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.

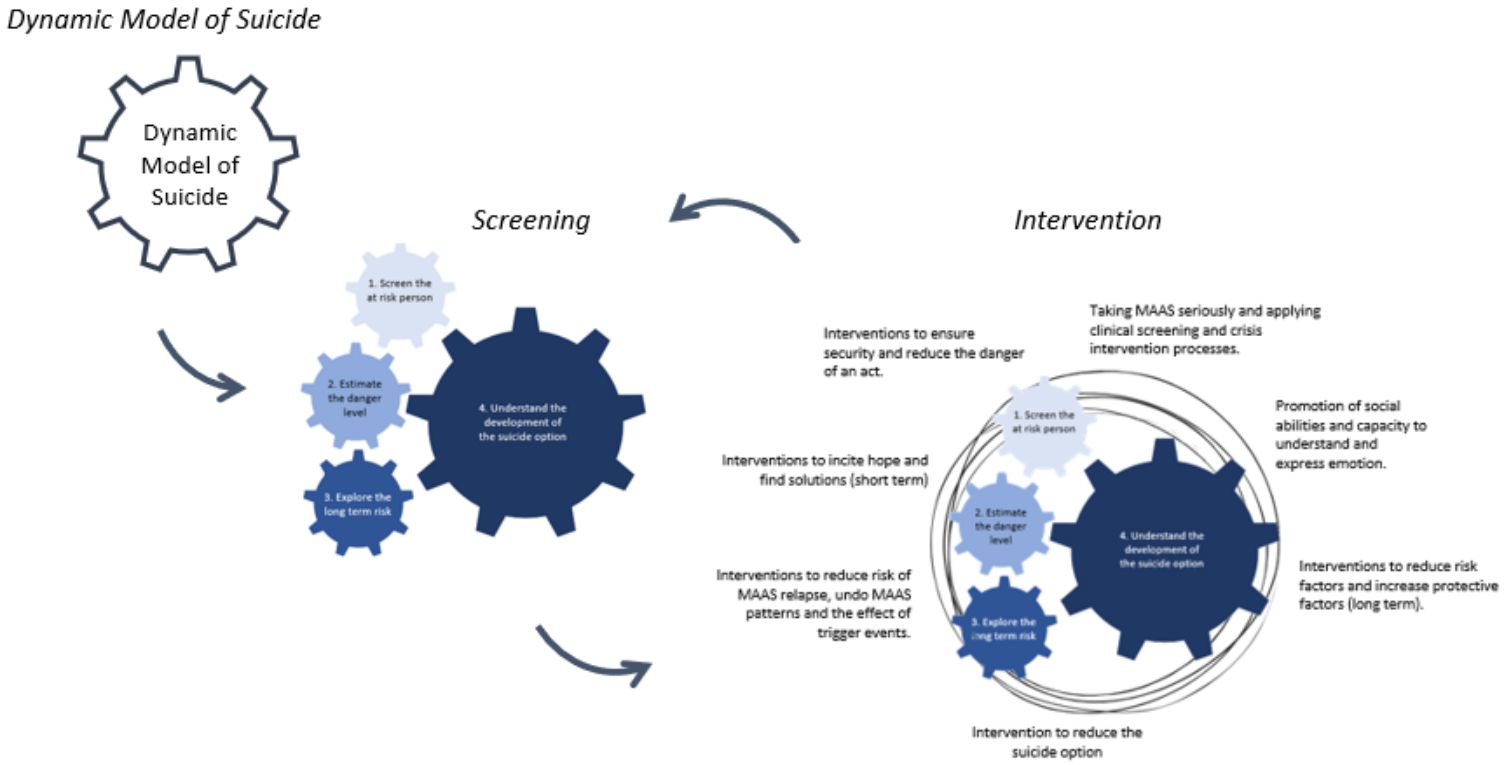
The IDAS Process is intended for professionals working in the field of intellectual and developmental disability rehabilitation, in community organisations or in suicide prevention.

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

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.

