. • I ask my sister for help by calling her on the phone and saying: "I'm unhappy, can I talk to you to discuss what's going on?”	• Yelling at my sister • Yelling at the other people around me.

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Asking for help from the counsellor	I feel miserable. I tried to ask my sister for help. It did not work, she did not answer the phone. I still feel unhappy. • I ask the counsellor for help by saying: "I'm unhappy, can I talk to you about what's going on?"	
Asking for help from the crisis centre	I feel miserable. I spoke with my counsellor, but I still feel unhappy. My suicidal thoughts are still there. • I ask for help from the crisis centre by calling (phone number)	
Asking for help from emergency services	I think very hard about killing myself and I tried to do everything in my plan. Nothing works. • I call security with my counsellor or with the crisis centre.	• Calling emergency services alone

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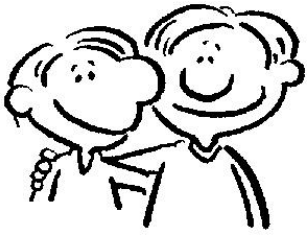
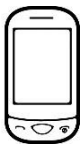
Some actions in the safety plan may be more detailed. For example, the act of asking my friend for help in Raphaël's plan may include a simple procedure written on a card, as shown below:

Peter 	Peter's number: 514-333-2211	Sentence to say to Peter: "I'm unhappy, can I talk to you to distract myself?"

A card of the same type can be used for asking for help from the emergency services:

l'Appoint  The crisis centre I can call	Crisis centre number: 514-333-2211	I call with my counsellor Julie

If possible, it may be worthwhile to arrange a visit to the local crisis centre with the person to show them around and explain what the workers are doing there. The person can be familiarized with the intervention procedures and the questions that are asked by counsellors when a person calls on their services. This will give the person a better understanding of what he or she can expect if he or she seeks help from the crisis centre. This visit can also be an opportunity to explore the various ways of contacting the crisis centre (telephone, text message, chat, e-mail, visit), some of which may be more suitable for the person.

Table 7 describes another example of a safety plan. This is Dominique's plan, which has more significant functional limitations. The safety plan is very simple, schematic and visual.

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Table 7 - Dominique's Safety Plan

I want to leave, I feel sad, I hit myself...	
I'm stopping what I'm doing.	
I give the counsellor my distress token.	

A safety plan can also be developed to prevent a suicidal episode. It can then take a form more similar to a de-escalation sheet in which alarm signals and levels of disorganization are identified, along with the means to be put in place to defuse the agitation or distress.

1.2 Ensuring the safety of a person in danger

Objectives

- Ensuring the immediate physical safety of the person and others.
- Preventing an imminent suicidal act if verbal interventions are not sufficient to reduce the danger (prevent) or managing a person to reduce the effects of a suicide attempt (treat).

Justifications/rationale

This type of intervention should only be done when the life of the person appears to be in danger within a short period of time. Its intensity depends on the level of danger and therefore on the assessment.

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An intervention to ensure safety must be followed by interventions to bring hope, to reduce the risk of recurrence and secondary benefits, and to reduce the suicide option.

There may be a gradation of intensity in interventions to ensure safety. It is important to adapt the intensity of the intervention to the safety needs of the person and not to overreact because of a high level of stress from the practitioners or loved ones. Overreacting could discourage the person to talk about their suicidal ideations and planning and seek help in the future.

The intervention can be based on a good knowledge of the person, his or her usual level of impulsivity, current impulsivity, and the environment's ability to physically control the person.

Removing the means the person has thought of to kill himself or herself is a good strategy for preventing a suicide attempt, since suicidal people often conceptualize a means in their plan. The loss of access to this means provides an opportunity to intervene to reduce distress and risk.

Intervention Process

Removing dangerous objects

The removal of dangerous objects can serve two purposes:

- Preventing a life-threatening gesture in the case where suicidal thoughts are accompanied by sufficiently elaborate planning according to the danger assessment (ex.: the person has hidden a knife in his room and wants to cut himself with it).
- Reduce the risk of a suicidal act when the person presents a high level of danger of acting out, regardless of the actual lethality of the act planned, defuse the tension and open up the space for an intervention focused on reducing the risk of committing suicide, strengthening hope and problem solving (e.g., a person thinks that vitamin pills can be used to commit suicide. It then becomes important to remove them from the immediate environment.)

The mere presence of suicidal ideation without a thorough danger assessment (IDAS-Screening during a suicidal episode) and risk (IDAS-evaluation of suicide risk) is not sufficient to remove objects considered dangerous from the person's environment. The removal of dangerous objects from the person's environment must be done carefully and ideally, in collaboration with the person. It is important to understand what the person considers to be dangerous before removing objects, and not to limit oneself to what practitioners or relatives consider as such.

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The removal of objects considered dangerous can be experienced as punishment by the person with little control over his or her life and may reduce the likelihood that he or she will talk about his or her suicidal ideas and plans in the future. If the reaction of family members or caregivers seems "excessive" (disproportionate to the perceived danger to the person), the removal of dangerous objects may be counterproductive and should not be a systematic intervention.

Withdrawal of the means (regardless of the level of lethality) contemplated or used by the person must be immediate and accompanied by an explanation that the person is important, that we are worried about them, that we do not want them to get hurt, that we want to be able to take the time we need to talk, to find solutions to problems and ways that would make the person feel better. A practitioner might say, “My job is to do everything I can to keep you safe and removing dangerous objects is part of that.” Or: "I will gladly return (the object in question) to you as soon as you feel better. I just want to make sure you are safe now.”

The removal of dangerous or potentially dangerous objects that are not related to an ongoing or planned suicide attempt should not be carried out without a prior danger assessment and exploration of the means envisaged by the person. If the objects have not been identified during the assessment, removing them poses the risk of giving the idea of a more dangerous means of suicide. For example, if a person says that he or she is thinking about killing himself or herself and caregivers remove his or her shoelaces, robe belt and trouser belt, he or she may identify strangulation as a good way to kill himself or herself.

Returning objects that have been removed from the person because of concern about the danger of committing suicide should not be done before a follow-up assessment of the danger. Returning objects should be presented and experienced as a clinical success. The person has managed to get through the difficult time and this should be primarily an opportunity to recall what has been put in place to help the person to no longer feel suicidal, to remind them of the available resources they can use and to review the actions they need to take to seek help.

When a person refuses to give an object that is considered dangerous by practitioners **and** presents a high level of immediate or imminent danger based on the danger assessment, the situation can quickly become complex. It is important here to be familiar with the person, the way he or she disorganizes, his or her triggers, warning signs and calming elements. Calling the paramedics may be the most appropriate option. On the other hand, an approach using the basic principles of Dialectical Behavioural Therapy can help defuse the dangerous situation:

- **Validation**: this consists in welcoming the person without judgment; it is necessary to reflect and recognize the fact that the person's behaviour, feelings and thoughts are perfectly logical and normal under the circumstances.

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- **Orientation**: this consists in describing what we understand about the person's situation, what we would like to do and why we think it could help, in clear terms that respect his or her autonomy.
- **Commitment**: this consists in engaging with the person in an action aimed at improving the situation and forming part of the plan developed from the orientation phase.

Here is an example that uses these basic principles. Jo is locked in his room with a belt that the counsellor tried to take off earlier when he said he wanted to kill himself. He refuses to come out and talk, but the practitioner hears him walking back and forth and he is agitated. The practitioner may begin by taking a few deep breaths herself to take time to refocus, calm down for a moment, regain control over her voice and her own emotions. She can then talk to Jo to validate what he is experiencing by saying:

> "Jo, I can see you're angry and unhappy. You've tried a lot of different ways to solve the problem and it didn't work. It's okay to be angry. It's okay. I understand that."

She can then give a guidance to her words, saying, for example:

> "I understand you had a fight with your mother and you're sad. You want to stop fighting with her. We can talk about it together if you want, later. Also, you want us to leave you alone in your room, because you're angry and sad. I agree with you. I want to leave you alone, but I want you to be safe, because it's important that you are safe. So I suggest we open your door. I'm not going in, you're not going out, but we just leave the door open so I can make sure you are safe. I won't take your belt and you open the door."

The counsellor may subsequently seek Jo's commitment. It could be expressed as follows:

> "What do you think, shall we do this? I'm doing my part and you're doing yours?"

The important thing is always to validate the source of distress and the person's reaction by giving them an authentic message that they are considered a person in their own right. He or she only reacted as best he or she could, with the means available to him or her, in the situation in which he or she was at the time.

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Physical intervention to block a gesture

Physical interventions to prevent a suicidal act are the same as those to prevent self-harm or violence towards others. They must be applied only when the person represents an imminent or immediate physical danger to himself or herself or to others. These interventions must be used in accordance with guidelines developed by the community and must be carried out in a manner that respects the dignity, rights and safety of each person.

They should not be trivialized either. An intervention to ensure safety in a suicidal context does not have the same objective as the same intervention aimed at eliminating undesirable behaviour. It cannot be experienced as a punishment. In fact, physical control must be explained as an intervention aimed at ensuring the safety of the person and it must be a step in the intervention aimed at reducing the danger of acting out, arousing hope and finding solutions to distress.

Transport to hospital

Transportation to hospital should always be a last resort in a suicide prevention intervention. Indeed, this type of intervention has potentially significant consequences for the individual, his or her entourage and the intervention structure:

- Stigma due to being taken away in an ambulance;
- Withdrawal from the usual living environment and confrontation with a potentially anxiety-provoking environment;
- Obtaining a secondary benefit.

The danger varies very quickly in a person. This means that by the time the person arrives at the emergency room and sees a doctor, the danger may have become minimal . It is therefore important that the intervention does not rely solely on transport to hospital and psychiatric intervention in the emergency department.

If the person calls 911 themselves, without consulting family or caregivers, a danger assessment must be made before letting them leave by ambulance (obviously, if they have not already made a life-threatening attempt). However, it may be difficult to reconcile the perspective of the practitioners who regularly work with the person and that of the emergency services responders. Indeed, while the former have knowledge of the person's functioning and usual mode of disorganization,, emergency responders judge the situation based on what they observe when they arrive on the scene. For instance, the person may make comments (including suicide planning) that could be considered worrisome for a practitioner who does not know the person, whereas these comments could be part of a known method of avoiding a constraint.

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After a visit to the emergency department and once the sources of distress are known and understood, an intervention can be planned with the person in order to minimize the possible secondary benefits from hospitalization, while also demonstrating to the person that MAAS are taken seriously. If there are secondary benefits from hospitalization, it is also possible to work with hospital staff to identify and understand the nature of these benefits. Involving hospital staff members in this analysis also helps to make them aware of the dynamics surrounding emergency room visits and the risk of developing a pattern of functioning that is harmful to the person in the long term.

It is important to validate the distress experienced by the person by acknowledging and normalizing their emotions. Ex.: "I understand that you don't feel well. This is okay. We'll take care of it and we'll take care of you". However, in the case where a person uses MAAS to negotiate a benefit, it is also crucial to carefully analyze why this person uses MAAS rather than another behavior. This way, we can help the person use emergency and hospital services more appropriately and not for the secondary benefits they might gain.

The post-suicidal episode follow-up tools described in the IDAS-Screening Process or the tools applied during the return to calm in situations encountered in other contexts may be useful for planning the return to the usual living environment after a visit to the emergency department. This return should include discussions about what happened. The person should be encouraged to talk about his or her emotions, thoughts and behaviours. He or she may also have questions about what happened in the hospital. Specific barriers that may have prevented the person from implementing the safety plan that was developed with them should be explored, as well as solutions and ways to do this that could be used next time. If necessary, the person can be encouraged to discuss this again with the navigator.

1.3 Close monitoring after a suicidal episode: Assessing the danger of committing suicide in the hours and days following the initial suicidal episode.

Objectives

The main objective of this intervention is to verify the persistence or disappearance of MAAS after an initial suicidal episode. This close monitoring differs from post-episode follow-ups aimed at adjusting the action plan.

Justifications/rationale

A person who has engaged in suicidal behaviour may present a high level of danger of suicide. Close monitoring allows the evolution of MAAS to be checked over a few hours / days in order to adjust the intensity of protective measures. Close

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monitoring is only done with individuals who present a high level of danger and with whom security measures have been put in place.

Intervention Process

The practitioner can use the Close Monitoring Grid below to track MAAS and assess the danger for a few hours, days or weeks after the initial suicidal episode.

The degree of danger can vary rapidly over time and the level and intensity of safety intervention must be adjusted to the level of danger. These regular assessments cease when the multidisciplinary team concludes that the person no longer presents a high degree of danger of a suicidal act. Relatives or community workers may be trained to identify warning signs specific to the person in order to monitor changes in danger following a high-risk suicidal episode.

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Close Monitoring Grid

Follow-up with:_____During the period: _____Rhythm of observations:_____

Elements for assessing the degree of danger of a suicidal act during close monitoring	Period 1	Period 2	…	
Types of MAAS present and change observed				
Elements of suicidal planning present and changes observed: means, time, place				
Danger: Access to the mean, lethality of the mean, planning ability				
Proximal risk factors that may increase danger				
Mood (type) E.g.: sad, agitated, anxious, happy, withdrawn...				
Mood stability improvement ↗, Stable→, worsening ↘ The mood variations noted here are global. It is impossible to know if they are directly related to MAAS or not. The goal here is to know to what extent the person regains their usual mood, whatever this usual level is				
Good times and more difficult times during the observation period				
Critical moments identified				
Protective factors				
Adjustment of the safety plan				

1.4 Train family and friends to identify MAAS.

Training people in the entourage of people with ID or ASD to identify suicidal behaviours is an interesting strategy. Indeed, suicidal and suicide-related behaviours occur in people's usual living environments and these environments often feel very helpless to deal with them.

Identification training can be based on the tools used in the screening stage. It allows family members and friends to feel equipped to observe, identify and intervene in the event of suicide-related manifestations (MAAS).

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Relatives or friends carrying out a screening can take the first steps to ensure the person's safety, apply a safety plan or contact the person's counsellors, depending on their needs. They can also effectively transmit information about suicidal episodes to caregivers, who can then base their clinical judgment on better information.

2. Interventions to foster hope and find solutions

From a suicide prevention perspective, it is essential to foster hope and find solutions. Interventions that target these objectives are put in place once the danger of committing suicide is no longer as great and imminent for the person. If there is no short-term danger of acting out, or if the screening has not revealed the presence of MAAS in the individual, this type of intervention should be implemented immediately after the screening and danger assessment. Five interventions aimed at increasing hope are presented in this section.

General Instructions for Story-based Interventions

Purpose of using narratives and interventions based on a social scenario structure

The general objective of the stories is to provide support for explanations, psychoeducation or intervention. The stories explain different aspects of the suicidal process and intervention. They describe cognitive and affective processes often observed in individuals with ID or ASD, as well as assessment and intervention strategies that can be applied by practitioners.

Explanation/rationale for the use of this approach

The stories use appropriate vocabulary for people with ID or ASD who are verbal. They are particularly suitable for people with basic knowledge of emotions since they describe emotions. A certain amount of introspection is also necessary since these stories serve as a vehicle to explore the person's own emotions. In the danger assessment process and in the intervention, it is important to use clear, exact and unambiguous terms that everyone agrees on the meaning of. Talking about suicide in a clinical context does not increase a person's risk of suicide, especially if certain principles are followed.

The stories are based on social scenarios and are intended to support the practitioner in explaining, assessing, intervening and discussing with the client. The left-hand column presents the dialogue between a user and a practitioner, and the sequence of the exchanges is indicated by numbering. The right-hand column describes the narrative of the situation and its issues. A specific guide accompanies each story to define its objectives and process.

General intervention Process with stories

It is important to read the story with the client in a calm situation. This tool cannot be used in a crisis situation or when the person is agitated. It is also necessary to contextualize the use of the story (e.g., the person witnessed a suicidal act in his or her living environment) and the objective (e.g., "It is important to explain

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what happened, I feel that you are wondering"), while indicating the time reserved for the activity (approximately 15 minutes, if the person expresses himself or herself a lot).

A story is a medium for exchange. It can be adapted to the situation, the needs of the person and the objectives of the intervention. It can be used in a variety of ways. The counsellor can choose to tell what is happening and describe the expressions and emotions of the characters, without necessarily reading the dialogue or the narration. The person can also read the story alone, do a written communication exercise related to the questions asked by the counsellor in the story, draw a picture of how he or she feels, or describe how close he or she feels to the character.

At each step, following the specific instructions for each story, it is important to take every opportunity to question the person about their experience, for example, by asking how similar or different they are from the character, or by asking them about what others have said or done, related to their experience or that of others. Finally, it is important to construct the intervention, whether in written form, orally, or with the help of drawings and symbols. It should be noted that the stories all use the same symbols and images to address concepts related to suicide.

If a person does not have the ability to identify, understand and recognize emotions, adaptations can be made with more schematic scenarios and simpler emotions, depending on the need for intervention.

Answer directing questions about suicide, what it means to commit suicide and how to commit suicide. It is normal for people to be curious and not answering questions can hinder the understanding of the process and potentially increase the danger.

It is also important for people to know the right terms for expressing their suicidal thoughts in order to be understood and helped appropriately.

For each story, the specific clinical accompaniment process is described in the intervention booklet.

2.1 Story: Daniel wants to live and wants to kill himself at the same time and finds hope again.

It may be necessary to discuss the topic of ambivalence, especially with people with rigid cognitions. These people may tend to believe that once you want to die, there can be no change. Ambivalence is a theme that can be used to discuss the reasons for living with people who have suicidal thoughts in order to reinforce the part that wants to live.

Ambivalence is always present in the phases preceding the act and is the main intervention tool used. The story also provides an explanation of ambivalence, in simple and concrete terms, in order to support the counsellors who would have to make the suicidal person understand this concept.

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Boxes 1 and 2 describe the situation that led Daniel to have suicidal thoughts and ambivalence. The aim of the intervention here is to identify the triggering factors for MAAS and the proximal reasons for living (thus identifying the ambivalence).

Box 3 illustrates the process of validating communication and the relevance of asking questions when we feel confused or disturbed by events or our thoughts.

Boxes 4 to 9 provide explanations of the different forms ambivalence can take. The intervention aims to identify with the person the ways in which he or she feels confused about his or her MAAS. It also aims to recognize the desires to live and die, their alternation or their simultaneous presence. The intervention helps normalize ambivalence.

Boxes 10 and 11 illustrate how the reasons for living can be explored and how they can be used to increase hope. Reasons for living are used to counterbalance suicidal ideation. The intervention allows the person to discuss his or her own reasons for living, the strategy being to help the person remember them in the event of MAAS. The goal is not to deny suicidal ideation or distress, but to remind the person that life is worth living, by reminding them of their own reasons for living. The intervention must also address the sources of distress in order to reduce the risk of recurrence.

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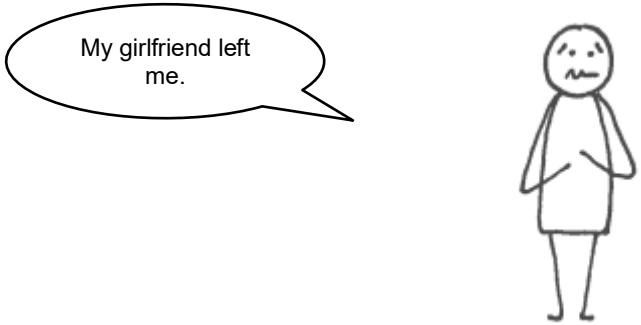
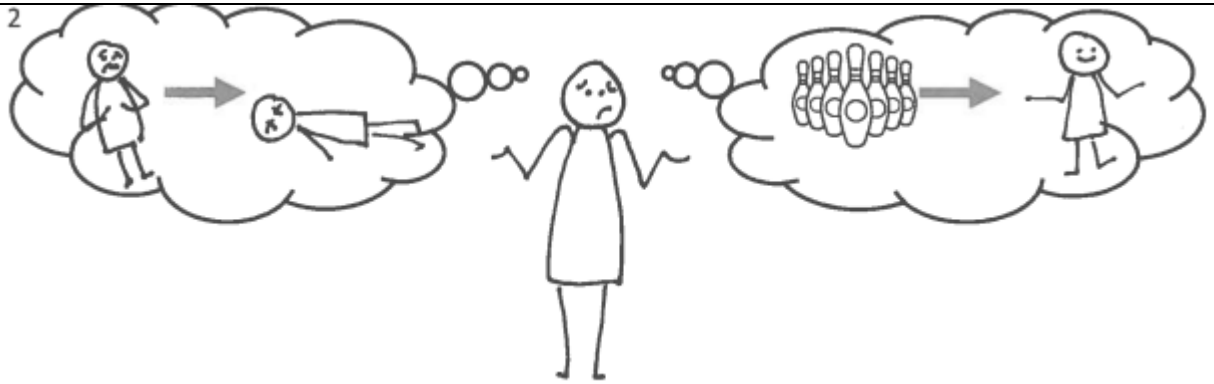
Daniel wants to live and wants to kill himself at the same time and finds hope again.

1 	Daniel had a girlfriend. She doesn't want to talk to him anymore. Daniel is sad.
2 	Daniel feels confused. He thinks about killing himself because he is sad that his girlfriend doesn't talk to him anymore. He also thinks that he wants to go bowling tomorrow. He likes bowling with his friends.

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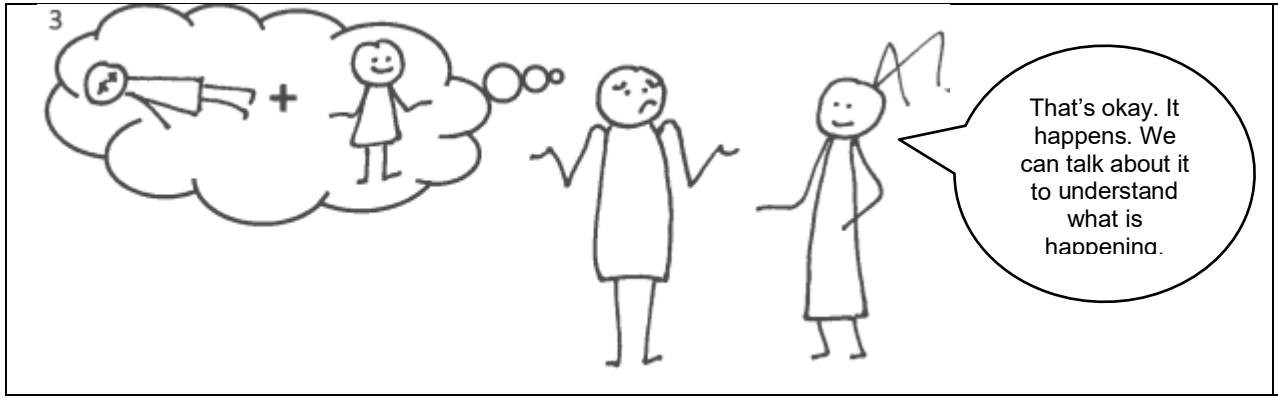
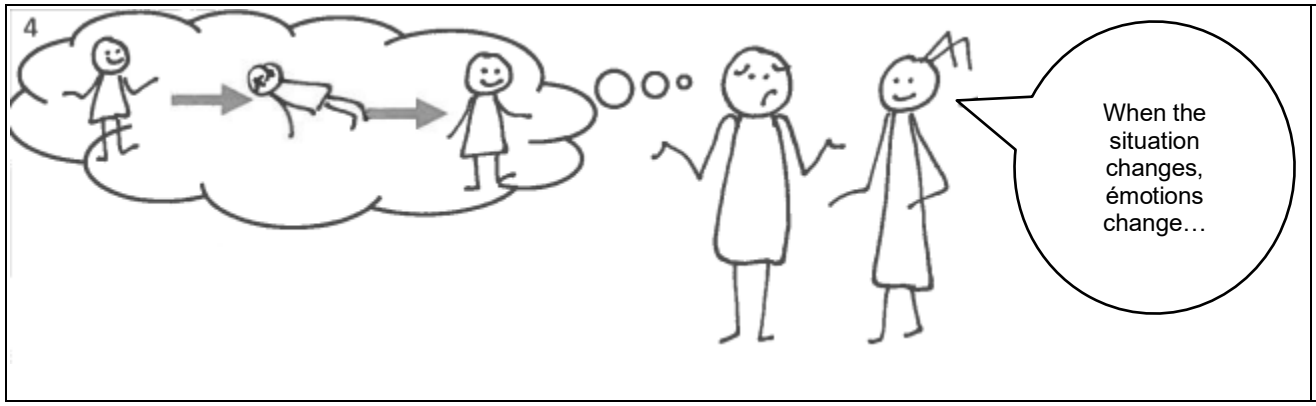


Sometimes, Daniel wants to live and die at the same time. His counselor explains that it's normal to feel like this.