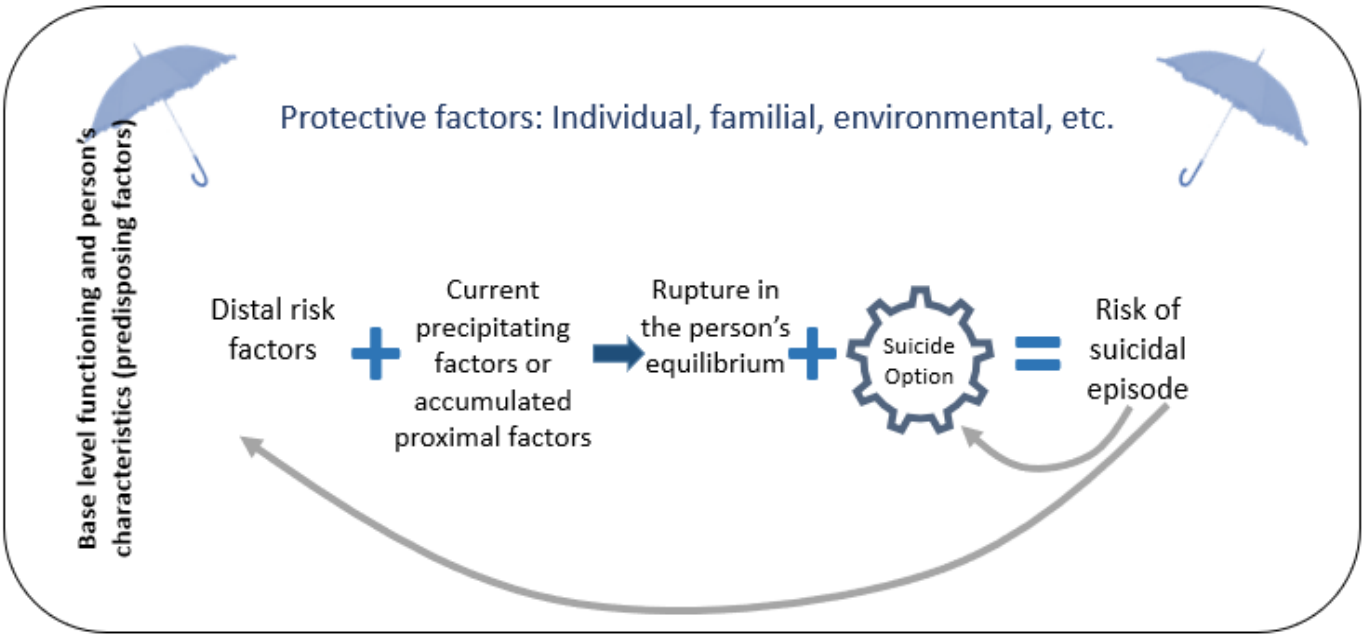


Figure 2 - IDAS Process Model – A dynamic model of suicide in people with ID or ASD

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

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

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.

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.

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)

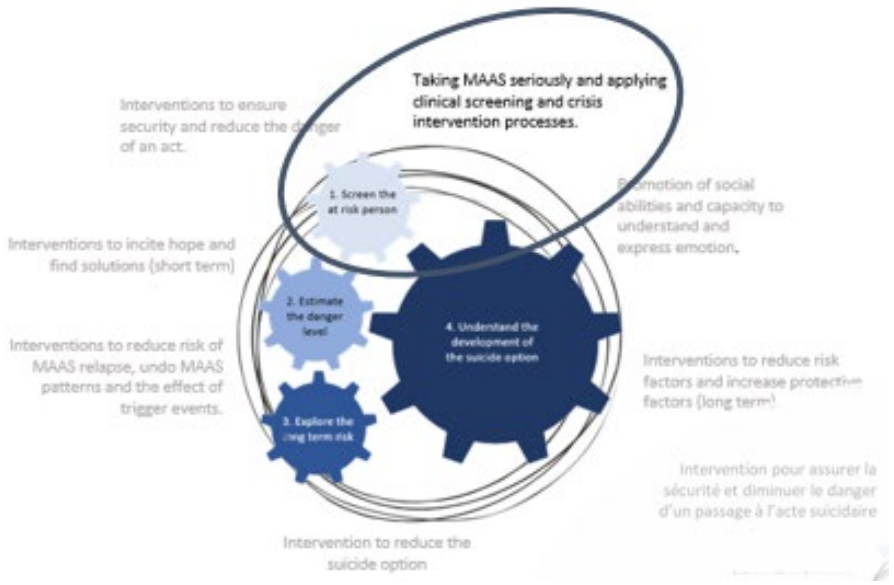
The assessment and intervention phases are interdependent at all levels of suicide risk management. From this perspective the clinical process is based on the sequence observe-decide-act (illustrated in Figure 3), which is found at all its levels.