Feeling like this can happen to anyone.



Sometimes Daniel wants to live and later, he wants to die, and after that he wants to live again.

His counselor explains that this can sometimes happen, it's okay.

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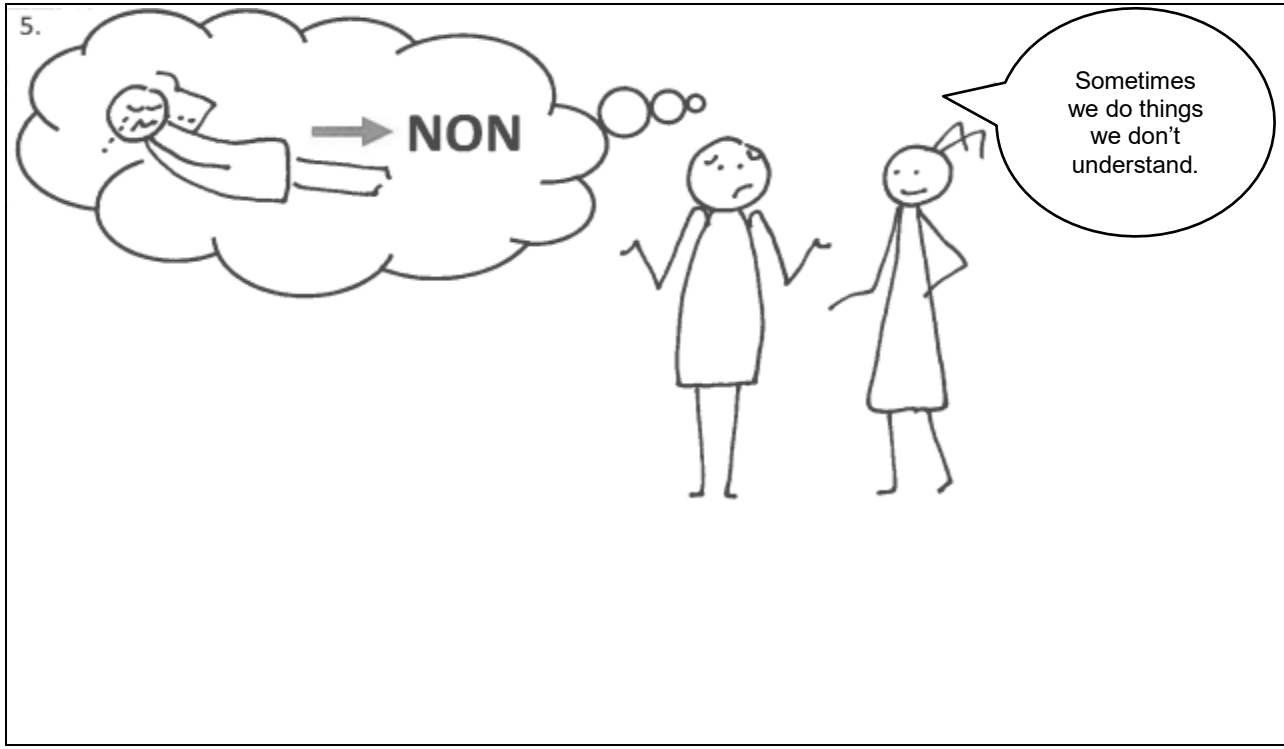

One time, Daniel tried to kill himself.

But right after, he said that he didn't want to die. He didn't know why he tried to kill himself.

His counselor explained that this happens sometimes. Sometimes we do things without thinking because we feel bad. When we feel better, we don't want to do those things anymore.

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6		His counselor reminds Daniel that there are days where we want to live and where everything goes well.
7		There can be days where things go wrong. We don't think about the people we love or what makes us happy anymore. On those days, sometimes people can feel like Daniel did and want to die.

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8 	Daniel feels a storm of emotions that are scrambled in his head, that change the way he sees situations. He feels very confused.

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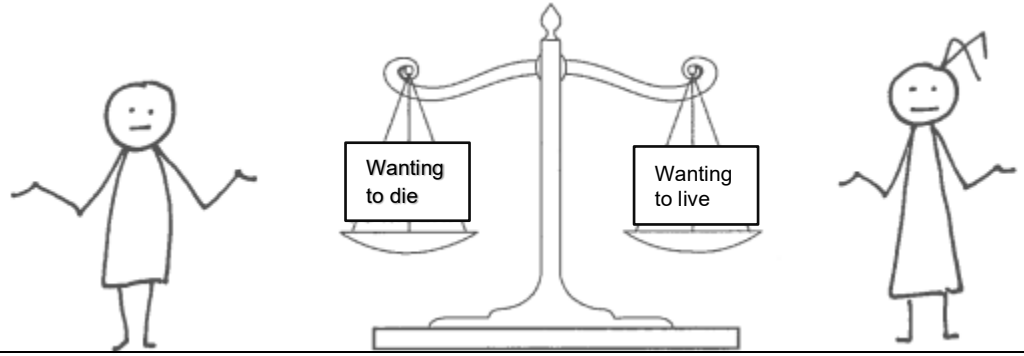
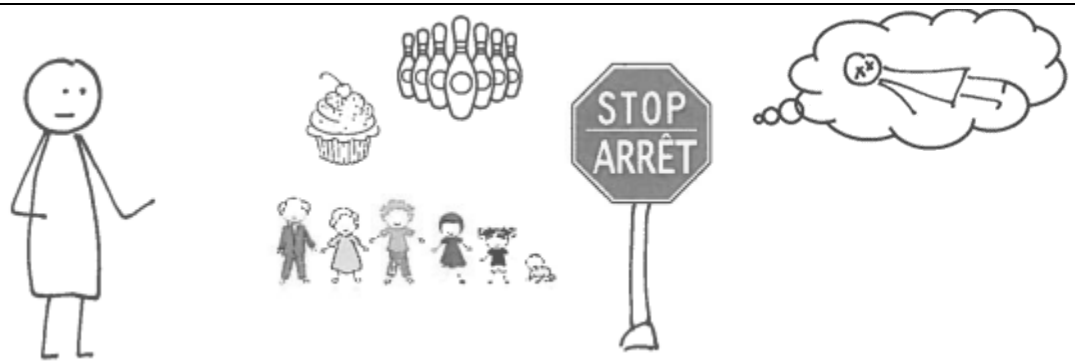
9 	It's okay to feel confused when we want to die. It's okay to feel confused when we want to live and die at the same time.
10 	When Daniel feels like this, he can try thinking of reasons for living. Daniel's counsellor helps Daniel remember his reasons for living. This helps Daniel feel better.
11 	Daniel knows it's possible to want to live and die at the same time. The urge to want to die may come back, but Daniel can fight it with his will to live.

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2.2 Story: Raphaël regains hope and finds solutions

In an ID-ASD context, solution-oriented interventions are used to discuss problematic situations that the person is living in the current moment. It is also used to defuse crises. It allows to reinforce hope and strengthen the person's empowerment regarding the situation and the envisioned solutions in order to improve the situation.

Of course, this intervention cannot guarantee the resolution of all problems. The objectives should be realistic in relation to the situation and the person's skills in the context of the current crisis.

Boxes 1 to 3 present the situation (risk factors, trigger events, despair, emotions, suicidal statements). The intervention aims to help the person describe their own situation and verbalize their ideations in their own terms. In the context of a discussion between the person and the practitioner, the practitioner might say: "Raphaël says "I'm going to kill myself!", and before, you said "xxx". What other words do you use to talk about your suicidal thoughts? Did you mean the same thing as Raphaël?" Another example that could be used by the practitioner is the following: "Raphaël is sad and frustrated. How do you feel when you want to kill yourself? Before, when you said it, how did you feel?" The practitioner can also suggest drawing their own emotions next to the ones described by Raphaël's character.

Boxes 4 to 6 explore the current problematic situation. The objective is to identify and name the suicidal episode's trigger events with the person and to validate their emotions. For example, the professional could say "Raphaël is not doing well because he had a fight with his friend. Is it the same for you? What things make it so that you don't feel good?"

Boxes 7 to 10 bring light to Raphaël's reasons for living, allowing him to reconnect with hope and reduce distress. This exercise also reminds Raphaël of how he feels when things are better, allowing him to project himself into a future situation where he will actually feel better.

Boxes 11 to 14 illustrate the search for solutions in order to improve the problematic situation. Prospective solutions should use the person's strengths and skills, serving as a reminder. The professional can also make suggestions and accompany the person in the implementation of these solutions.

Boxes 15 to 17 show the importance of looking back on the emotions and recognizing the observed improvement, when positive changes occur. It also brings forward the importance of encouraging the person to use the developed strategies. The close monitoring is also part of the discussed themes.

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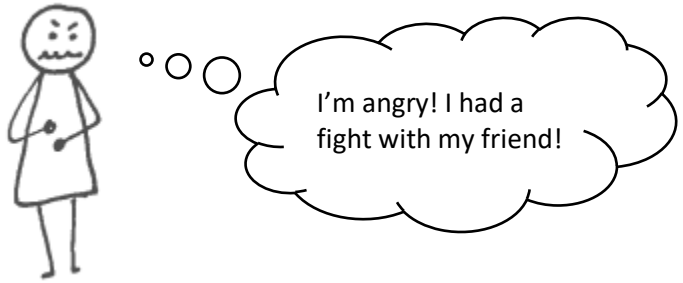
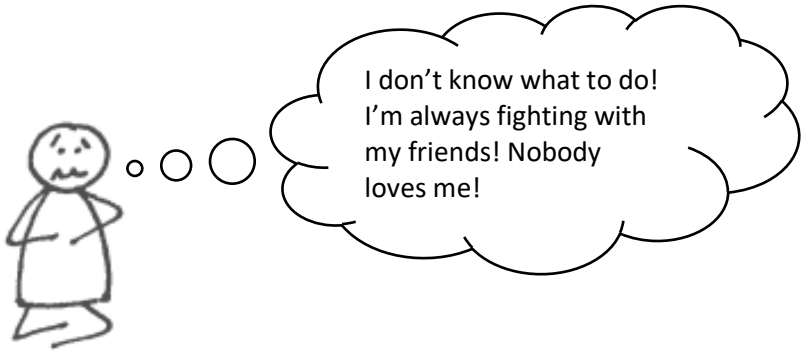
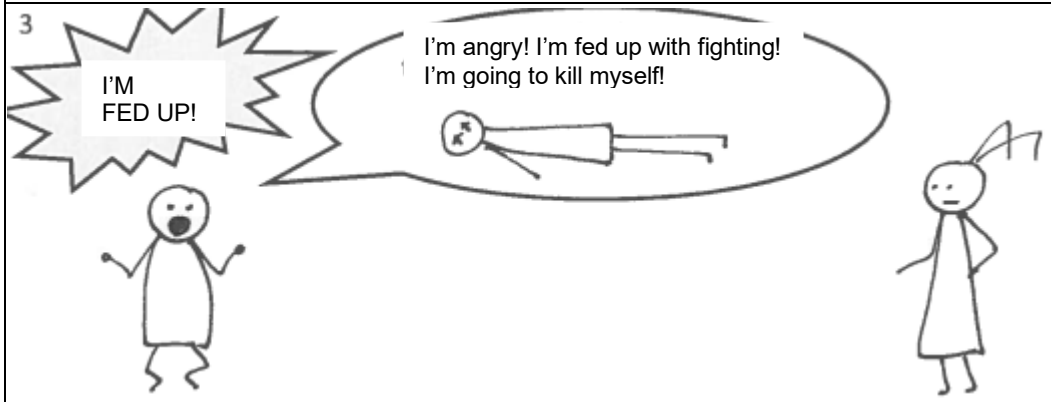
Raphaël regains hope and finds solutions.

1 	Raphaël is frustrated. Too many things are going wrong for him right now.
2 	Raphaël is unhappy. He doesn't know what to do to feel better. He thinks it will always be like this.
3 	Raphaël speaks with his counselor. He tells her that he's angry, unhappy and that he wants to kill himself.

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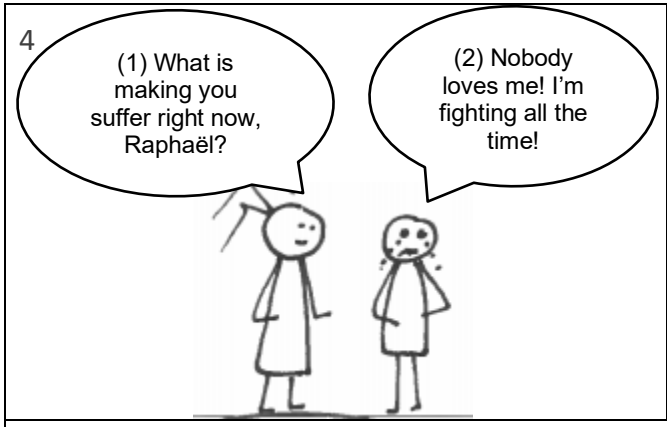
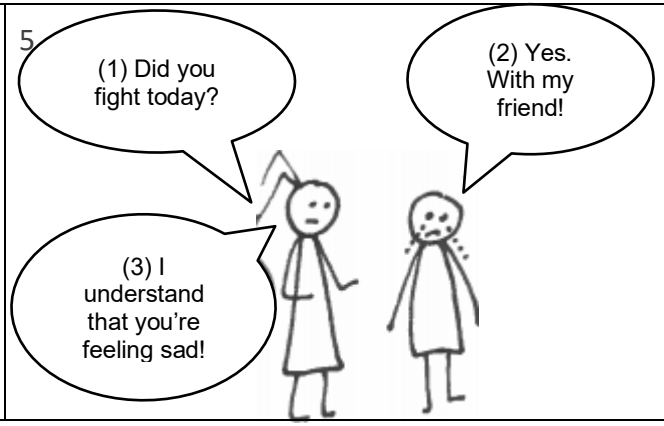
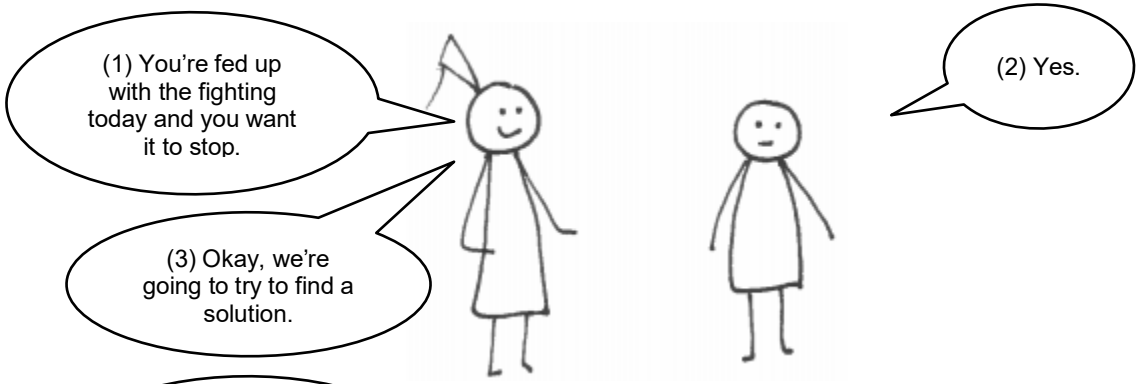
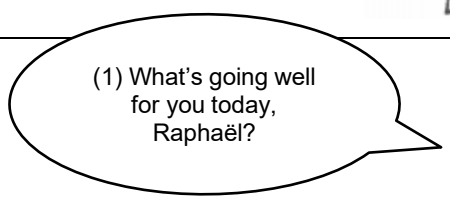
4 	5 	The counselor is happy Raphaël is talking to her. She asks him questions to understand what's wrong.
6 		The counselor wants to help Raphaël feel better. They find out that what is making Raphaël unhappy today, what is making him think about dying. It's important to feel better.



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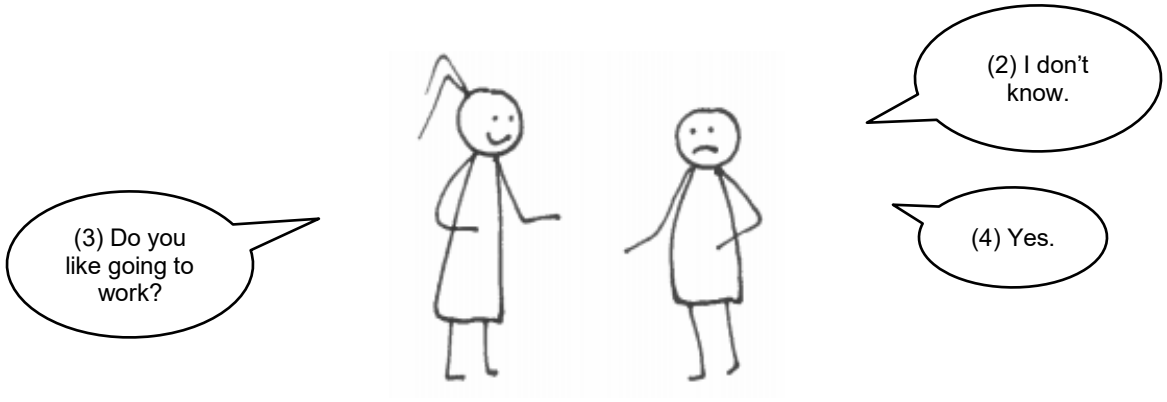
7 	There are also things in Raphaël's life that are going well, so it's worthwhile to keep living. The counselor asks Raphaël questions to understand what is going well.

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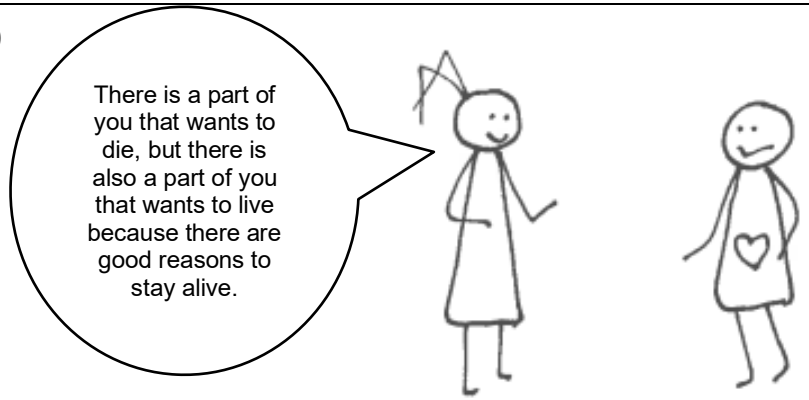
8 	It's important to also concentrate on the things that are going well right now. They help us feel better and live.
9 	Also, when we think about all the things that are going well, it makes us want to find solutions to make our heart happy.
10 	Raphaël and his counselor remember the reasons that make Raphaël want to live. Raphaël regains the will to live. He regains hope.

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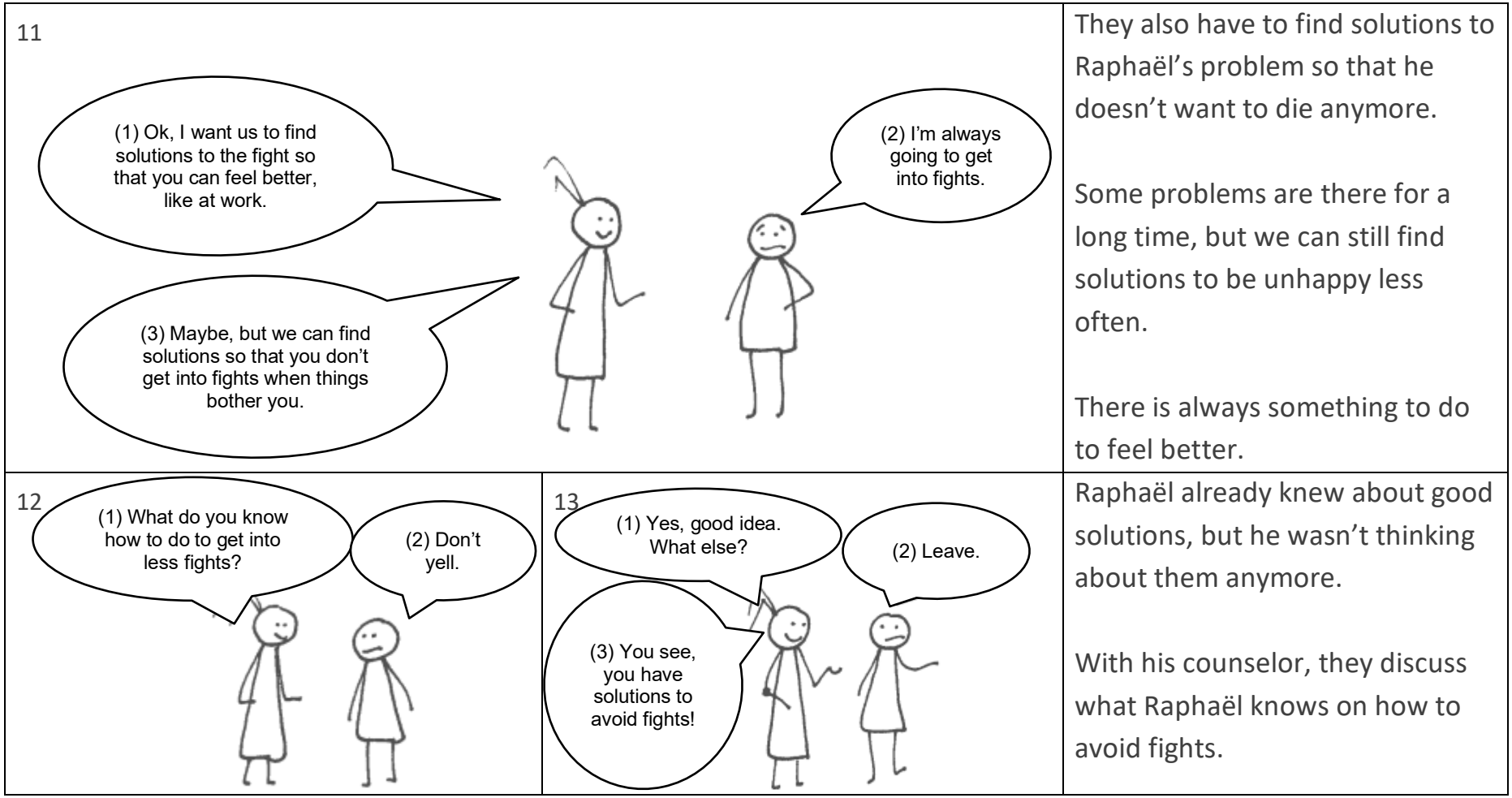

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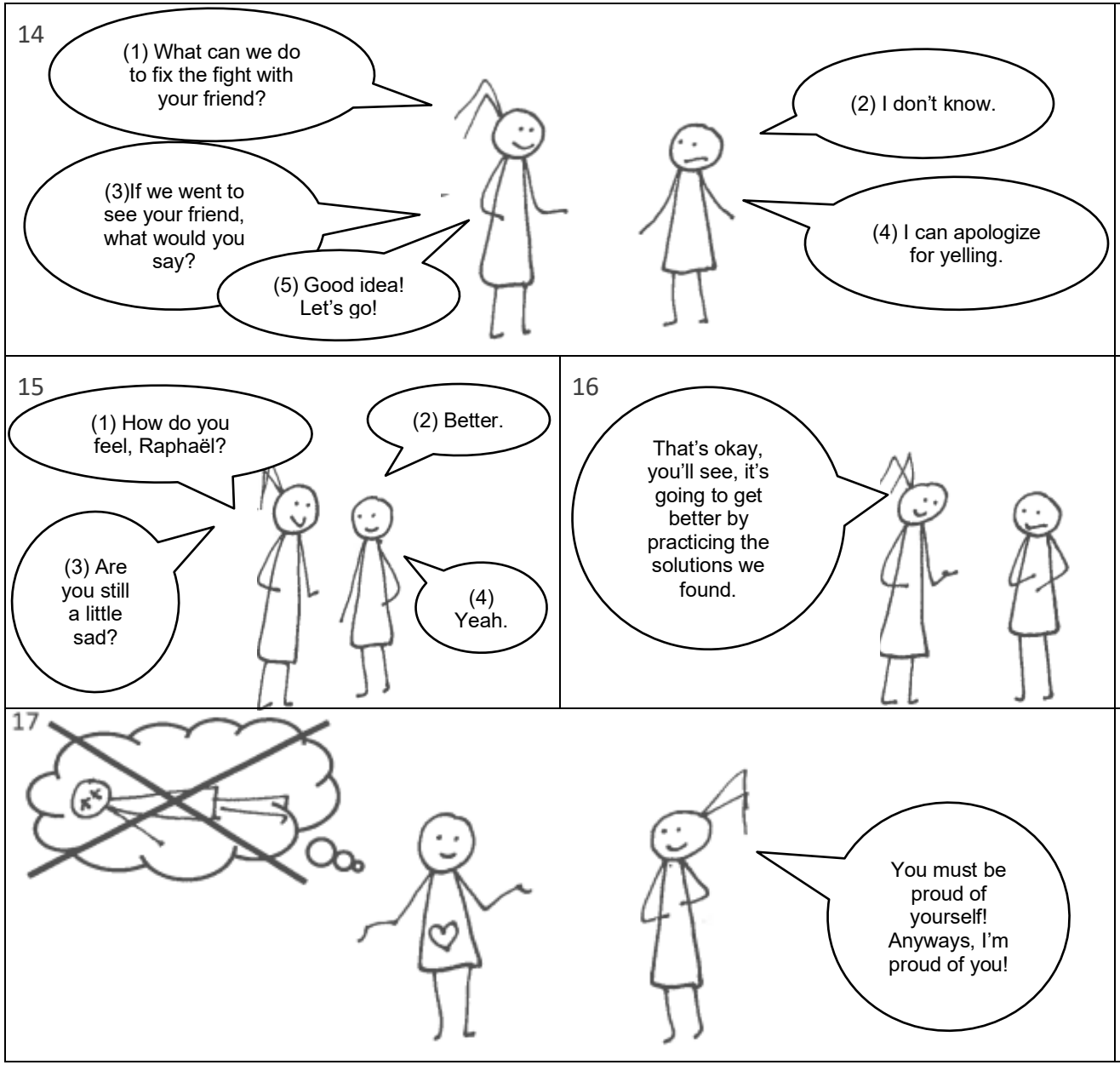

With his counselor, Raphaël finds new solutions to the problem.

Raphaël is doing a little bit better. He knows there will sometimes be harder moments, but that he will be better afterwards.

Raphaël continues using the solutions until he feels better. He doesn't want to die anymore.

He smiles again. He feels proud.

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2.3 Story: Dominique has suicidal thoughts without really knowing why

This story aims to develop an intervention strategy for a person with whom we cannot identify a trigger event. Sometimes, suicidal ideations arise from a diffused feeling of unease that is difficult to identify clearly. In this case, the solution-oriented approach does not aim to find ways of managing a problem or event, but instead to identify and reduce the feeling of unease by attempting to affect their general mood in a positive way.

This intervention obviously cannot guarantee the resolution of every problem. The objectives should be realistic based on the situation and the person's skills in the context of the current crisis.

Boxes 1 to 3 present the situation in which Dominique thinks of suicide with no apparent reason. The intervention here aims to open a discussion with a person who is also in this situation.

In **box 4**, the counselor still explores different possible trigger events in Dominique's life. When intervening, it is important to explore what could have caused these recent ideations with the person. Be careful, however, to not give precise potential trigger examples. In fact, this could worry the person or suggest that they should be having suicidal ideations when they experience a certain event. Referencing box 4, the counselor could say: "And you, did something happen that made you sad, angry or bothered you today?"

Box 5 is an example of validating a person's experiences.

In **boxes 6 to 8**, the counselor explores the person's emotions to identify the moods accompanying their suicidal ideations. This can be helpful to identify with the person moments when things are not going well and when the ideations appear. Box 8 also includes validation of the person. Even if the unease is diffused with no apparent trigger event, it is important to use words that represent the person's ideas and emotions so that they can further express how they feel when they have suicidal ideations. The counselor could say: "How do you feel when you think about killing yourself? Do you feel discouraged like Dominique? Different?"

Boxes 9 to 12 illustrate the way in which the counselor also explores the things that are positive in Dominique's life and her reasons for living. The goal is to remind the person that when we feel bad, we can also think about the good things in our life. Be mindful however not to minimize the person's suffering or replace the emotions of sadness and hopelessness with other, potentially artificially positive ones. It is also important to avoid negating the person's experience and invalidating them. This intervention essentially aims to show that there also exists, in the person's life, positive things on which they can rely on when they feel bad.

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In **boxes 13 to 15**, the counselor proposes that Dominique does the Hope garden exercise described in the intervention manual. Together, they implement a strategy adapted to Dominique to identify the moments when she feels bad and has suicidal ideations for no apparent reasons, and to help positively modify her mood. In an intervention context, it is possible to develop a similar strategy with the person, taking into account their self observation and communication skills.

Box 16 concludes the story by validating the person's feelings and experience.

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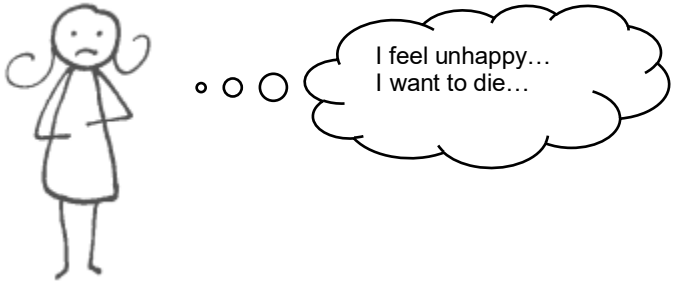
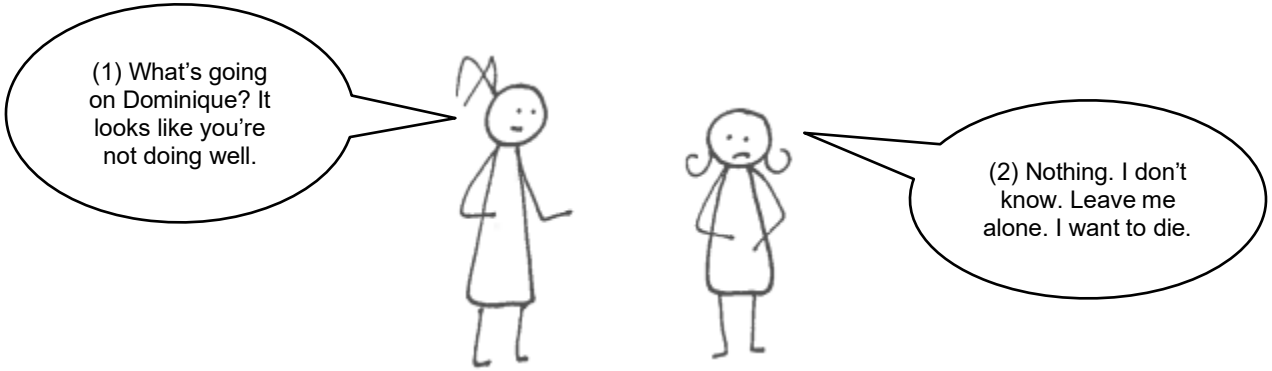
Dominique has suicidal thoughts without really knowing why

1 	Dominique feels unhappy. She has suicidal thoughts.
2 	Dominique does not know why she feels this unhappy. When her counselor asks her, she doesn't know what to say.

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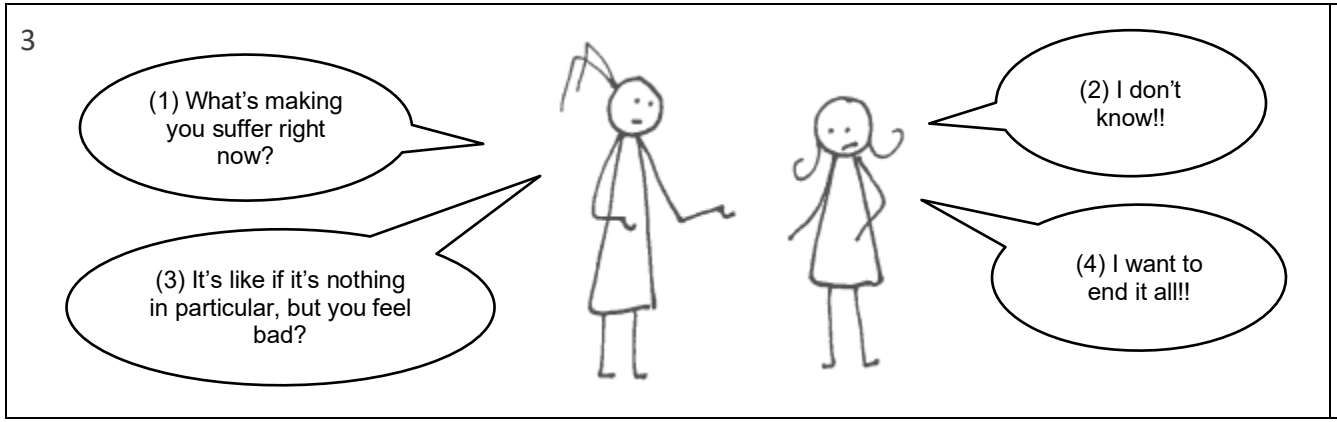

Dominique can only think that she wants to die so it all ends.

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4 (1) Did somebody make you sad? (2) No. (3) Did you lose something important to you? (4) No.	The counselor asks Dominique questions to see if there is something making Dominique feel sad and want to kill herself. They don't find anything!
5 (1) Don't worry! Feeling bad and not knowing why happens sometimes. (2) Yeah?	The counselor explains to Dominique that it's okay to not know why we feel bad sometimes. It can happen to anyone.
6 (1) It's important to know how you feel in those moments. (2) I'm fed up with everything. (3) I understand. And it's when you're fed up with everything that the suicidal thoughts come? (4) Maybe.	The counselor also explains that it's important to talk about it to learn to recognize the moments when we feel bad without knowing why.

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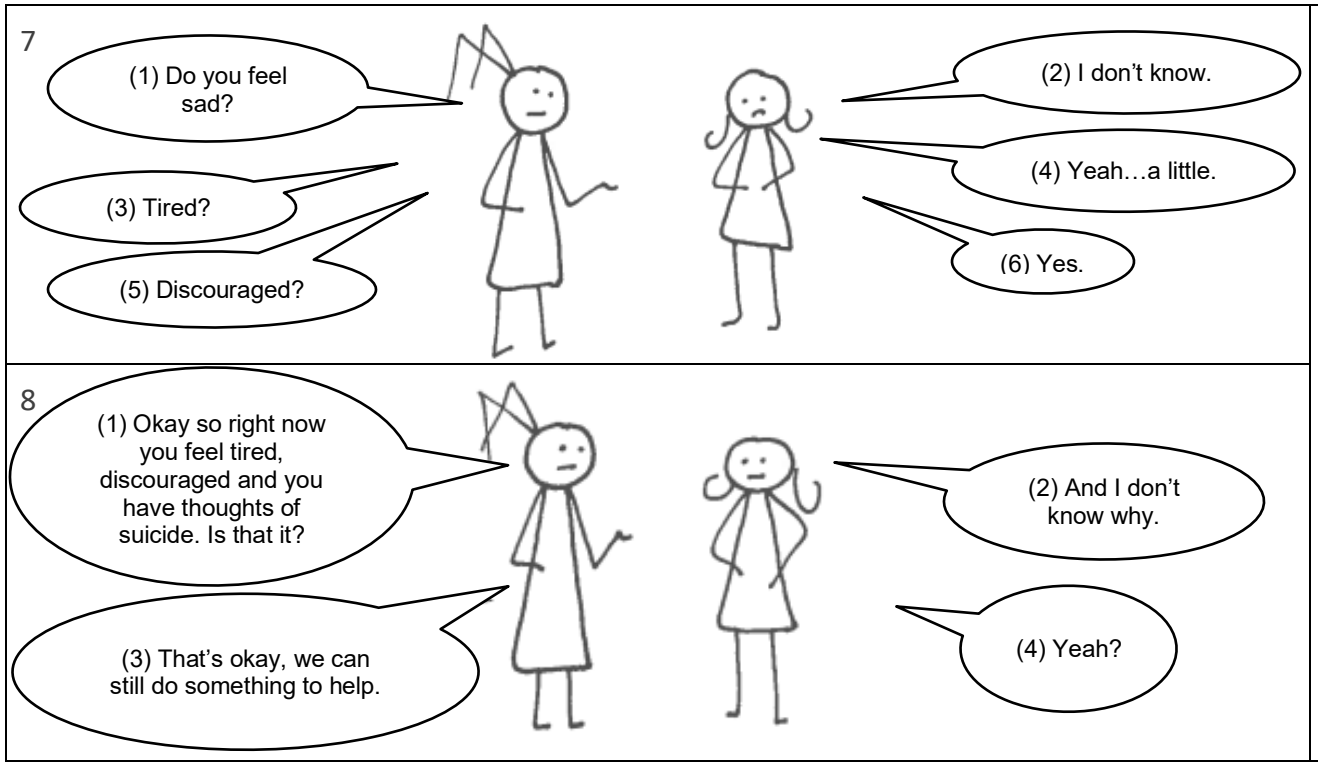

So that way, in those cases, Dominique can do something to feel better anyway.

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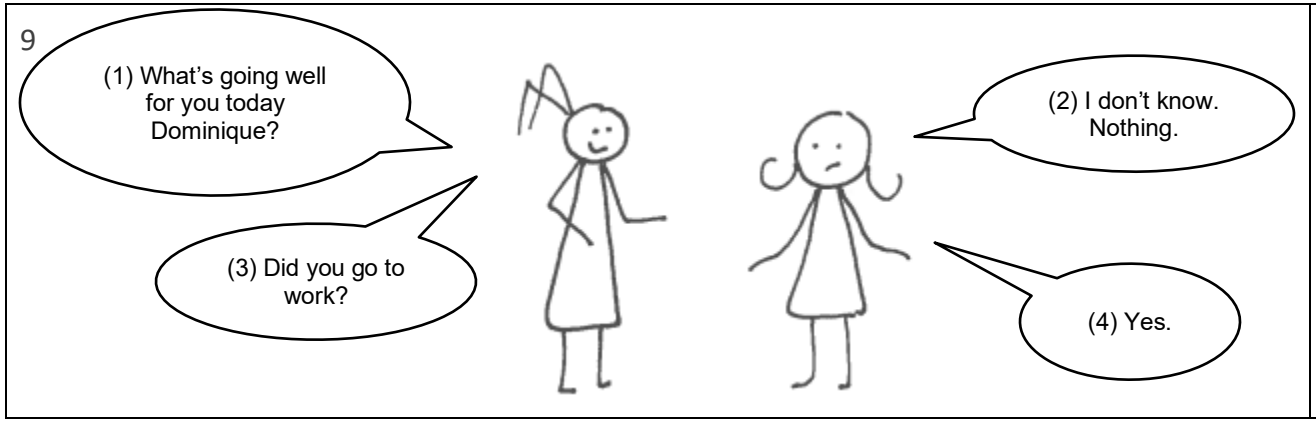
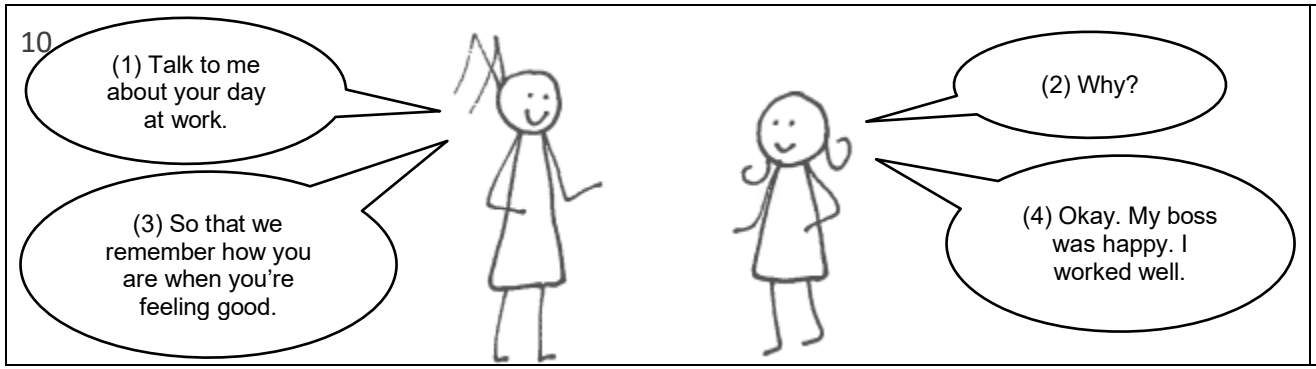


There are things in Dominique's life that are going well too. So, it's worth it to go on living.

The counselor asks Dominique questions to understand what is going well.



It's important to also focus on the things that are going well right now.

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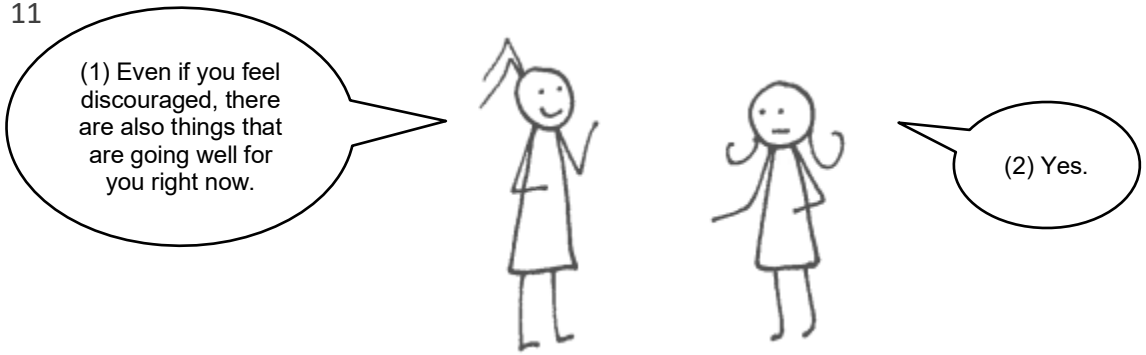
11 	They help us feel better and to live in the moments where we feel bad without knowing why.
12 	Dominique and the counselor remember the things that make Dominique want to live. Dominique finds her will to live again. She is less sad and discouraged.

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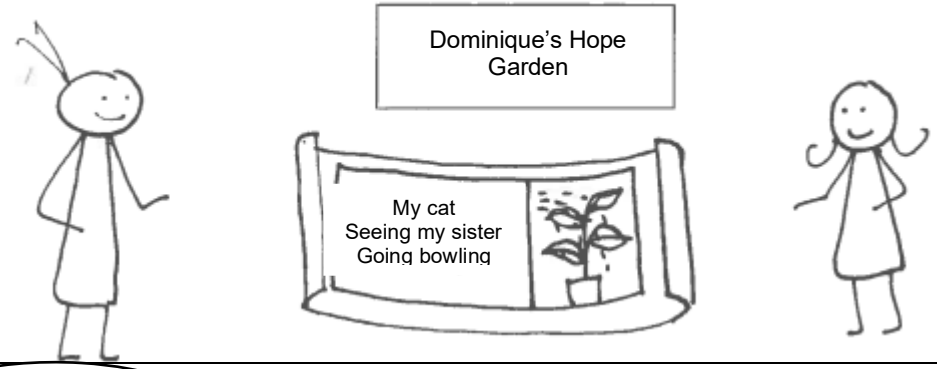
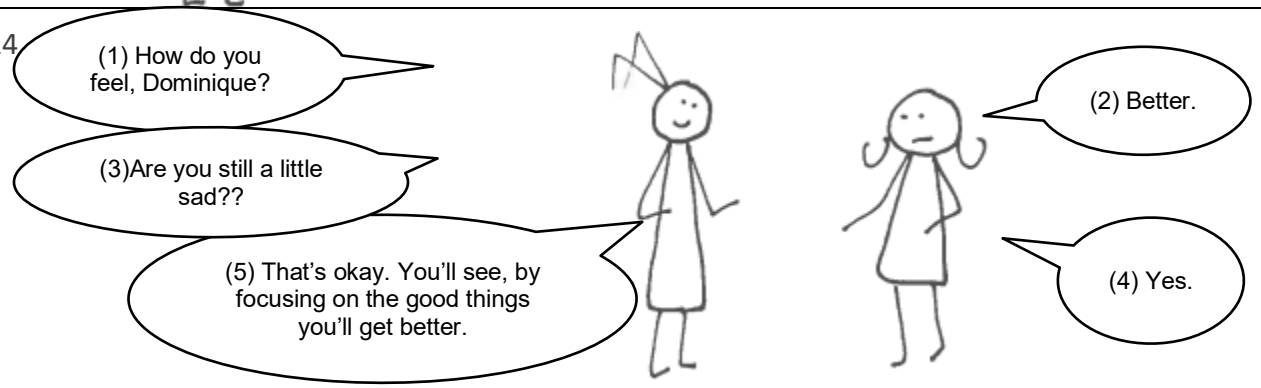
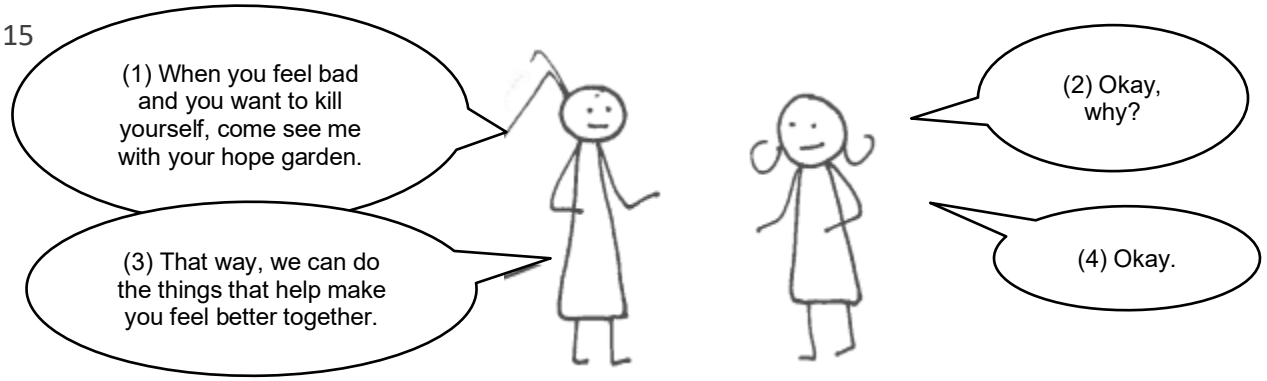
13 	Dominique and the counselor make a hope garden for Dominique. It contains everything that Dominique loves and that makes her feel good.
14 	Dominique feels a little bit better. She knows that there will sometimes be difficult moments where she'll feel bad, but she'll feel better after.
15 	Dominique and the counselor make a strategy to help Dominique when she has suicidal thoughts and doesn't know why.