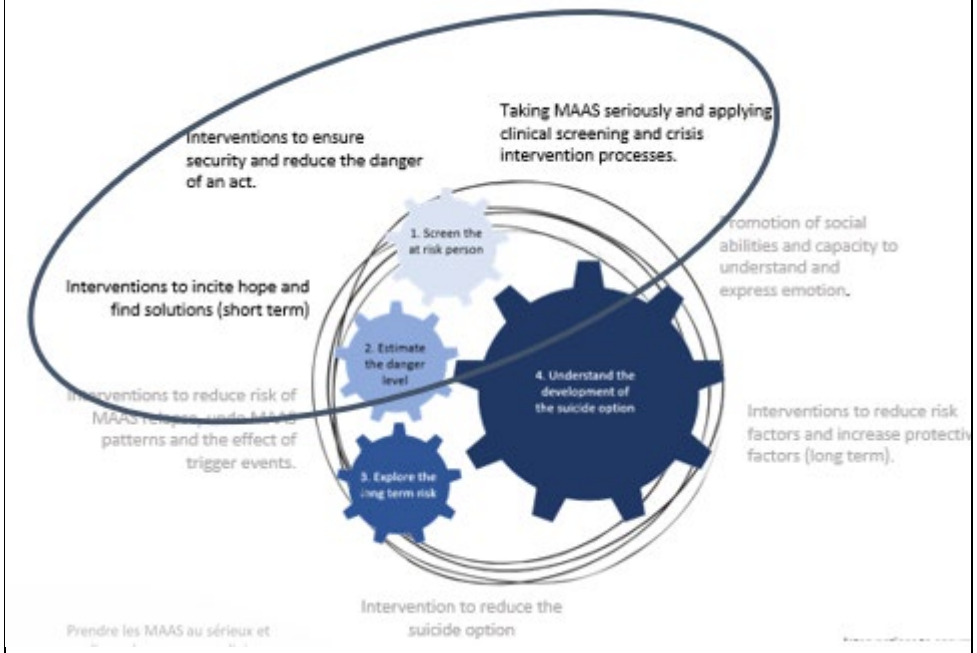
Figure 3 - Basis of the clinical process

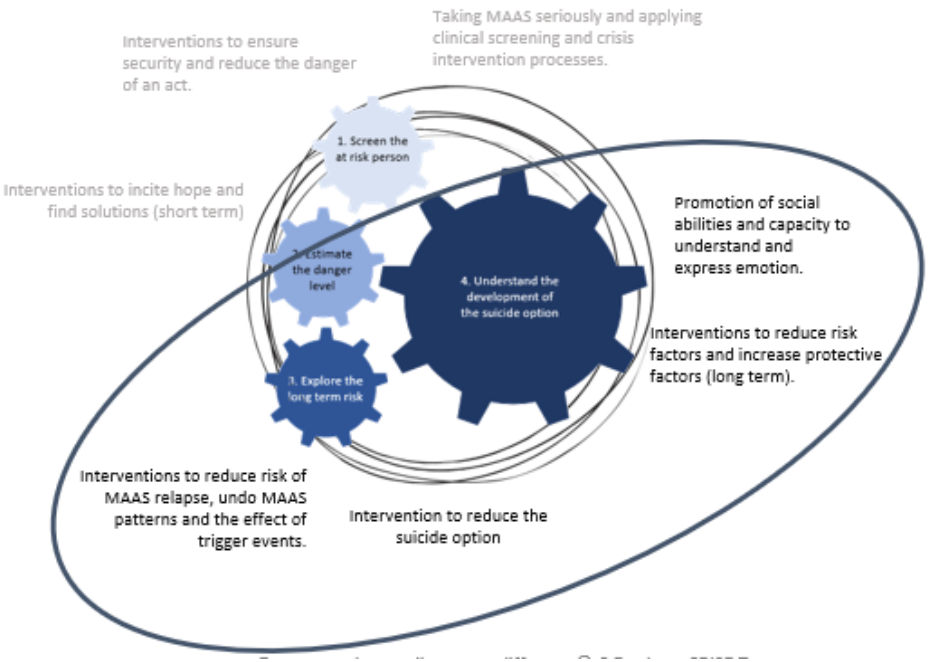
Keeping this sequence in mind, the clinical process includes three complementary parts based on the dynamic model of suicide (see Table 2). The steps are: 1) screening, 2) management of the suicidal episode, and 3) risk reduction.