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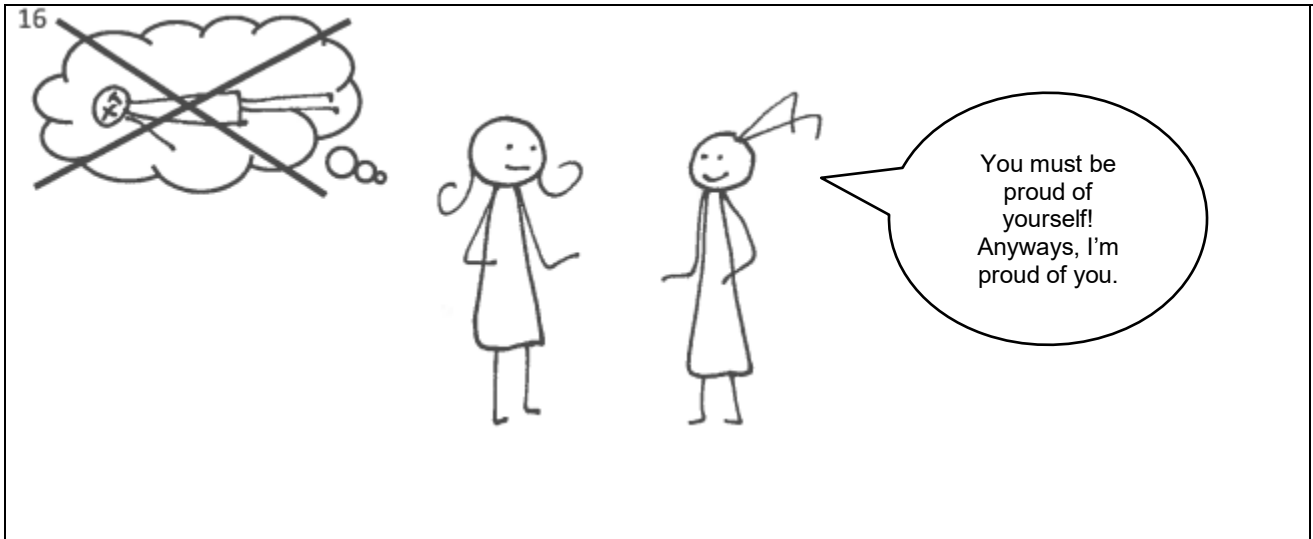	Dominique is able to see how she feels thanks to the tools she has learned to use with the counselor. She works to try to think about the things that are going well and her reasons to live when she feels bad. Then, her smile comes back. She feels proud.

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2.4 Calendar of Hope and the Timeline of Hope

These two interventions are more or less complex versions of the same exercise aiming to help the person project themselves into the future in a positive way.

The Calendar of Hope

Objective

In a situation where the person has difficulty orienting themselves in time and is experiencing a specific difficult situation (even if the situation can present itself multiple times), the calendar of hope can help them project themselves into the future to anticipate a future improvement. It can also allow to identify possible actions to accelerate this process. This exercise is particularly adapted to people who already use calendars to manage their daily lives and those who have a good capacity to identify their own emotions.

Justification / rationale

This intervention aiming to increase hope relies on the key presence of hopelessness within the suicidal dynamic. This hopelessness is modelled into triads as shown in figure 8.

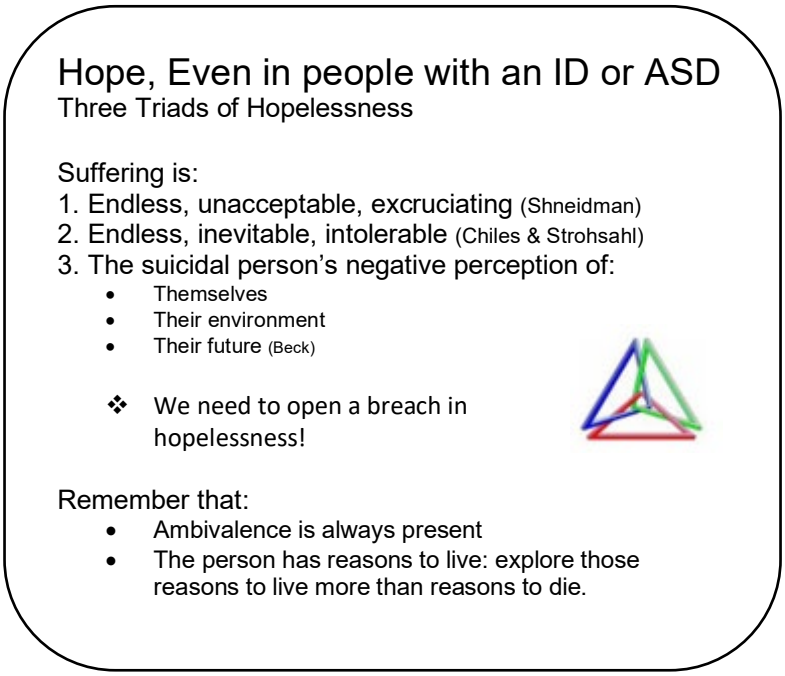

Figure 8 – The triads of hopelessness

The Calendar of Hope is also based on helplessness and the feeling of not having control on themselves and the things they experience. This component is an important element of the suicide model of people having ID or ASD. Working to bring back hope,

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therefore identifying things that are going well and that the person can do in the near future, helps them take control of the situation. Having a better understanding of what they are experiencing can also give the person a sense of control on the process they are going through and on the actions to take to change the process if they wish to reduce their hopelessness.

It can also help to visualize the way in which the suicidal episode is playing out as well as the associated emotions and it can help the person project themselves into a moment where they will feel better than they do now and the steps to take to get there.

Intervention process

The first step consists of validating the truth and legitimacy of the emotions felt by the person. Many emotions can be identified in relation to the situation over time. For example, after feeling sad, the person could be tired or feel the need to be alone. It is important to validate with the person that the tiredness or need to be alone could be present for a period of time before wanting to see other people. In this sense, the aim is to show the person that the sequence of emotions is normal and legitimate (see Table 5 below).

Next, the professional would identify with the person the moment that should correspond to a return to calm or relief in the sequence of emotions. The professional could express this thought in this way: “Tomorrow, you’ll feel better.” We must reinforce the fact that the person will feel better compared to how they currently feel, while making them understand that the process takes a certain time. This time should be illustrated with the calendar, in column 2 of table 5.

The third step consists of identifying what we can do between the present moment and the one where the person will feel better in order to accelerate the process and reinforce the person’s feeling of control over the situation.

The expected results are the following : 1) Helping the person understand and recontextualize what they are experiencing; 2) Anticipating and acting in order to improve their state; and 3) For the person, taking back control over what they are experiencing.

An adaptation of the calendar of hope can be done when the person is experiencing particular periods of fragility during the year (for example, during the holidays or back to school) or when an expected event represents a possible trigger event (for example, a planned activity with a parent who rarely visits). In this case, it may be useful to prepare a monthly or weekly calendar with the person that indicates when the event will occur so as to plan positive activities in the calendar during this more difficult period. The professional should also ensure a follow up on the progress of

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these planned activities, by emphasizing the positive elements that will allow the person to more easily make it through this difficult period.

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Table 8 - The Calendar of Hope

Timeline similar to the one usually used by the person	What is happening	How we feel- by using signs normally used with the person	What we are going to do to feel better
Questions and themes to address to construct the calendar:	• I think what is making you (perceived emotion) is… • What do you think?	• How do you feel? Do you feel sad or angry? • It's okay and normal to feel like… • After a while, emotions like…. go away and after we feel… • How do you think you'll feel in (amount of time adapted to the person) • After a while we feel better. • What is feeling good for you? • How are you going to feel when you feel better?	• What can we do so you feel better more quickly? • What are the things we already know how to do that make us feel better that we can reuse?
Now			
In a few minutes			
In an hour			
Tomorrow			

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The Timeline of Hope

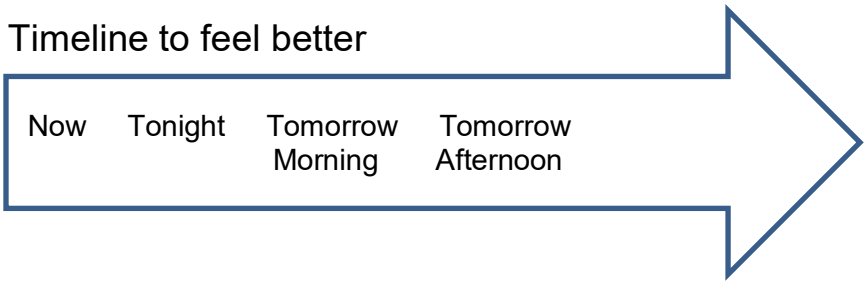
The timeline of hope is a simpler option than the calendar and is better suited to people with a reduced understanding of their emotions. It fulfills the same objectives and is based on the same principles.

Objective

The timeline is built from actions. It allows the planning of events and actions that will help the person feel better. The visual representation of these events and actions on a timeline helps the person to regain hope and notice a positive change in their life and mood.

Intervention process

The method is similar to the calendar, except that the emphasis is put on the activities that are going to take place, the actions needed to feel better, the planned social contacts, or even the positive or gratifying activities the person will participate in during the following hours or days. Before building the timeline of hope, it is important to recognize, validate and relieve the current distress.



Below is an example of a timeline:

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2.5 The Hope Garden: Focusing on the good things

Objective

The objective of this intervention is to bring out the positive elements in a person's life, despite their difficulties and the things that are not going well in their life. This exercise helps foster hope and anticipate positive things.

Justification / rationale

Hopelessness is a key component in MAAS development (see 2.4.1 below for further details). Thus hope is an important element on which we can build a suicide prevention intervention. Reinforcing hope can be done in the short and long term.

Intervention Process

The identification of elements to put in the list of good things must be done with the person. The retained elements should be reproduceable and attainable. For example, if we include a good relationship with a family member, we should also include the possibility of a future contact that will reinforce the positive feeling.

The first step consists of writing or drawing the things that are good in the left panel. We can also glue pictures of people, animals or loved objects.

It is the second step that solidifies the Hope garden metaphor: We *cultivate* and *water* the good things. Every time an identified element happens, we make a note of it in the right panel by applying stickers to the plant, coloring one of the leaves, applying tactile objects or by using any other method that helps the person notice they are helping their garden grow.

If the right panel fills up completely, we can start another one while keeping the old one and continuing to cultivate the garden of good things. When the person feels bad or expressed despair, we can consult the garden and discuss the things that are going well. We must not deny what is going badly or too quickly resort to the garden. It is important to validate the distress or frustration before being able to talk about the good things.

The expected results are the following: 1) support in reframing negative perceptions; 2) visualisation of the positive to counterbalance the perception of the negative; 3) improvement of humor; 4) a base to develop other good things.

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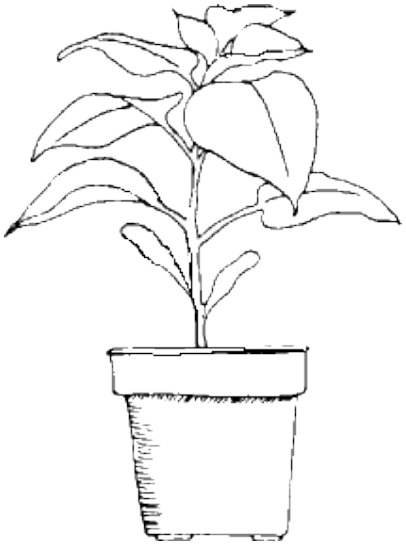
_____'s Hope Garden

Made on_____

The list of things that are good, that are going well, that we want to start again, that make us proud	Watering
	 

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Section 4 - Post-Suicidal Episode Follow-Up (SPP-F)

This step is often overlooked and often, people with ID or ASD do not wish to re-discuss a MAAS episode once it is over. Many professionals are also reluctant to revisit the question, often concerned about provoking a recurrence of suicidal ideations.

However, it is important to follow-up within an appropriate period of time for the situation, for several reasons:

- A MAAS episode can last longer than it appears after the initial expression of suicidal ideations
- There is a natural fluctuation to suicidality and danger. It is important to properly verify that the MAAS episode has run its course and that it is not a transient fluctuation.
- A follow up allows to enrich the understanding of the consequences of a MAAS episode and its progress over time.
- It allows to adjust the action plan in relation to the person's evolution and to verify the effectiveness of interventions performed during the suicidal episode.
- A follow-up is part of the process of "taking MAAS seriously" and shows the person that what happened is taken into account and is important.

The follow-up bases itself on the results of the initial assessment and is done in the form of informal discussions or formal interventions with the person, based on the situation and their needs.

Following up is important after an observable suicidal episode. The fact that the MAAS seem too have disappeared is not a reliable indicator that the person no longer thinks of suicide. In addition, as in other situations of distress and disorganisation, and as illustrated in Figure 8, ideations can fluctuate with time over a long or short period, according to the person's ability to solve problems and use help resources. This case illustrates a situation where MAAS are persistent but not perceptible because they have not been explored (see figure 9).

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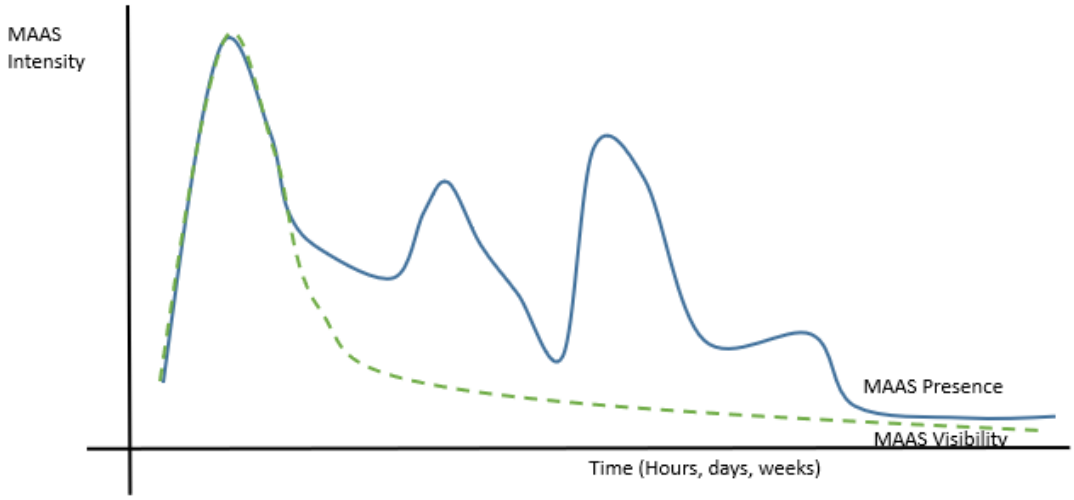

Figure 9 - Illustration of MAAS variation over time

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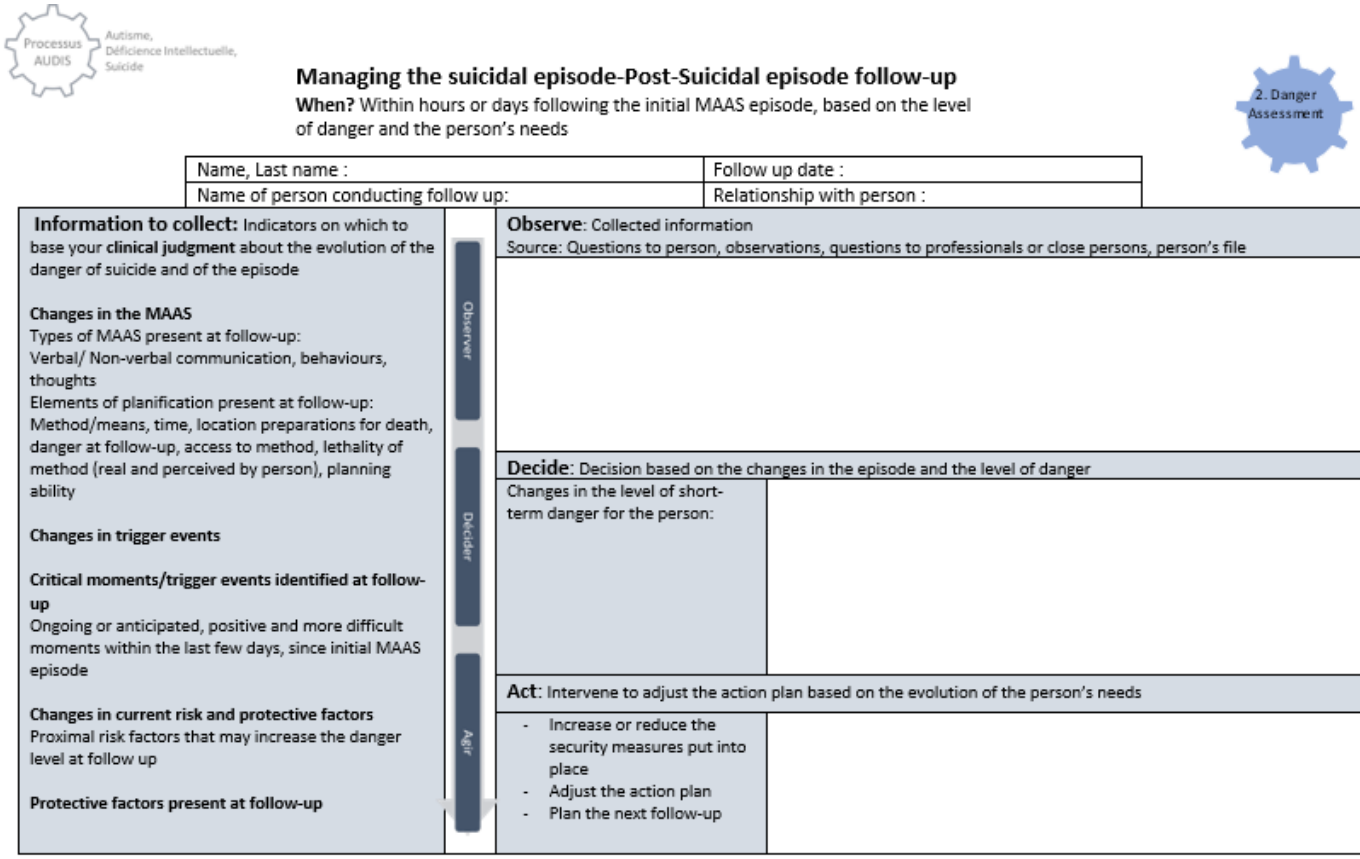
General Structure of the follow-up process

The follow-up step is based on the structure below:



Follow-up objectives as part of suicidal episode management

The objectives of the Post-suicidal episode follow-up are:

- Verify that the MAAS episode has run its course and that it is not a transient fluctuation. (Natural fluctuation to suicidality and danger)
- Enrich the understanding of the consequences of a MAAS episode and its progress over time. (A MAAS episode can last longer than it appears after the initial expression of suicidal ideations)
- Adjust the plan according to the person's evolution
- Verify the effectiveness of interventions performed during the management of the suicidal episode.
- Show the person that what happened is taken into account and is important (as part of the process of "taking MAAS seriously")

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Observe: Sources of information and follow-up indicators

The follow-up allows, a few days after the implementation of the Suicide Prevention Plan - Episode (SPP-E), to redo a summary evaluation in order to verify:

- Changes in the MAAS
  - **Types of MAAS present during follow-up** (Verbal/ Non-verbal communication, behaviours, thoughts)
  - Elements of planification present at follow-up
  - Method/means, time, location, preparations for death
  - Danger at follow-up
  - Access to method, lethality of method (both real and perceived by person), planning ability

- Changes in trigger events
  - **Critical moments/trigger events identified at follow-up**
  - Ongoing or anticipated
  - Positive and more difficult moments within the last few days
  - Since initial MAAS episode

- Changes in current risk and protective factors
  - Proximal risk factors that may increase the danger level at follow-up
  - **Protective factors present at follow-up**

Decide: Decision made from analysis

The central questions at the follow-up are:

- Are there any changes in the person's short-term danger? Yes/no
- Are adaptations to the SPP-E necessary? Yes/no

Act: Intervene to adapt the management of the suicidal episode

If an adaptation to the SPP-E is necessary, it must be based on changes observed during the collection of information of the follow-up. The adaptations are meant to increase or reduce the close monitoring, adjust interventions and the intensity of the implemented measures.

To conclude, a subsequent follow-up must be planned as needed.

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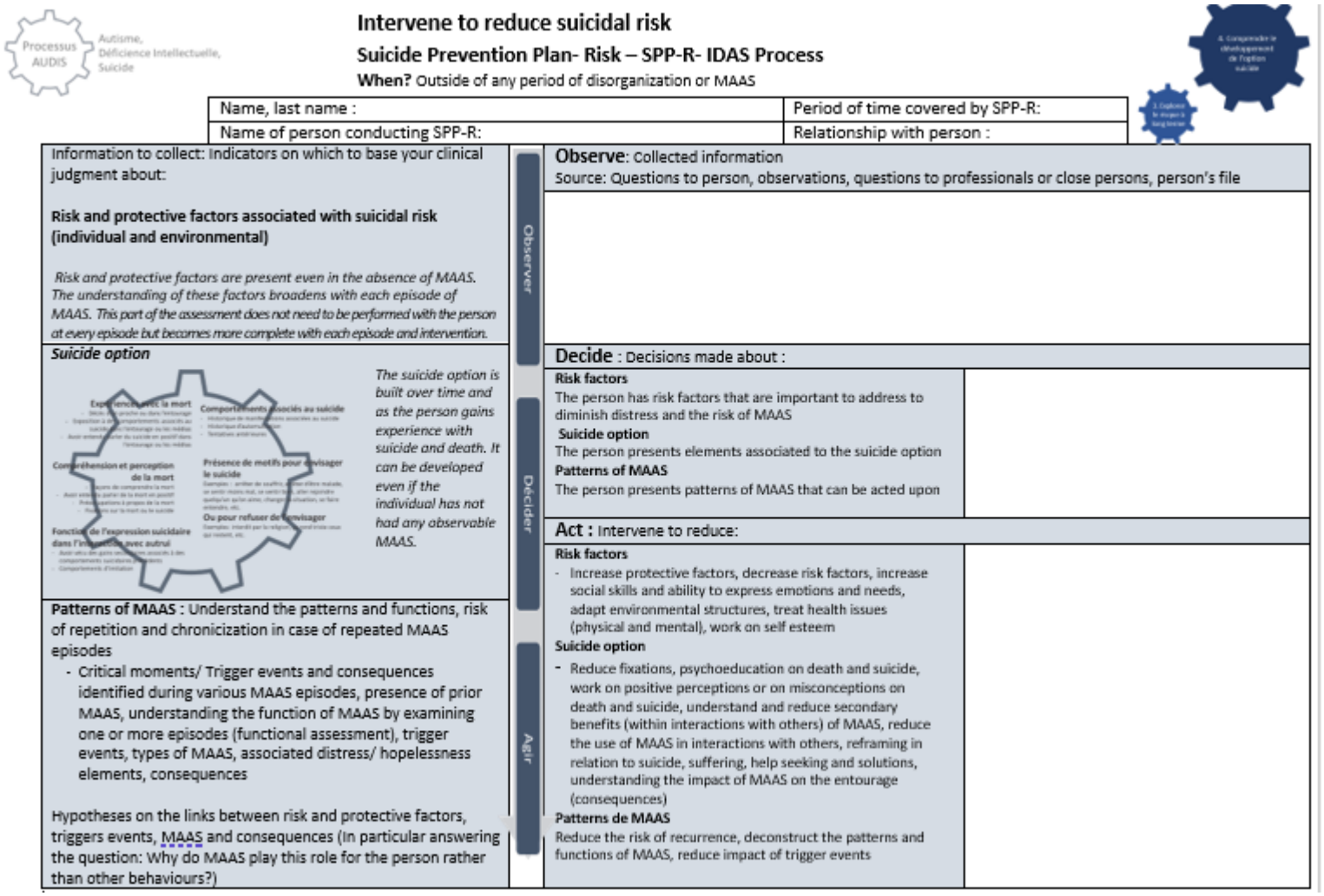
Section 5 – Reducing the Long-Term Suicide Risk - Suicide Prevention Plan – Risk (SPP-R)

This last step of the suicide prevention clinical process is crucial and must not be neglected. It is completed in the long term based on a functional analysis of the person, and of their risk and protective factors.

General structure of the suicide risk reduction process

This step is based on the structure below:



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Objectives of suicide risk reduction

The objectives of SPP-R are in terms of evaluation and intervention:

Evaluation objectives	Intervention objectives
▪ Complete collected information ▪ Identify distal risk factors, vulnerability and protective factors acting in the long term in the development of suicide risk ▪ Understand the person's suicide risk ▪ Make decisions related to the suicide risk	▪ Define interventions to reduce risk factors, reinforce protective factors and modify the suicidal process. ▪ Identify and implement intervention possibilities to improve the person's wellbeing and reduce their distress

It aims to identify the more distant risk factors and complete the information collected during the suicidal episode management in order to understand the person's suicidal process, make a decision on their long term suicide risk (including the danger of a subsequent suicidal episode), and define interventions to reduce risk factors and reinforce protective factors.

This step allows the continuous collection of information on suicidal vulnerability factors that can be modified or have their effects on the person be diminished as well as possible interventions to reduce risk factors and reinforce protective factors. The decisions made from this information must be collegial and included in the long-term intervention plan and the action plans for subsequent suicidal episodes. The collected information can be used during a therapeutic follow-up or in the development of the person's activities.

Information collection for this step is done from different sources (file, discussions with different implicated practitioners, loved ones, interviews, observations during planned meetings and habitual activities, etc.). It is not necessary to mention suicide to explore identified risk factors.

A large portion of the subsequent analysis to data collection follows the model of a behavioural functional assessment. It can be done using the IDAS process tools or directly within the functional assessment grids used in the field, at the discretion of the professionals. It can also be integrated into the multimodal analysis plans (MAP).

The suicide risk reduction step includes three major sections:

- The **risk and protective factors** that can underlie the long-term development of suicide risk and on which psychosocial and psychiatric interventions can be built (intervention plans, skill development activities)

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- The **development of the suicide option** that allows analysis of the cognitive and interactional components of suicide risk. This section is cross-sectional and supports the entire process of suicide risk assessment. It contributes to the implementation of a long-term intervention plan. The objective is to understand how the idea of suicide started in the person's mind and behaviour in order to implement psychoeducation, reframing, and other interventions to reduce the importance of these factors, in turn reducing cognitions favorable towards suicide.
- **The MAAS patterns**, if the person seems susceptible to experiencing multiple episodes. This analysis is integrated in the functional assessment approach and the MAPs.

The exploration of the suicide option aims to understand a person's understanding of suicide and how it came to be seen as a solution to problems encountered by the person or by others. It addresses cognitive and social components of suicide, its acceptability, as well as the role suicidal behaviours play in social interactions.

The suicide option can help understand the source (or sources) of suicidal ideations, identify elements that can fuel these ideations and consequently, the elements that can help diminish their impact. It can support an individual effort, but can also provide possible interventions and activities to put into place for suicide prevention in small groups, for example, once a person shows suicidal behaviours in front of peers, when a suicide-related event is presented in media or social media, or when a death occurs in the social environment. During the collection of this information with a person having an ID or ASD, their way of addressing the topics can be revealing of their understanding of death and suicide, and help professionals to determine an effective communication strategy with the person on this topic.

Observe: Information sources and risk assessment indicator

The following elements can be observed in order to assess suicide risk and determine possible long-term interventions.

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Information to collect	Description and instruction
Risk factors *Risk and protective factors are present even in the absence of MAAS. The understanding of these factors broadens with each episode of MAAS. This part of the assessment does not need to be performed with the person at every episode but becomes more complete with each episode and intervention.*	
Predisposing factors	Cognitive rigidity, poor adaptation capacity, general anxious affect, unstable mood, attachment issues, history of substance abuse, mental health disorders, type and level of ID or ASD, associated disorders (ADHD, Behavioural disorders, etc.)
	History of significant or traumatic events including negligence, abandonment, abuse, aggression, intimidation, family dysfunction, difficulties in school experience
Contributing factors	Feeling of being limited/dependant, perception of self as being abnormal, misconception of diagnosis, poor self-esteem, substance abuse, impulsivity.
	Inadequate activity structure, issues with mental health follow-ups, difficult relationships with loved ones, isolation/rejection, inadequate social integration, difficulties with life goals, environment that limit opportunities for self-determination.
Activating factors and trigger events	Aggravation of mental health disorders, current substance use, any element that can act as the last straw (trigger).
	Any element that can act as the last straw (trigger) that acts from the outside: Bad news, loss, etc.
Protective factors	
	Ability to self-calm quickly, ability to identify solutions and to adapt, feeling of having control on their life, presence of reasons for living. Ability to express emotions and needs.
	Balance between environmental demands and the person's capacities, adapted social integration, presence of people providing security, presence of sources of satisfaction, knowledge and acceptance of diagnosis by social environment, presence of trust relationships.

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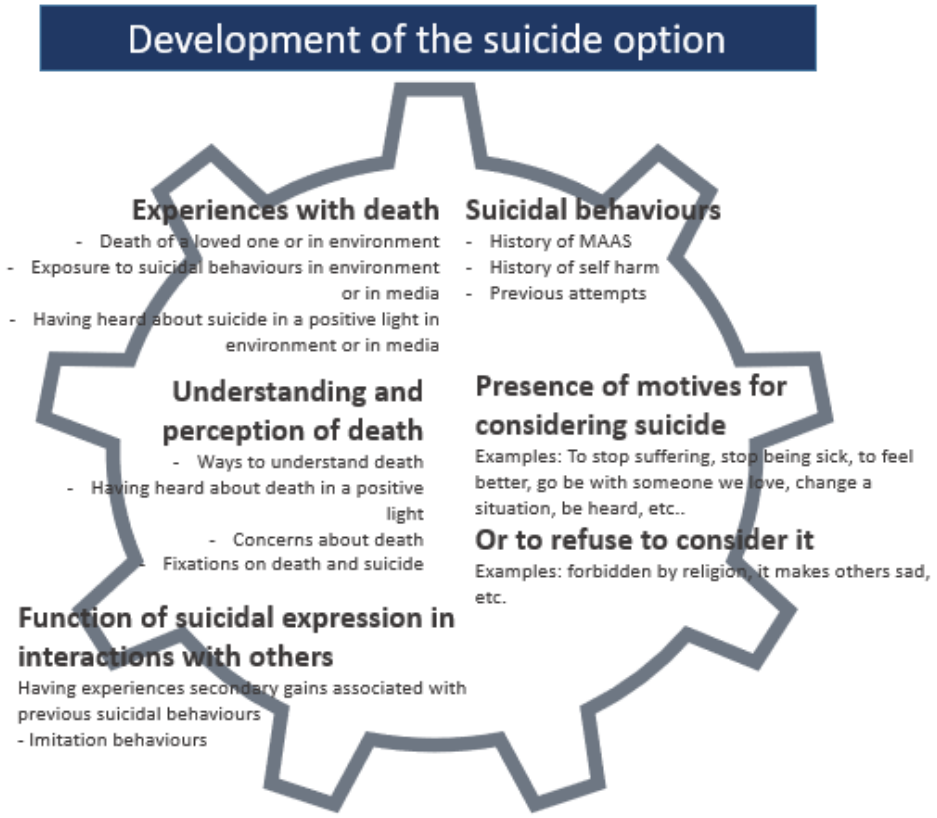
Information to collect	Description and instruction
Exploration of the suicide option	
	
Understanding patterns and functions, risk of recurrence and of becoming chronic	
Critical moments in all MAAS episodes experienced by the person and consequences	Difficult periods lived between follow-ups and possible predictable trigger events that require the implementation of a safety net. The identification of trigger events is made by observing the person's reactions in their environment and by consulting their loved ones and associated professionals. **If there is only one episode, it is not necessary to re-indicate the information here. This section aims to understand patterns over multiple episodes.**
Presence of previous MAAS and summary of different episodes experienced by person	Analysis based on the behavioural functional assessment, by describing MAAS patterns, if one emerges from the observation of multiple MAAS episodes. Triggers identified (More than the trigger itself, indicate the category): Type of MAAS and escalation structure (precursory behaviours, words used, behaviours, means, rituals, etc.): Immediate consequences (including the behaviours of loved ones, peers, professionals, emergency responses, medical consultations, changes in expectations or routines, etc.): **Here again, if there is only one episode, it is not necessary to re-indicate the information here. This section aims to understand patterns over multiple episodes.**

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Information to collect	Description and instruction
Understand the function of MAAS by examining one or more episodes of MAAS (multimodal assessment plan)	The objective here is to develop hypotheses as to the relationship between triggers, risk and protective factors, MAAS and consequences (including possible hypotheses on secondary benefits, if applicable). This step is similar to what is done during the MAP. Each hypothesis must be supported by arguments identified in previous steps.

Decide: Decision made from the analysis of factors associated to suicide risk

The decision on risk factors can be made based on the following questions:

- Does the person present risk factors on which it is important to act to reduce distress and the risk of MAAS recurrence? Yes/No
- Does the person present elements associated to the suicide option? Yes/No
- Does the person present MAAS patterns on which to base interventions? Yes/No

Act: Interventions to reduce suicide risk

The implemented long-term interventions do not target the MAAS directly, but the associated factors instead. Their implementation does not require discussing the suicidal episode with the person. The following subjects can be discussed and are illustrated in Figure 10.

Risk and Protective factors

- Reduce impact of trigger events
- Increase protective factors
- Decrease risk factors
- Increase social skills and ability to express emotions and needs
- Adapt environmental structures
- Treat health issues (physical and mental)
- Work on self-esteem

Suicide Option

- Reduce fixations
- psychoeducation on death and suicide
- Work on positive perceptions or on misconceptions on death and suicide

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- Understand and reduce secondary benefits (within interactions with others) of MAAS
- Reduce the use of MAAS in interactions with others
- Reframing in relation to suicide, suffering, help seeking and solutions
- Understanding the impact of MAAS on the entourage (consequences)

MAAS Patterns

- Reduce the risk of recurrence
- Deconstruct the patterns and functions of MAAS

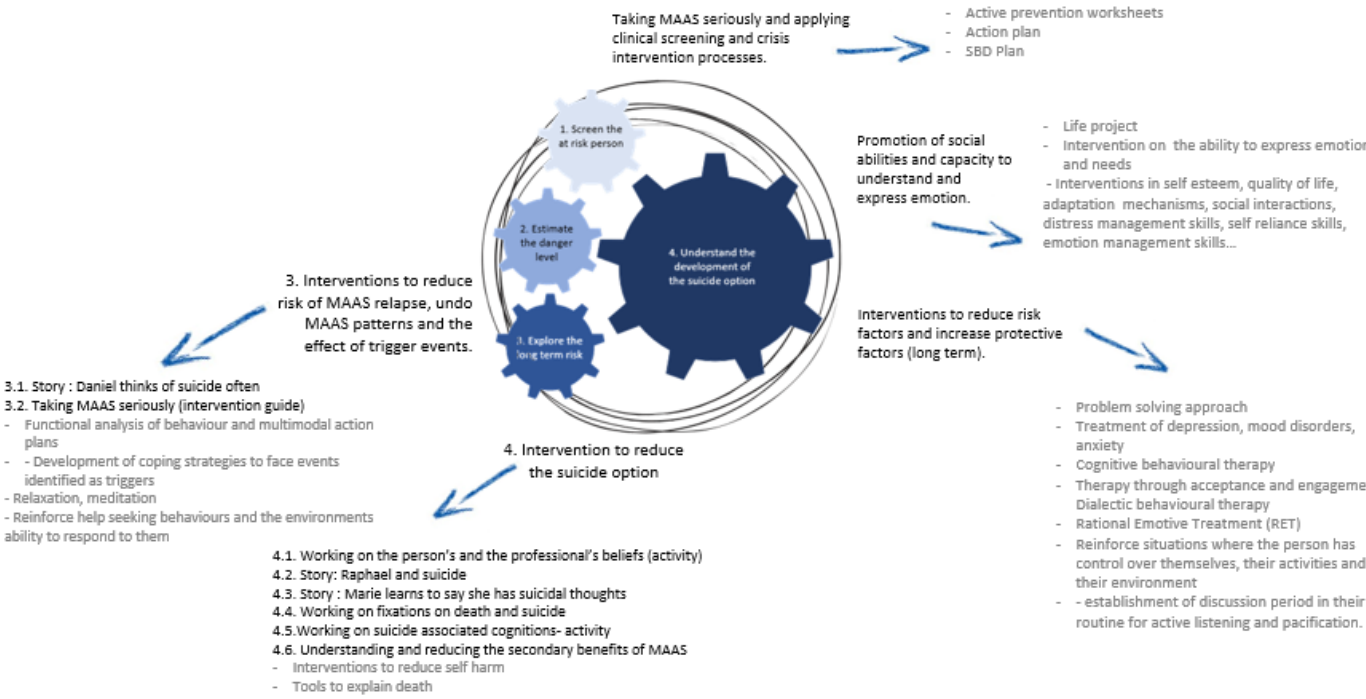

Figure 10 - Strategies for suicide risk reduction

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Intervention tools for reducing suicide risk

3. Interventions to reduce the risk of short-term MAAS recurrence, undo MAAS patterns and the effect of trigger events

People presenting ID or ASD are sometimes at risk of MAAS recurrence when they re-experience distress. MAAS can also become a communication tool and a way to interact within a complex dynamic with loved ones and professionals. It is however important to consider the fact that the use of MAAS as an interaction method is not systematic, and that above all, MAAS should always be considered as the expression of some form of distress.

Changes in behavioural patterns developed over long periods of time are very difficult to achieve in intervention. However, the existing intervention tools (Intervention plan, functional assessment, multimodal analysis plan) and a good understanding of the reasons that have led to the person's distress and construction of the suicide option (e.g., how the idea of suicide became acceptable for the person) can help modify certain patterns, if they exist.

3.1 Story: Daniel thinks of suicide often- He often says that he wants to kill himself

We speak of MAAS recurrence when a person experiences multiple MAAS episodes. It is sometimes possible to identify a MAAS apparition pattern. For example, MAAS can always present themselves in similar situations. However, these recurrent patterns are not necessarily systematic. One person can experience MAAS in different contexts.

It is important to understand the functions of MAAS for the person. It is essential to explore their distress in order to identify its sources and put interventions into place aiming to reduce it. MAAS must always be taken seriously, even if they seem to be a method of communication or "manipulation", as it could be perceived by professionals. It is never harmless to try to manipulate with their own life. MAAS that do not produce the desired effect can evolve and become dangerous for the person. For example, the failure to escape a frustrating situation by expressing suicidal ideas may lead a person to an attempt.

MAAS recurrence is an important issue with ID-ASD clientele. Reliable data does not yet exist to estimate the prevalence of this recurrence, but it is often described by professionals.

The presented story of Daniel describes a situation of recurrence that touches on multiple specific issues reported by professionals working with these clients. These issues address impulsivity, refusing to discuss a suicidal episode once it is over and the

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use of MAAS to communicate a frustration or a need. This story aims to support the professional in their work alongside a person that has experienced multiple MAAS episodes.

Boxes 1 to 3 expose Daniel's current crisis situation. The intervention aims here to help the person identify and describe the trigger of the crisis they experienced (assuming this is not the first situation in which they experienced MAAS). Box 3 underlines the importance of MAAS in a manipulation dynamic. It can be useful to mention to the person that they sometimes express wanting to die when they want to avoid a situation or to obtain something. It is important to name the function of MAAS in this context, without criticizing the behaviour. The objective of the intervention is to allow the person to recognize the MAAS's function so that it is possible to subsequently develop strategies that will replace MAAS with them, while allowing them to express their needs.

Boxes 4 and 5 describe Daniel's resistance in discussing the situation and the distraction strategies that can be used to lead to healing. The intervention aims to address this resistance with the person who experiences it as well ("you're also like Daniel sometimes, and you don't want to talk about the times when you said you wanted to die"). The professional must not judge or insist that the person discusses this in the moment

Boxes 6 and 7 describe the professional's feedback in relation to Daniel's resistance to discussing the suicidal episode. The intervention's objective is to show that MAAS are taken seriously and commands the professional's attention, without necessarily leading to obtaining something. MAAS are subjected to an intervention to allow the person to feel better in the present as well as in the future.

Boxes 8 to 10 describe Daniel's MAAS patterns. The intervention aims here to describe the person's MAAS pattern, if they have one.

Boxes 11 and 12 allow to validate and normalise Daniel's experiences so that he will be more receptive to intervention. The objective is to show the person that it can be advantageous to accept working on alternative means of expressing their needs when they do not feel well. Once this step is started, the intervention aims to establish those alternative means so that the person can express their needs without resorting to MAAS. The professional can reward the use of these new means and set up suicide preventative interventions for when the MAAS resurface.

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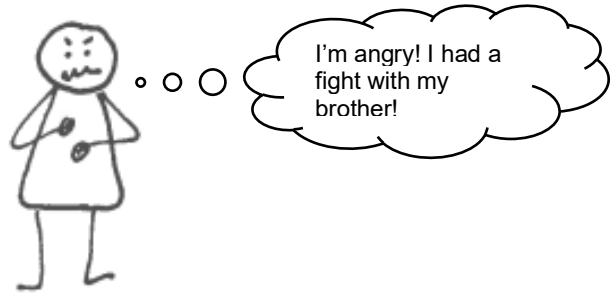
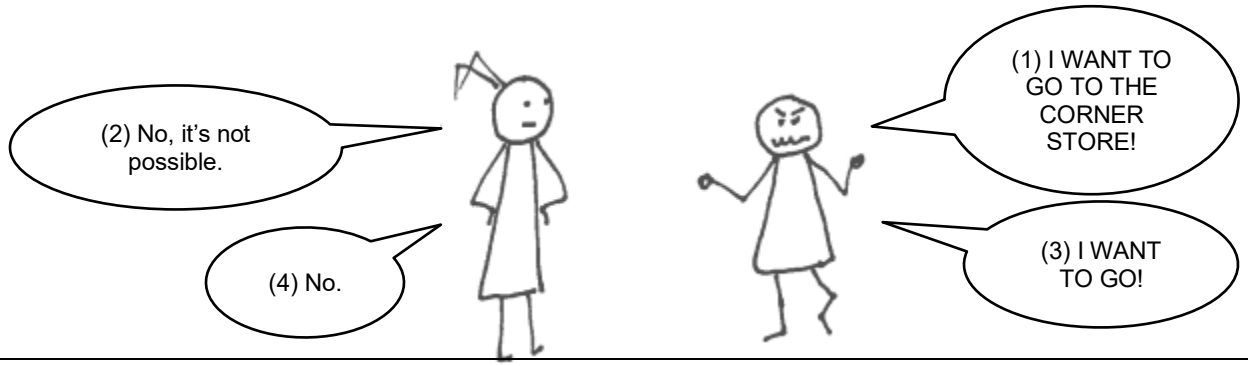
Daniel often thinks of suicide- Daniel often says he wants to kill himself

1 	Daniel is frustrated. He fought with his brother and got punished.
2 	Daniel wants to go to the corner store, but his counselor refuses. He is punished.
3 	Daniel cries. He screams and says he wants to kill himself. His counselor doesn't remove the punishment

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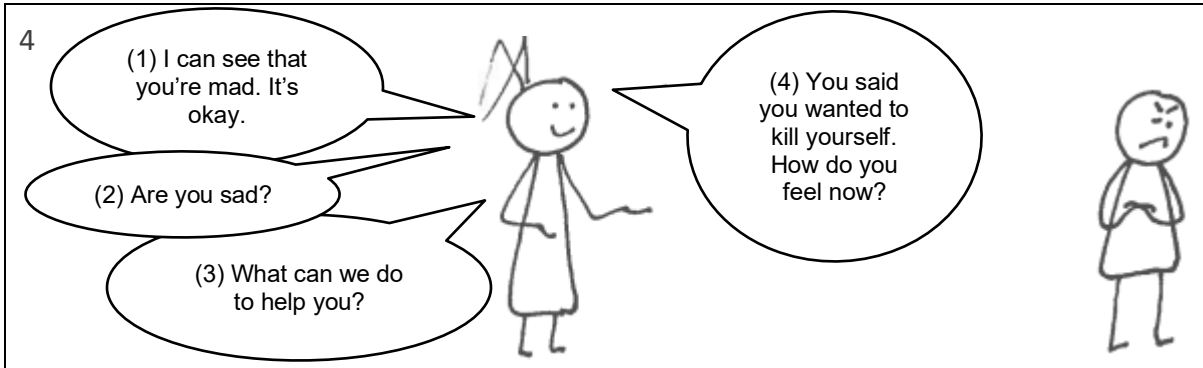
4 	His counselor understands that Daniel is not doing well. She asks questions, but he doesn't answer. She tries to help find solutions, but he is too upset.
5 	The counselor suggests that Daniel watch TV. Daniel calms himself down. He likes the TV. His smile comes back.

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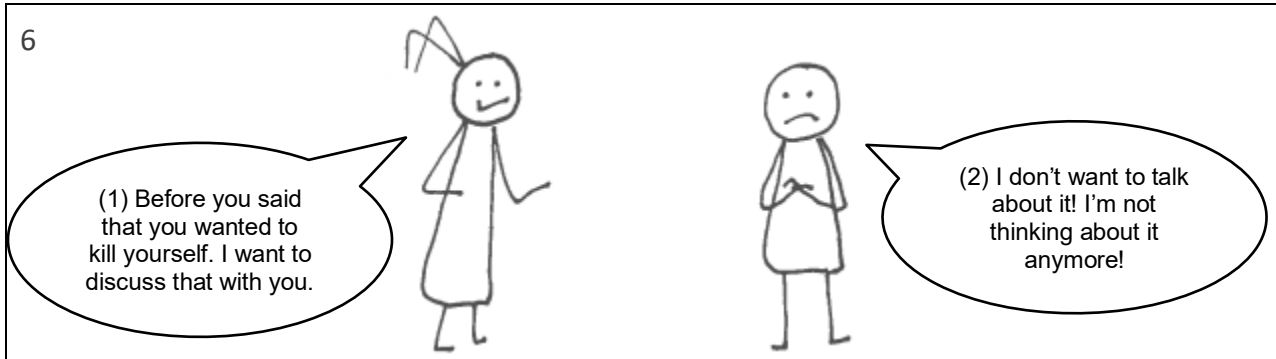
6



Before dinner, the counselor comes to see Daniel.

She wants to talk about what Daniel said when he was upset.

He doesn't want to talk about it, it's done.

7

The counselor explains that it's important. He said something serious, something has to be done to find a solution.

Daniel doesn't want to talk, he's embarrassed.

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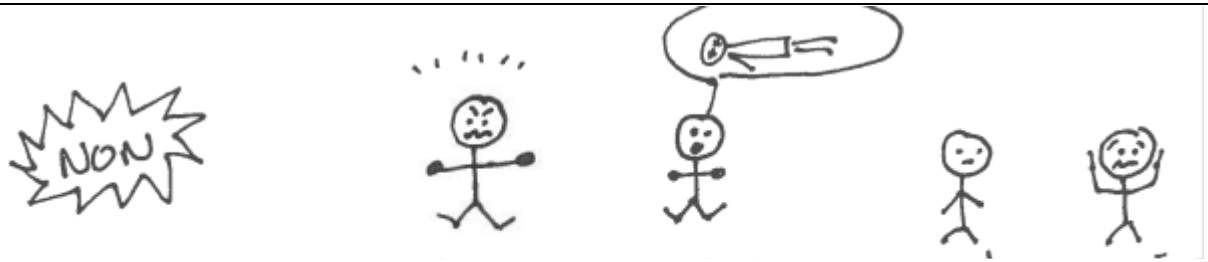
8  	The counselor explains that she has noticed that sometimes, when things are not going the way Daniel wants, he is frustrated and angry, he yells and says that he's going to kill himself.
10  Restriction → Frustrated! → Angry! →Calmed down →Embarrassed Punishment Wanting to kill yourself	The counselor draws a scenario for Daniel that explains what happens when he says he wants to kill himself. She draws badly, but Daniel can see what happens.

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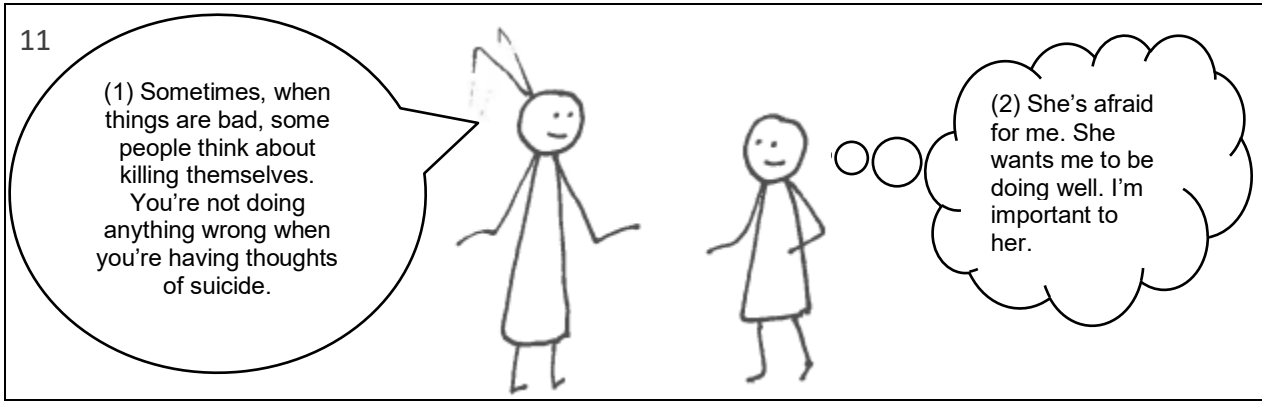
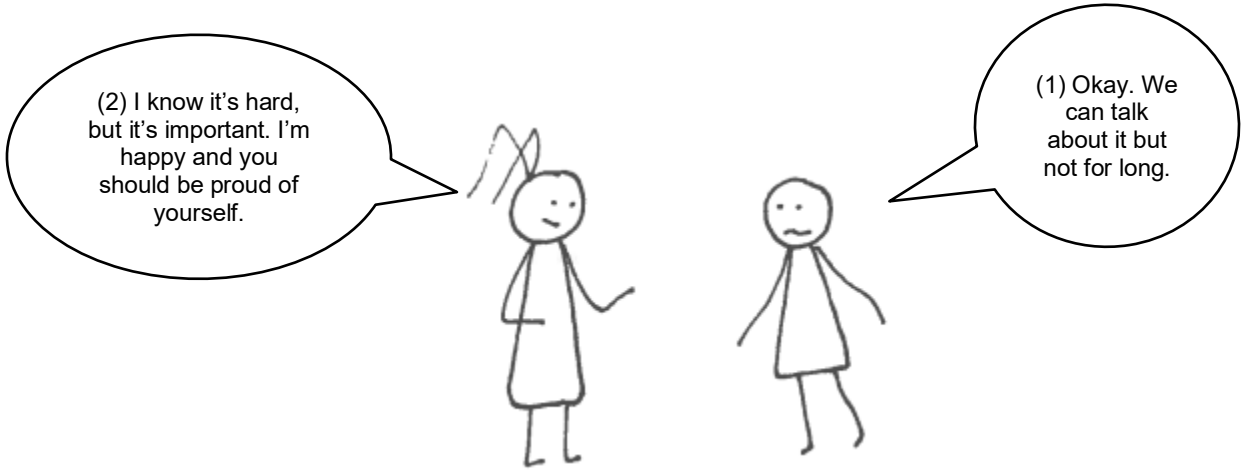
11 	The counselor explains that she wants Daniel to be doing well. She wants to find solutions with him so that he thinks of other things instead of killing himself when he is frustrated.
12 	Daniel is not very happy, but he accepts talking to his counselor about the times when he said he wanted to kill himself He doesn't like wanting to kill himself. He wants to find other solutions.

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3.2 Taking MAAS seriously

Objectives

Taking every MAAS episode seriously aims to reduce the risk of trivialization, as well as avoiding an over reaction when the person expresses suicidal ideations, makes plans, mimes a suicidal act or makes a minimally dangerous suicide attempt.

Explication / rationale

Taking a MAAS episode seriously is different from:

- Reacting intensely
- Stopping all current activity to address the suicidal statements or behaviours

It is important to take all MAAS episodes seriously. It is never trivial for a person to express themselves while jeopardizing their life and death. Distress, regardless of intensity or type, is present during a MAAS episode, even if the person seems to be repeating statements without really understanding the meaning or scope, or if they seem to have developed automatisms related to suicidal ideation. Taking MAAS seriously is showing that we have heard them and that we are genuinely going to address it.

A person whose MAAS are not taken seriously enough can react in different ways:

- The person may think that their distress or suffering is not important and become withdrawn within themselves.
- The person can intensify their message and increase the danger in order to be heard.
- The person could commit an act without understanding the meaning of their action, if this action is not understood and explained correctly by another person.

Intervention Process

Taking a MAAS episode seriously involves the following elements: 1) Confirm what we have heard, perceived and understood regarding the expressed distress; 2) reassure the person on the fact that we will address this distress together and find ways to avoid having it happen in the short term; 3) conduct a danger assessment.

It is important to meet the person is a calm environment, in a moment when they are attentive. For example, here is how a professional could introduce the discussion: “I want us to discuss what we can do so that you feel better, and so that your thoughts and behaviours (describe the MAAS episode) don’t come back. It’s important to me that

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you're doing well, and I want to work with you on that. We don't need to discuss the episode in detail, just the trigger events."

The following are traps that the professional should look out for and things that they should particularly avoid:

- Minimize MAAS.
- Assume a function or purpose to the person's behaviour without having assessed the situation to know how the person understands of the situation and their behaviour.
- Analyzing MAAS with the same model as behavioural disorders in order to make them disappear like a bothersome behaviour.

4. Interventions to mitigate the suicide option

These interventions aim to understand and reduce the suicide option, which constitutes a key element of the development of suicide risk (figure 15). The purpose here is to explore the person's perceptions, cognitions, beliefs and experiences with death and suicide in order to reduce suicide risk. These interventions can be realized with a person who has exhibited MAAS or one that has been a witness to MAAS in another person. In the latter case, these interventions are recommended when the witness to MAAS seems disturbed or is asking questions on suicide and death. The interventions should be done outside of a MAAS episode and when the person is calm.

4.1 Working on the person's and the professional's beliefs

There exist many beliefs about suicide generally or with people with ID or ASD transmitted by people, families and professionals. These beliefs affect MAAS comprehension, the type of intervention chosen and the suicidal person's behaviour. Certain beliefs are founded but others are false and should be demystified in order to favour an appropriate intervention.

Table 8 presents the most common beliefs. Those that appear in red in the table are featured in vignettes that can be discussed with a person presenting ID or ASD. It is recommended to not be limited to the ones presented and to develop ones based on the person's needs. The other beliefs of table 8 that are not in red more often concern professionals that have been interviewed as well as their observed discourses and actions.

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Table 9 – The most common beliefs about suicide

Suicidal people are determined to die, and their mind cannot be changed.	**False**
Committing suicide takes courage. *The desire to die is essentially a desire to stop suffering and this does not take courage, or cowardice, or weakness. These people see no more possible solutions to their suffering and suicide occupies all their thoughts.*	**False**
Only a coward commits suicide. *The desire to die is essentially a desire to stop suffering and this does not take courage, or cowardice, or weakness. These people see no more possible solutions to their suffering and suicide occupies all their thoughts.*	**False**
People that talk about suicide or threaten to commit suicide do not actually commit suicide. They talk to attract attention or to manipulate their social environment. *Many people discuss their suicidal thoughts in one way or another, sometimes clearly and sometimes less so. Some people have suicidal thoughts for long periods of time and discuss them. They seek and obtain help. Among people having suicidal thoughts, some attempt suicide and can die. Suicidal ideations must never be considered "mere" attention seeking and we must always explore suicide risk, as well as understand why the person is communicating this way. It is not trivial that someone gives the impression of manipulating their social environment with their own life.*	**False**
People that use suicide to manipulate or obtain something are not in danger. *If a manipulation component is present in suicidal behaviours, it is important to be conscious of it and help the person develop other means of communicating their needs. A person that has learned to express their suicidal ideations to obtain something could increase the danger of their behaviour if they do not obtain what they are looking for. Furthermore, a person can have suicidal behaviours outside of wanting to manipulate. The fact of talking about suicide can often desensitize the person to danger, trivialize suicidal behaviours and they may be more likely to make an attempt during a period of distress.* *The use of suicidal behaviours to manipulate is done in social interaction and is the result of learning.*	**False**
Suicide happens precipitously in youth. *It can be difficult to understand the signals sent by a suicidal person, which gives off the impression that there was no warning. Often, we understand these signals after the fact.* *Impulsivity seems to play an important role in youth, and coupled with a poorer understanding of death, it can increase the danger of an attempt.*	**Often true**
Suicide occurs without warning. *It is however sometimes difficult to see the warning signs in certain people. The observation of changes in behaviours, attitudes, interests, and sleep and eating habits can serve as indicators of mood decline. To validate the concern with the person then becomes important.*	**False**

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Suicide is a problem that lasts a lifetime. *Most people exhibit suicidal behaviours in difficult psychosocial situations and are no longer suicidal when the situation improves (Once their depression is controlled, once they obtain support to help with a difficult situation, etc.). The fact of having had suicidal behaviours in the past increases the risk of having them again during a future difficult situation. It is one of the most important risk factors. However, when people receive the support they need, it can remain an isolated episode. Most people having suicidal ideations or having attempted suicide at one point in their lives never have it happen again.* *A person cannot be categorized as suicidal their entire life. However, it is important for professionals to know that the person has had suicidal behaviours in the past, in order to take into account the potential risk during difficult situations.*	**False**
When somebody commits suicide, their family members become more at risk.	**True**
All suicidal people suffer from mental illnesses. *It is estimated that about 80% of suicidal people have mental health problems. However, most people that suffer from mental illnesses are not suicidal. The presence of mental disorders is not a sufficient direct cause to explain suicidal behaviour. Even when a person suffers from a mental illness, a suicidal episode can be provoked by a psychosocial crisis in no way related to this disorder.*	**False**
The improvement that follows a suicidal episode means that there is no more danger. *It is important to have a post-episode follow-up and a longer-term intervention. The improvement may only be temporary. If the sources of distress having caused the suicidal episode are still present, the danger is likely to maintain itself.*	**False**
Thinking of suicide can happen to anyone; rich, poor, healthy, sick…	**True**
Discussing suicide directly with someone can incite them to make an attempt. *In an intervention context, it is always appropriate to discuss suicide openly with a person that incites concern. This allows to put into words how the person is feeling, to validate the presence of ideations and to help the person understand how they feel. Studies show that there is no danger of provoking suicidal behaviours by discussing it in a clinical setting. There exists a concern about this risk in people with ID or ASD. However, the existing data do not show that there is a danger in discussing suicide during interventions with these clients.* *On the other hand, certain people begin thinking about suicide or make suicide attempts after having heard it discussed in their environment. It is a question here of contagion and imitation phenomena, effects well described in literature. It is a different process than what occurs in intervention.*	**False**
When we think of suicide, we will inevitably make an attempt.	**False**
It is impossible to prevent someone from committing suicide.	**False**

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When a person is suicidal, it is obvious, they look depressed. *Many suicidal people do not look like they are, they are not visibly sad or depressed. In some cases, people manage to hide their emotions to their loved ones. In other cases, they are not sad. They can be angry, agitated, aggressive, or detached from their emotions. There is no typical profile of a suicidal person. We must never trivialize suicidal communications or assess the risk based on a person's appearance of sadness or depression.*	**False**
Suicidal people are weak.	**False**
Intellectual disability is a protective factor against suicide. *ID is often perceived as protective factor against suicide because people with ID are perceived as being incapable of planning a suicidal act or understanding death. However, different levels of ID interact differently with suicidality. In fact, suicidal behaviour is rarely observed in people presenting a severe ID. Difficulties in communication and planning ability seem to protect them from suicide. Nonetheless, this does not protect them from distress and a desire to stop living can exist and manifest itself in other ways (refusing to eat, for example). The people presenting a moderate and mild ID have similar suicidal behaviours to the general population. The inability to plan and execute a suicide attempt does not minimise the distress felt by a person either. Suicidality must be understood in its entirety and the presence of ideations must be taken seriously since it reflects distress.*	**True and False**
People who do not understand the concept of death completely cannot want to kill themselves. *A partial comprehension of death can even be a risk factor since the person may want to die one day and assume they will return the following day if they do not understand the permanence of death.*	**False**
Miserable, depressed or sad people commit suicide. When we are sad, we have to commit suicide.	**False**

4.1.1 Vignettes: What I think of suicide

Objective

The following vignettes aim to support interventions with people presenting ID or ASD around themes having to do with beliefs on suicide. They aim to: 1) Identify the beliefs of a person with an ID or ASD concerning suicide for a more effective reframing; 2) Help the person understand what is happening when they or a person around them thinks of suicide in order to give intervention ideas to reduce suicide risk and the appeal of the suicide option.

Explication / rationale

When a person experiences MAAS or when they are confronted to someone else's MAAS, their beliefs in relation to suicide, if they are false, can harm the intervention or create cognitive fixations that can be damaging to them. Being aware of these beliefs and intervening to correct them can help reduce tension related to those

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cognitions and limit the risk of contagion. Furthermore, a constructive explanation of suicide can help the person to understand without putting themselves at risk of developing or maintaining MAAS.

Intervention Process

The following vignettes, that represent different beliefs on suicide, can be used to initiate an exchange and ask questions to the person having an ID or ASD. The person's perception can be discussed based on the answer given by the story. We can ask the person if they know people in the described situation, to then ask if they themselves have ever felt the emotions described in the situation.

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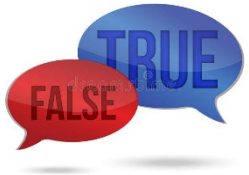
A person who wants to commit suicide cannot change their mind.



I agree I do not agree

And you, do you know anyone who has thought of killing themselves like Heather and that has changed their mind?
Tell me what happened.

Have you ever had thoughts like Heather?
Tell me what happened.

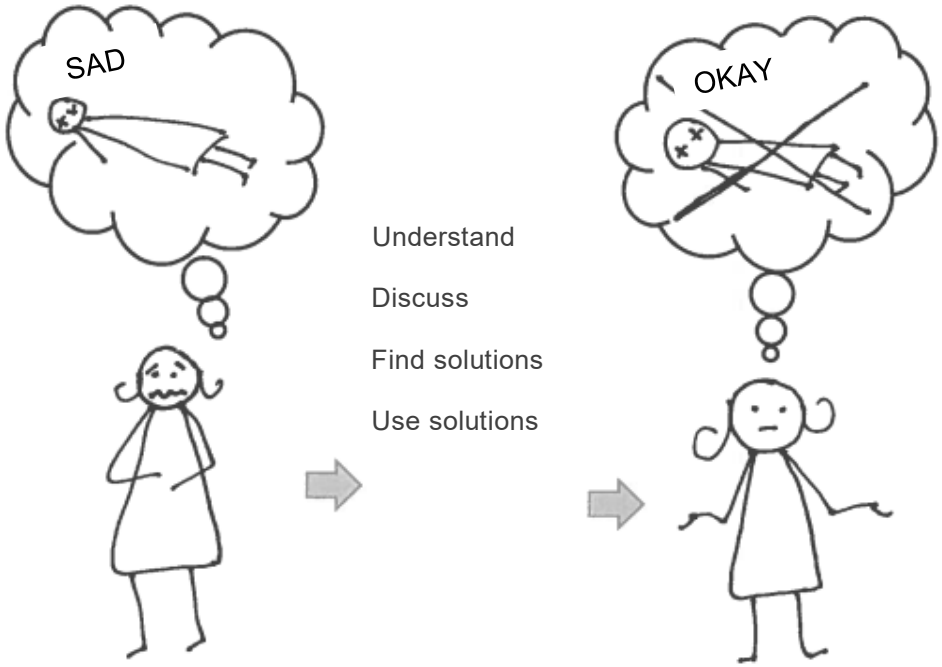
People who think about killing themselves often change their minds. They find other solutions and later they feel better.

Heather is sad because her boyfriend left her. She thinks she will never find another boyfriend and is very sad. She thinks about killing herself. She can't see a solution.

Heather's sister sees that she is very sad. She chats with her. Discussing what is wrong makes Heather feel better.

After a while, Heather is less sad. She knows that having a boyfriend is hard, but she also knows that there are good things in life like the love of her sister and her parents. These things are positive and important for Heather.

Heather does not think of killing herself anymore and this is good news! She has changed her mind.



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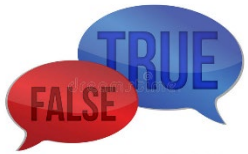
If someone commits suicide or thinks of suicide, other people will do it for sure.



I agree I do not agree

Do you know someone who thought about killing themselves after they saw someone else do it? Tell me what happened.

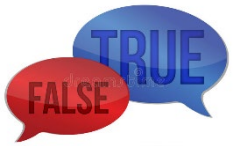
Have you ever thought of killing yourself after seeing another person do it? Tell me what happened.

When a person thinks of killing themselves, tries to kill themselves or dies by suicide, it can happen that other people think about it too, but not everyone. Those that think about it talk about it and get help.

Marie heard Alex say that he wanted to die. Alex is very angry and sad. He yells, he cries. He says: “If that’s how it is, I’m going to kill myself!” Marie is sad. She feels bad. She starts to think that she could also kill herself like Alex. She is scared! She told the counselor that she wants to kill herself. The counselor helps Marie understand what is going on. Marie feels better.

Jenn also hears Alex say that he wants to die. She doesn’t understand what is going on. She is sad for Alex. Jenn does not think about killing herself. She knows that sometimes, we can be sad, but after things get better. The counselor helps Alex. Jenn sees that Alex is doing better. Everything works out.

We can't stop someone from killing themselves.



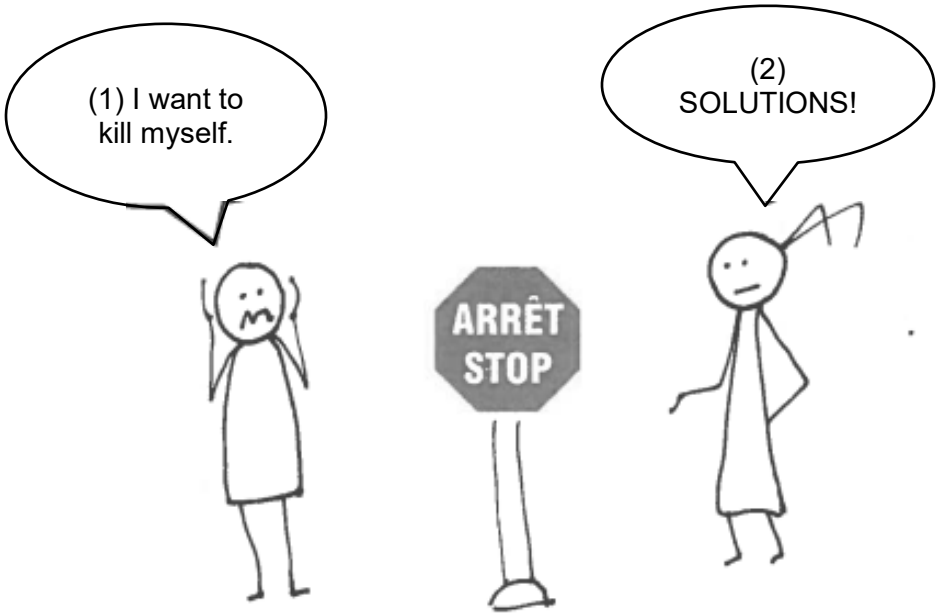
I agree I do not agree

Do you know someone who thought about killing themselves and someone stopped them from doing it? Tell me what happened.

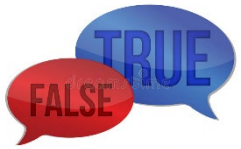
Have you ever tried to kill yourself and someone kept you from doing it? Tell me what happened.

When a person thinks of killing themselves, we can keep them from doing it by making them feel better.

Raphaël wants to kill himself. He is sure, he wants to die. He is fed up of everything and wants to stop suffering. He finds a way to kill himself.
He is in danger. He says he wants to kill himself.
His counsellor sees that Raphaël is thinking about killing himself.
The counsellor quickly goes to see Raphaël and discusses with him.
Raphaël agrees to give her the thing he had found to kill himself. His counselor helps him protect himself so he doesn't hurt himself anymore.
Afterwards, she works with him so he can feel better and to find solutions.



Miserable, depressed or sad people commit suicide. When we're sad, we commit suicide.



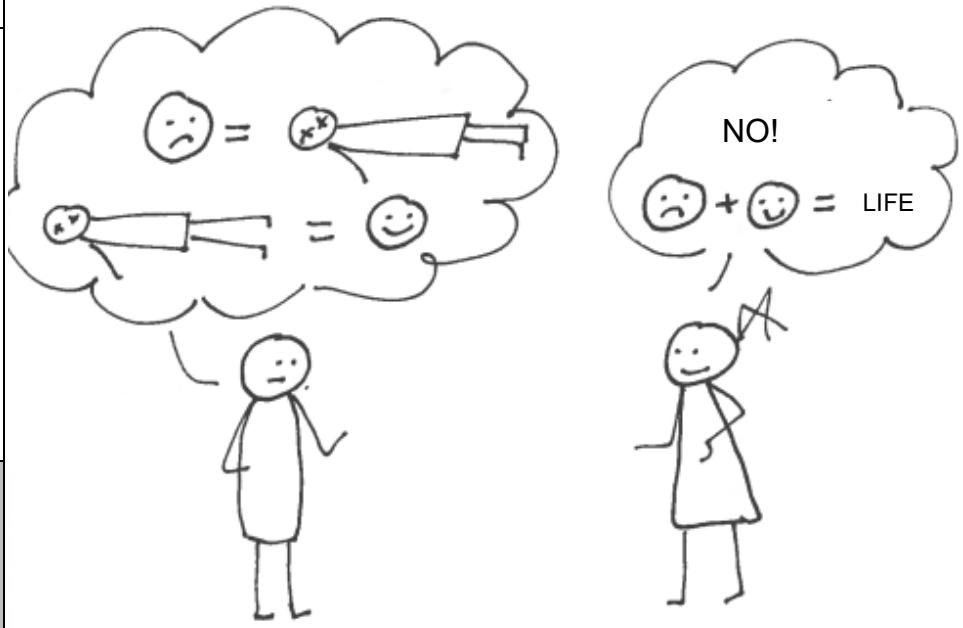
I agree I do not agree

Do you know someone who is sad (or miserable) and is still alive?
Tell me what this person does to be less sad.

Have you ever felt sad? What do you do when that happens? What do you do to be less sad?

Most people don't commit suicide when they are sad or miserable. They do things to feel better and they stay alive. Even if they are sometimes sad, most people are happy to be alive.

Daniel has a cousin who committed suicide, John. Daniel's mom explained that John was very sad and that is why he killed himself. Daniel thinks that if he becomes sad like John, he should kill himself too.
Daniel also knows other people who died. People say they're not suffering anymore.
Daniel thinks that do not be sad anymore, he has to be dead. He is confused and scared of this thought.
Daniel talks to his mom. She explains ways to not be sad or miserable anymore. When we are dead, we're not happy anymore either. When we are sad, we can become happy later. That's life! When we're dead, we can't say anything anymore.



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Thinking about suicide can happen to anyone.

I agree I do not agree

Do you know anyone that has ever thought of suicide? Tell me about this person.

Have you ever thought of suicide?

Different kinds of people can think of suicide. Sometimes, when a person tells us they have thought of suicide, it can surprise us.

Rich

With an ID

A friend

A character in a movie

Someone's parent

Young

An actor

An older person

A person that laughs often

A celebrity

Without ASD

A person that looks depressed

Poor

With ASD

A person that doesn't look sad

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Saying that we have suicidal thoughts is bad.	Daniel thinks about suicide. Daniel's family is mad at what he said. Myriam, Daniel's sister, is very mad at him. She tells him: "you're not allowed to kill yourself, that's bad! You're going to get punished!" Daniel's mom says: "Don't ever say that again! That's not allowed!" The counselor explains to everyone that it's not bad to think about suicide. Daniel shouldn't be punished for it. She explains that when we think about suicide, it's because we're suffering, that we want to stop suffering and that we need help. Thinking of suicide is not Daniel's bad behaviour, but a sign of distress. But it makes the people that love him scared, and the people that love him don't want Daniel to suffer or think of suicide.
 I agree I do not agree	
Do you know anyone that says that having suicidal thoughts is bad? Why do you think they think that way? Do you think thinking about suicide is bad? What do you think about people who have suicidal thoughts?	
Thinking about suicide doesn't make someone a bad person. It means we need help. We shouldn't hesitate to get help.	

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4.2 Story: Raphaël and suicide

Explanations on the process of suicidal ideations and attempts may be necessary when a person makes a suicide attempt or has been sent to the emergency room for a suicide attempt. These explanations may also be necessary when the person knows someone who has gone through these experiences. The exploration of a person's ideations and behaviours can also lead to this type of intervention. This intervention presents the story of Raphaël that allows to initiate a discussion on suicide attempts.

Boxes 1 to 4 discuss the most common risk factors (perception of social isolation, feeling of helplessness, despair) and trigger events. The intervention aims to explore the person's risk factors and trigger events. The counselor can formulate questions like this: "In the story, Raphaël thinks he will always be unhappy. Do you feel like Raphaël?"

In box 3, Raphaël expresses suicidal thoughts. The intervention aims to explore the person's ideations as well as their reasons for considering suicide (Suicide option). For example, a counselor might say: "Raphaël thinks that if he killed himself, he wouldn't feel so bad. What do you think? Have you ever thought about killing yourself? What do you think happens when you kill yourself?"

Boxes 5 to 7 present the sequence of events around Raphaël's suicide attempt and its effects on himself and on others. The intervention's aim here is to show the consequences of the attempt. However, the method used to attempt suicide must never be described. The intervention aims to discuss the consequences of the attempt (problem not solved, pain, unhappiness still present) and the transport to the hospital.

Box 7 describes the negative effect of the attempt on Raphaël's loved ones. The intervention aims to bring the person's attention on the people in their environment for whom they are important, in order to reinforce reasons for living and social support. The goal is not to blame, but rather to help the person to project themselves within the relations with others that are important to them.

Boxes 8 to 10 show the meeting between Raphaël and the doctor, during his visit to the emergency room. We also understand that an intervention is put into place upon his return from the hospital. The story ends on a positive note of improvement. The intervention here aims to discuss what happened at the hospital with the person. It also aims to discuss the importance of putting an intervention plan into place upon their return to their life environment. It should be discussed that the intervention plan is put into place to help them feel better following a suicide attempt or suicidal ideations.

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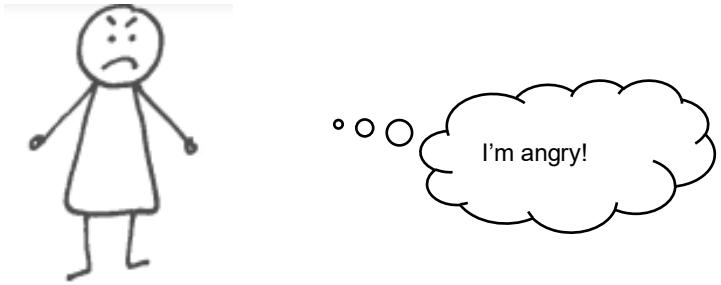
Raphaël and suicide

1		Raphaël is frustrated. Too many things are not going well for him right now.
2		Raphaël is unhappy and he doesn't really know why. He doesn't know what to do to feel better. He thinks it will always be this way.
2b		Everyone is worried for Raphaël. Mom wants Raphaël to smile. His friends want to play with him. His counselor wants Raphaël to participate in activities he likes. But Raphaël doesn't see this. He feels alone.

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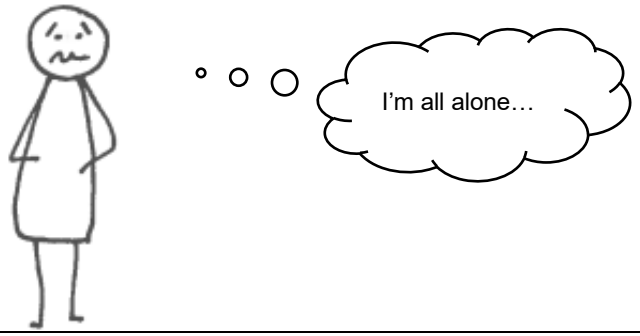
3 	Raphaël wants to stop feeling bad. He thinks that if he killed himself, he wouldn't feel so bad.
4 	Raphaël feels that no one understands him. He feels alone and scared.
5 	Raphaël tries to kill himself. He is injured, it hurts. He is still unhappy.

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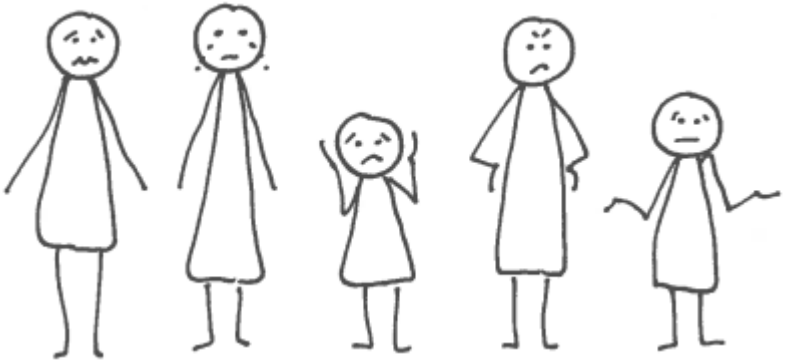
6 	The ambulance comes and Raphaël goes to the hospital.
7 	Everyone is worried for Raphaël and they want him to get better. Mom and Dad want him to come home. His friends want him to come back and play cards. His counselors want him to come back to continue to learn all kinds of things.
8 	At the hospital, the doctor asks Raphaël plenty of questions to understand why he tried to kill himself. He wants to help Raphaël feel better and go back home quickly.

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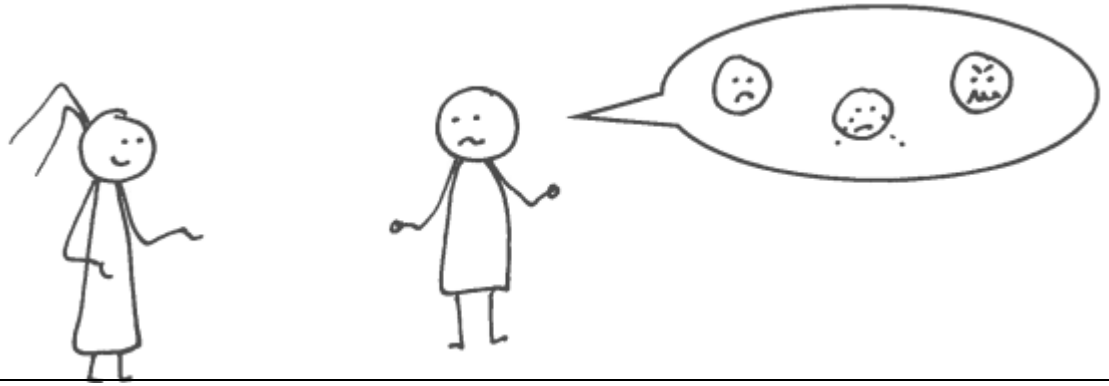
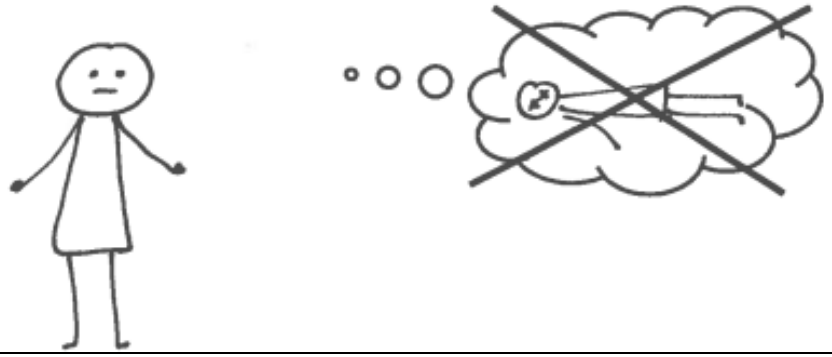
9 	At home, Raphaël works with his counselors and his family. Raphaël learns to express how he feels and when he's not doing well. That way, we can help him feel better.
10 	With help, Raphaël finds solutions to his problems. He learns that he can feel better without killing himself.

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4.3 Story: Marie learns to say that she has suicidal thoughts by observing others

This story discusses the theme of imitation or the MAAS contagion effect. This effect exists within the general population and is well documented: When a person commits suicide or shows MAAS, they can be imitated by other people in their environment. Imitation can happen in small groups (at school, for example) or in small communities (in small villages, for instance). It can also happen when people hear of a suicide in media or in other communities, or when they feel related to the deceased person (for example, in the case of a celebrity suicide, a character in a film, a person in another residence, etc.).

Studies conducted with the general population show that discussing suicide from a clinical intervention standpoint does not increase the risk of MAAS. On the contrary, it allows to clarify a person's experiences and emotions, as well as adjust the intervention to the reality of the situation. With people presenting ID or ASD, imitation has been described by professionals and seems to affect verbal communication, suicidal planning and suicide attempts. The models can be from real life (loved ones, friends, residents, colleagues, etc.) as well as from media (news, film, tv, etc.). As with the general population, there does not seem to be a contagion effect when discussing suicide in a therapeutic context, with the condition that it is well explained.

This story can be used by the professional that suspects that a person exhibits MAAS as a result of imitation, that is, when MAAS have been observed in their environment. It aims to defuse contagion and reinforce adequate communication strategies about needs and distress, without judging the use of MAAS. This story and its accompanying intervention should be used after a complete danger assessment has been made. Discussing imitation does not mean that the MAAS are not serious; they hold here a different function than the communication of distress. Imitating MAAS is not trivial and such behaviours must be taken seriously. Beyond danger assessment, the intervention aims here to understand the imitation process and name it in order to have the possibility of reinforcing other adaptation and communication mechanisms.

Boxes 1 to 4 describe Marie's imitation situation. The intervention aims to identify the person's possible source of imitation in their environment.

Boxes 5 to 8 provide explanations on what imitation is and aim to normalize it. The intervention here allows the professional to identify, along with the person, other behaviours, ideas or emotions they might "catch" from others or from media.

Boxes 10 to 13 display Marie's MAAS imitation. The intervention aims to explain what may have happened to the person, to identify and normalize the suicidal behaviour.

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Box 14 displays the identification process of the triggers of Marie's actual distress. The intervention aims to bring the person back to their current internal state, in the here and now. It also aims to identify what may have triggered their MAAS, outside of any imitation process (taking MAAS seriously).

Boxes 15 and 16 allow to identify and name the methods usually used by Marie (outside of MAAS) to express her needs and emotions. The intervention aims to re-enter the person on the means of expression they usually use in order to reinforce them, without judging or punishing the use of MAAS.

Box 17 illustrates the way the counselor reassures Marie regarding what happened with her friend who showed MAAS. The goal of the intervention is to explain that the person Marie imitated is doing better, as the case may be. If the imitated person is deceased, it is important to explain that they are dead because they did not have enough solutions. It is then important to contrast this situation with the person's by reassuring them on the fact that they have solutions, and they will come out of this. It is also possible to explain that people sometimes use MAAS to express discomfort or that they are not well, and they can use other methods. The goal here is to reassure the person, if possible, as to the wellbeing of the imitated person and put an emphasis on their strengths.

Box 18 illustrates the search for solutions to the person's situation in order to reduce distress. This step is part of the solution-oriented approach used in suicide prevention. It is therefore important to validate and emphasize the person's strengths. It is by leaning on the person's strengths that the person will be able to use the solutions that benefit them and will help them feel better. It is counterproductive to re-discuss MAAS in a negative way.

Box 19 shows how we can attempt to consciously break the vicious cycle of MAAS imitation. We can attempt to eliminate the thoughts that do not belong to the person by erasing or scratching out a drawing that represents this idea. We can also choose to use words instead.

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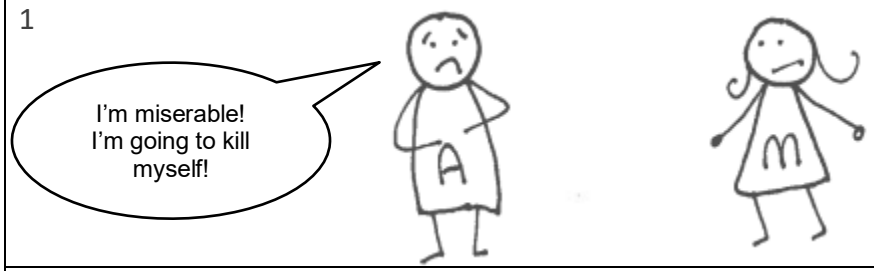
Marie learns to say that she has suicidal thoughts by observing others

1 	Marie has a friend: Alex. Alex said that he wanted to kill himself and Marie heard him.
2 	Marie is sad. She feels bad. She starts thinking that she could also kill herself.
3 	Marie's counselor discusses with her to understand what is happening. She notices that Marie has suicidal thoughts ever since Alex had some.

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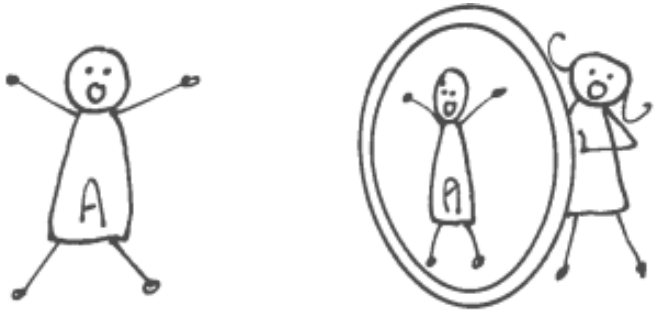
4 	The counselor explains that sometimes that happens. When we see or hear someone say something, we can start thinking like them.
5 	For example, when we see a person feeling sad, we can feel sad too, like the person. We feel like a mirror.
6 	For example: When we see someone do something, we might have the same behaviour, like the person. We feel like a mirror.

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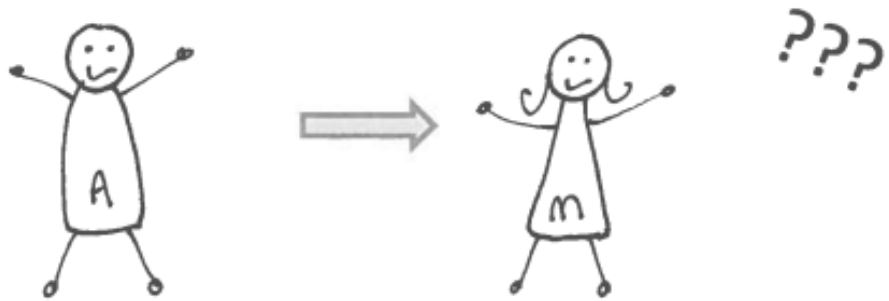
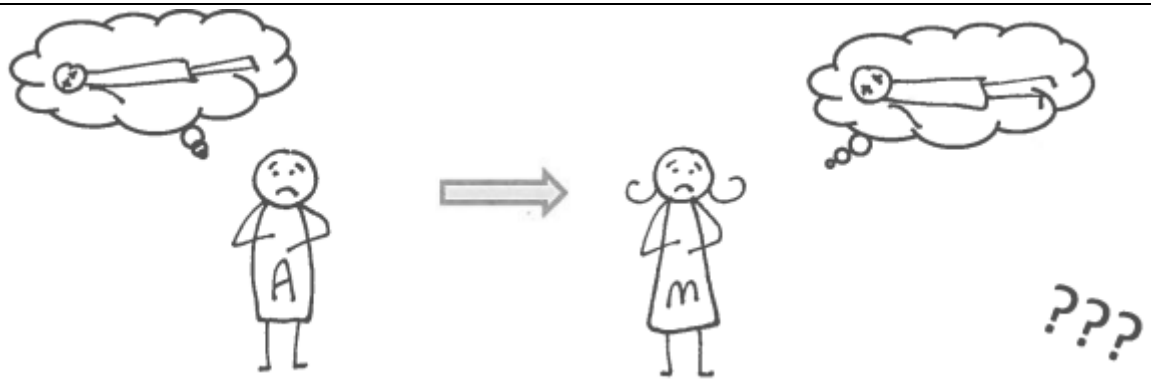
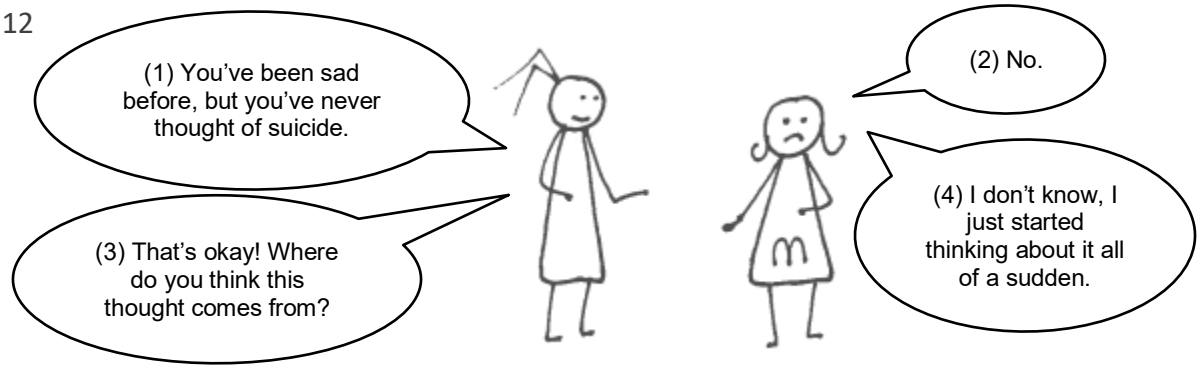
10 	Sometimes, we don't know why we act like others. It happens to everyone. And often, it's not a big deal. It's okay!
11 	Sometimes, the things we do like others are serious. We risk putting ourselves in danger.
12 	In those cases, it's important to think of what happened. The counselor asks Marie where her suicidal thoughts come from. Marie doesn't know. She Feels confused.

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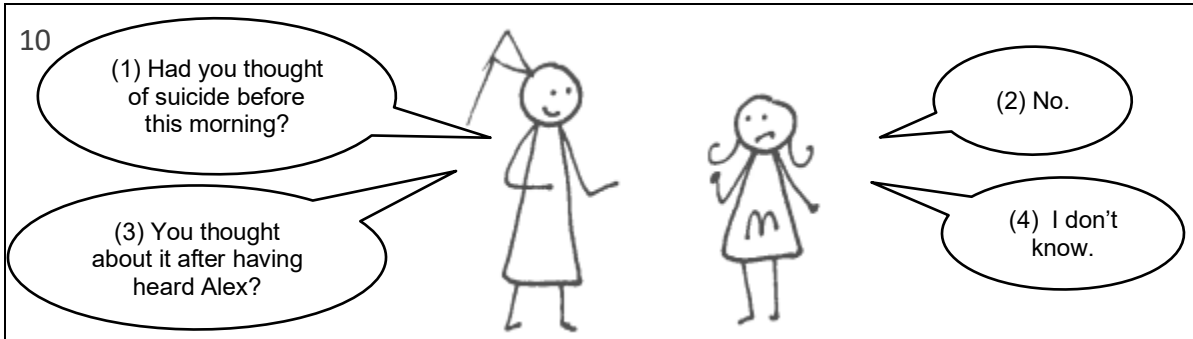
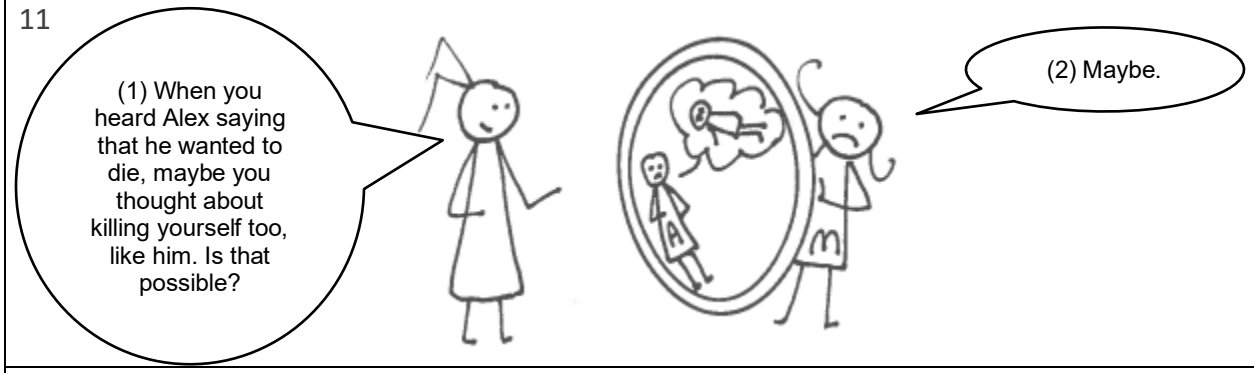
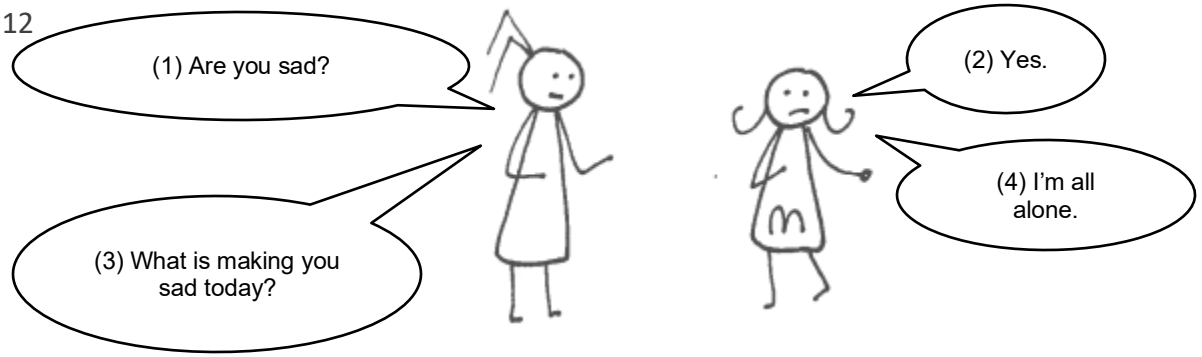
10  	Marie had never thought of suicide before Alex said it.
11  	The counselor asks Marie if her suicidal thought was like a mirror to Alex's. It's hard to know. That's okay! These things are hard for everyone!
12  	The counselor discusses with Marie to understand if she is sad, angry or worried because of something specific in her life.

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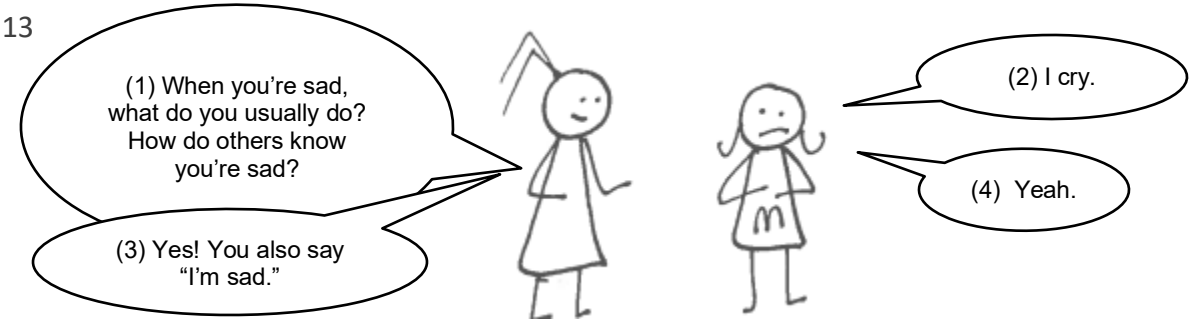
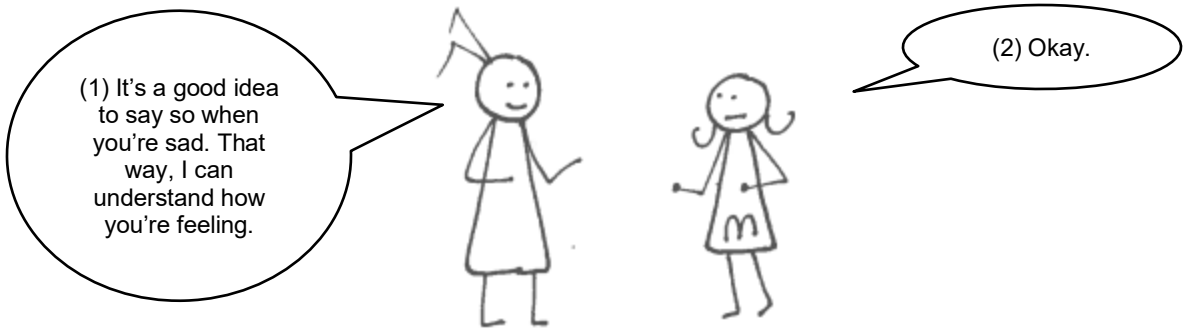
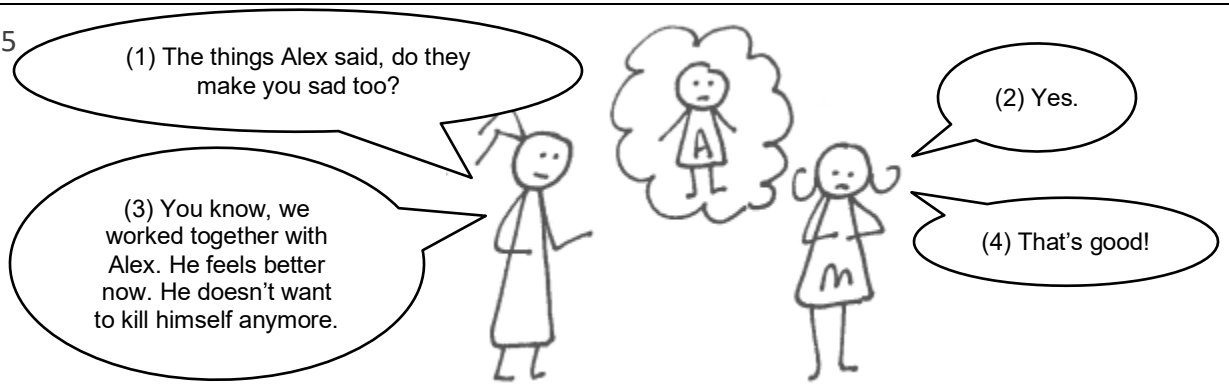
13 	Marie and her counselor discuss strategies for Marie to express how she is feeling.
14 	They remember that it's important to use these strategies
15 	The counselor also explains what happened with Alex.

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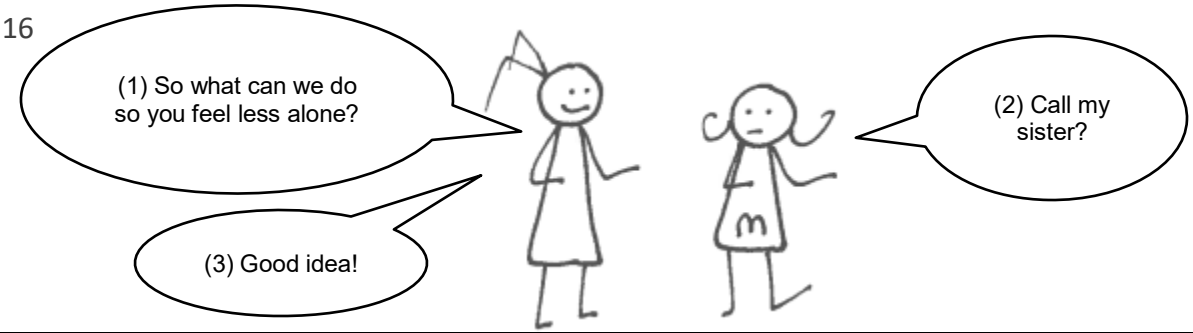
16 	The counselor and Marie work together so that Marie feels better and finds solutions.
17 	The counselor and Marie work together so that Marie does not keep Alex's suicidal thoughts inside her.

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4.4 Working on fixations on death and suicide

There is no typical outline to work on fixations on death and suicide. In fact, these fixed ideas can play a very different role depending on the person and context. It is not recommended to confront the person on this subject because they may push back and get stuck in an even greater cognitive rigidity. To our knowledge, there is currently no validated good practice guide to support interventions that would allow to reduce the impact of cognitive fixations on suicide in people with an ID or ASD. However, this section makes a few recommendations from the experiences of clinicians having the potential to support an intervention plan aiming to reduce the impact of fixations on suicide or death.

The presence of fixed ideas on death and suicide can contribute to the increase of suicide risk by the reinforcement of the appeal of the suicide option. For this reason, fixations on death and suicide should not be discussed during a MAAS episode. Interventions on these fixed ideas should instead be done in the context of a mid- and long-term follow-up. It is therefore not necessary to discuss the MAAS episode to address the person's fixations with them.

Certain people can have fixed ideas on suicide and death without having had known MAAS episodes. These cognitions, as well as the associated interpretations and beliefs, can weaken these people in relation to suicide when they are faced with trigger events. It therefore may be appropriate to intervene on these fixations concerning death and suicide, even in the absence of MAAS.

In all cases, the first intervention step is to thoroughly analyse the form, structure, expression pattern and function of the person's fixed ideas on death and suicide. This evaluation can help answer questions like:

- How are the fixed ideas expressed (behaviours, statements, attitudes, etc.)?
- How often do these fixed ideas occur? Can we identify external triggers when these ideas are manifested?
- Has this interest been present for a long time? Has it appeared recently? Can we associate the emergence to an identifiable outside event (film, death of a loved one or pet, suicidal behaviours in social environment, etc.)?
- Do the fixed ideas play a particular role for the person (appeasement of anxiety, relaxation, interaction, etc.)? What is the function of these fixed ideas on death and suicide for the person?
- What is the impact of the fixed ideas on the person's social environment (loved ones, family, counselors, peers, etc.)? What is the feedback effect on the person and on the expression of their fixed ideas (conversation, increase or inhibition of ideas, anxiety, provocation, etc.)?

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The second step consists of analysing the cognitive, emotional, behavioural, medical and social context in which the fixed ideas are being produced. The person may be confronted to all kinds of situations like a depressed mood or a depressive episode, an increase in anxiety, difficult life situations or an adjustment period to medication. They can also have seen a movie, been witness to suicidal behaviours or been confronted with the death of a loved one or pet.

Before intervening on fixed ideas about death and suicide, it is important to conduct a screening and danger assessment (screening and danger) in order to detect, if applicable, the presence of current disguised MAAS. In fact, the person can express an intense interest for suicide in general, while also having indirectly expressed suicidal ideations.

The intervention should first and foremost deal with the identified sources of the fixations on death when they are able to be identified (treatment of depression, anxiety, behavioural activation, social activation, working on self esteem, goal reinforcement and self empowerment, etc.).

The interventions for fixations can have a few simple objectives:

- Clearly identify the rigid thoughts or potentially harmful fixation's content with the person in order to favor the development of their ability to nuance their judgement.
- Incite the person to see the potentially negative effect of these thoughts on their mood, in order to encourage them to replace them with more positive thoughts.
- Identify the person's questions in relation to death and suicide. It may be necessary to explain death, to discuss alternatives to suicide when we are living a difficult situation, and to correct inaccurate understandings.

4.5 Working with suicide-related cognitions - reasons to think of suicide and reasons to not think of suicide (reframing)

Objective

This intervention allows the person to identify situations in which they think one can become suicidal. Situations that do not lead to suicidal thoughts are also identified by the person. This exercise lets the person understand the cognitive context in which MAAS can become acceptable for them.

This activity can be done: 1) When a person worries their loved ones without necessarily showing obvious MAAS; 2) When a person in their social environment has presented MAAS; or 3) When a person asks a lot of questions about suicide. This activity

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cannot be done when the person is actively showing MAAS, since the exploration or reasons to live or die is part of the danger assessment process.

Explication / rationale

By identifying these situations, it is possible to reveal: 1) the person's values and beliefs concerning suicide, while distinguishing those that increase and decrease suicide risk; 2) the person's reasoning in relation to death and suicide and the causes they attribute to suicide; and 3) the situations in which the person could become at risk of developing MAAS. All these elements can become the subject of interventions, of cognitive reframing and emotional exploration.

Intervention Process

It is firstly important to be in a calm environment with the person. We must then explain to them that we are about to discuss suicide because it is something that worries them generally and that we will help answer their questions.

With the professional's support, the person explores reasons to consider suicide. These reasons are noted in the first column of the table (See Table 10). We complete the exercise by identifying means to make these reasons disappear. These means can be applied by themselves or by their social environment.

With the professional's support, the person explores the reasons to not consider suicide. These reasons are noted in the second column of the table (See Table 10). We complete the exercise by identifying means to reinforce these reasons. These means can be applied by themselves or by other people around them.

We determine the reasons for considering and not considering suicide, showing that there are elements on both sides, with the goal being to show the person that when they think of killing themselves, they must focus on the elements for refusing to do it.

The exercise relates to those on hope, but introduces external situations to the person that can have a contagion effect on them, by exploring the cognitions associated to suicide for the person more closely as well as those that can reinforce the appeal of the suicide option outside of moments of distress and serious worry.

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Table 10 - The reasons to commit suicide and the reasons to not commit suicide

What reasons can a person have to think of killing themselves?	What reasons can a person have to refuse thinking of killing themselves?
According to you, are these good reasons? Why?	According to you, are these good reasons? Why?
How can we make these reasons to want to kill themselves disappear in their mind (their thoughts)? What are alternative methods to arrive to the same goal?	How can we make the reasons to not kill themselves grow (reinforce) in their mind (their thoughts)?

Table 11 presents a few examples of considering or refusing suicide. This list is not exhaustive. These reasons can be named as ideas or to allow the professional to initiate the discussion if the person says that they do not know. The professional can also make suggestions based on what is known about a situation that has incited worry or prompted the exercise. The goal is ultimately to give more reasons for the right column than the left and to finish the exercise on a positive and constructive note.

Table 11 - Examples of reasons to consider or refuse suicide

Reasons to consider suicide	Reasons to refuse suicide
• Stop suffering • Stop being sick • To not feel so bad • To feel better • To go be with someone we love • Change the situation • To be heard	• We won't be able to do what we love • It's not allowed by our religion • It makes other people sad • We don't come back • There are good things in life

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4.5.1 Sample exercise on the reasons to consider or refuse to consider suicide

The person has been witness to suicidal statements from another resident (Jo). He is asking himself a lot of questions on the reasons why Jo thought of killing himself. The counselor (in italics) can encourage him to express himself on the subject (Table 12).

What reasons does Jo have for thinking of killing himself? • To go see his grandpa who died and he is sad. • So others don't bother him anymore. Everyone bothers Jo.	*What reasons can a person have to refuse to think of killing themselves?* • It makes his mom sad.
According to you, are these good reasons? Why? • Yes. He misses his grandpa a lot. • Yes. Because when we die, nobody bothers us anymore.	*According to you, are these good reasons? Why?* • Yes. Jo doesn't want to make his mom sad because he loves her.
How can we make these reasons to think of killing himself disappear in his mind (his thoughts)? What can Jo do to be less sad?  • When Jo misses his grandpa, he can talk about good things he remembers about him. • We can have a grief activity at the residence. • Jo can do an activity with someone else that he liked doing with his grandpa *What can Jo do so that people don't bother him anymore?* • Jo can explain to the counselors that others are bothering him and find a solution. • When we die, we can't have any more fun either, so it's boring.	*How can we make the reasons to not kill themselves grow (reinforce) in his mind (his thought*  • Find solutions to problems so he won't want to kill himself anymore. • Tell his mom he loves her. • Thinking of his mom when we wants to kill himself.

Table 12 - illustration of the reasons to kill yourself and not kill yourself

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4.6 Understanding and reducing secondary benefits of MAAS

Very little information is available in the scientific literature to understand the process involved in the development of secondary benefits related to difficult and suicidal behaviour. Likewise, factors associated with clinical environments that lead to suicidal behaviour becoming chronic are not well known. It is however important to take this phenomenon into consideration during interventions.

Secondary benefits are gains or advantages that the person obtains from their behaviour. They occur in the context of an interaction between the person and their environment and can depend on the demands made on the person by their social environment, the relations between people and organisational structures.

Our study with professionals who work with suicidal people having an ID or ASD has revealed a series of interactional processes through which secondary benefits of MAAS can be created and maintained. Here are a few examples:

- A MAAS episode resulted in the cancellation of a requirement or undesired activity. During subsequent similar situations, it is possible that the person learn to use MAAS to escape a similar undesired situation.
- Certain people can learn to use the terms and expressions from screening tools to be considered at risk in order to receive special attention from professionals.
- Professionals often think that people with ID or ASD do not really think of suicide and that their behaviour has another function. They then identify a specific function to the MAAS and their interventions reflect and convey this. People with ID or ASD can end up aligning their behaviour to the professional's expectations and can use MAAS the way the professionals think they use them.

Professionals often think that people use MAAS as a negotiation tool. However, the process is more complex and iterative. The expression of distress and MAAS may have brought on a particular attention and the person learned to use this behaviour to obtain a desired response. It is therefore the professional's response that has caused learning and the use of MAAS as a negotiation tool, in a general structure where many behaviours are developed by learning, in relation to the professional's reaction.

Other processes in relation to interactions with the professional can act as factors for the creation and maintenance of MAAS. Here are a few:

- A discrepancy between the person's current capacities and the environment's demands. This situation can create a rupture in functioning and MAAS. The intervention and support environment should therefore be attentive to

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variations in the person's capacities and environmental demands to try to keep a balance between them.

- The multiplication of professionals working with the person. This situation can create fatigue when the person is constantly being solicited to work on objectives, modify behaviours, or to improve skills. These multiple demands from professionals can lead to frustration, a rupture in functioning or MAAS.
- The internal attribution of the person's difficulties by the professionals. This situation can limit interventions on the environment and create MAAS responses.
- Changes. People with ID or ASD are susceptible to experience many changes (routines, professionals, living arrangements) that are potential risk factors.
- Conflicts with professionals and the escalation of aggressive or disruptive behaviours in the presence of professionals. These situations can be a risk factor.
- Ignoring a behaviour to not reinforce can create an escalation of MAAS danger to obtain an effect desired by the person.

The processes involved in the structures of the interventions and services should be known and taken into consideration when an intervention plan is created to reduce the recurrence and appearance of secondary benefits of MAAS by people using these services.

Interventions to reduce risk factors and reinforce protective factors: Useful clinical interventions to help prevent suicide in the long term

Several intervention practices participate in reducing suicide risk in the long term, like those reinforcing emotion regulation, improving the comprehension of social situations, reducing anxiety, treating depression symptoms, reinforcing the comprehension and expression of emotions and needs, supporting the acceptance of their situation and the development of positive and realistic life projects. Many of these evidence-based best practice clinical interventions are available to professionals, and are often already used in at-risk clients. Figure 16 illustrates some of these interventions. In parallel, it is also important to implement interventions aiming to treat the impact of childhood negative life experiences and potentially traumatizing events that are highly associated to an increase in suicide risk.

These interventions should be adapted to each person and put into place based on the results of the danger assessment and exploration of the suicide option. These interventions should also be backed by a thorough knowledge of the person's functioning by the multidisciplinary team that accompanies the person on a regular basis.

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In order to complete what is already being done with clinical intervention in the ID and ASD field, certain intervention tools for suicidal people, validated for the general population, show a potential for adaptation towards an ID and ASD clientele.

Acceptance and Commitment Therapy (ACT)

Acceptance and Commitment Therapy (ACT) belongs to the third wave of cognitive-behavioural therapies. It was developed on solid theoretical bases concerning cognitions and language. It leans on six principal axes that address the functional aspects of behaviours and difficulties associated to language characteristics. Each of these axes is presented in Table 13 along with a brief definition.

Table 13 - Principal axes of Acceptance and Commitment Therapy (ACT)

Axes	**Definition**
Acceptance	Active process aiming to limit escape or evasion behaviours to events or harmful psychological events.
Defusion	Understanding and managing thoughts that do no not reflect reality.
The self as context	Perceiving the self as the context in which thoughts and emotions appear and not only as the author or object of these thoughts and emotions.
Contact with the present	Focusing attention on the here and now in order to limit verbal impact, put themselves back in contact with the immediate consequences of their behaviours.
Highlighting values	Identifying what really matters, the orientations they wish to assign to their lives.
Action	Act to develop behaviours related to identified values, concentrate on behaviours that work.

ACT has been evaluated with individuals presenting ID in the treatment of mental disorders with very promising results, even if this approach rests on the use of language and metaphor. It seems particularly suited to the completion of a behavioural analysis with people who present problematic and intrusive thoughts and emotions. Studies are rarer when it comes to the application of ACT with people with ASD, but as with ID, the prospects are promising, particularly with high functioning individuals. ACT is an approach more and more used with people having had suicidal behaviours, and it has lead to significant improvements of underlying conditions. It is therefore promising to use ACT principles with suicidal people with ID or ASD.

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Dialectical Behaviour Therapy (DBT)

Dialectical Behaviour Therapy (DBT) was developed specifically for people presenting important difficulties with emotional regulation. Its efficacy in reducing recurrent self harm and suicidal behaviours is very well demonstrated in diverse clienteles of adults and adolescents, particularly with people presenting borderline personality disorder.

One of the advantages of this approach is that it is contained in a manual and freely available in adult and adolescent versions. The interventions are structured around activities to be done individually or as a group and are accompanied by clearly written activity sheets.

The DBT approach is starting to be used with clients having ID and mental health disorders. It seems promising for reducing difficult behaviours, emotional dysregulation and anxiety disorders. However, it seems like DBT should be subjected to adaptations in order to become more effective with people having an ID. There does not currently exist a significant corpus of research concerning the application of DBT with an ASD clientele.

Even if it is not used in its entirety, DBT includes relevant elements for interventions with suicidal people presenting ID or ASD. For example, it can be used in order to obtain the cooperation of a person who, at the start, refused all forms of intervention (see intervening with a person in ways to approach a non-cooperative person written in intervention 2, ensuring security, intervention 1.2. of this book)

General improvement in quality of life

The improvement in quality of life is a vital objective in suicide prevention, especially with people having an ID or ASD. It allows to reinforce their reasons for living, control on themselves and on their life, their feeling of belonging, self-esteem, and wellbeing. Moments of fulfillment are necessary every day and no targeted intervention in suicide prevention can be effective in a general environment where the person feels they have no quality of life. The essence of long-term intervention should concern the people's improvement of wellbeing and quality of life, and the effects of these interventions will allow to reduce suicide risk in the long term.

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