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.

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

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

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

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).

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.

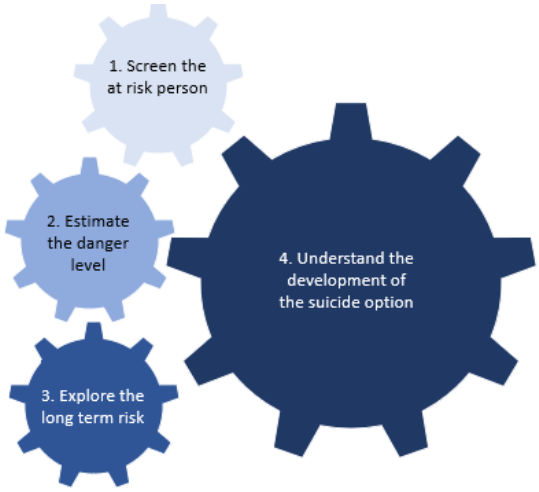


Figure 4 - Elements of screening

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.

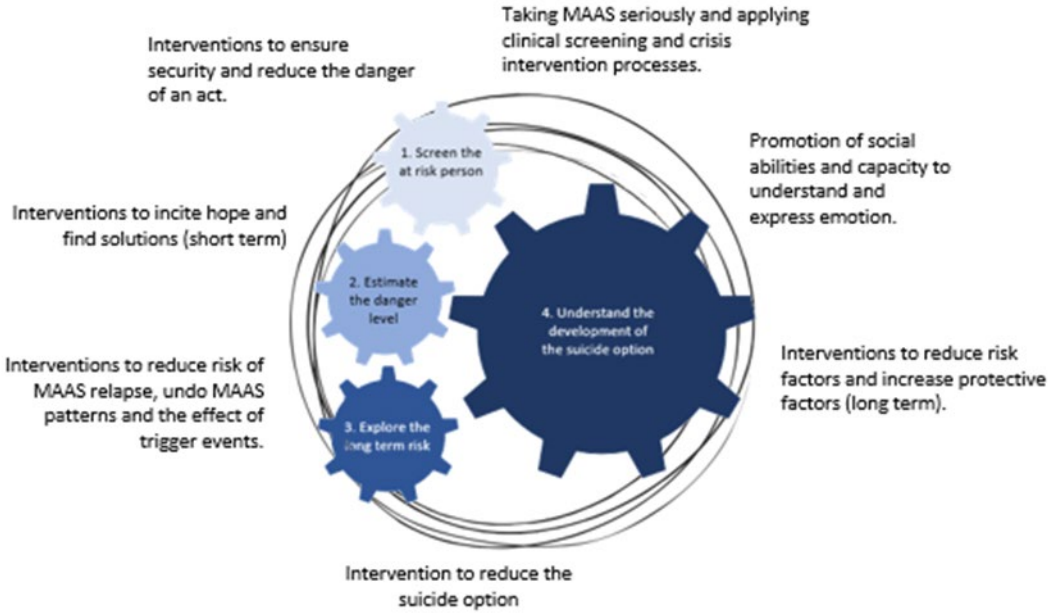


Figure 5 - Intervention strategies adapted to the objectives identified during the screening

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.

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

<table>
<tr><td rowspan="6">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</td><td rowspan="6"> 
</td><td colspan="2">Observe: collected information
Source: Questions to the person, observations, questions to professionals, friends or relatives, person's clinical file</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Decide: Decisions resulting from the screening / episode management / risk reduction process</td></tr>
<tr><td>Decision criteria in the form of questions</td><td></td></tr>
<tr><td colspan="2">Act: intervene to prevent suicide</td></tr>
<tr><td>Possible intervention strategies at this stage and to be adapted according to the decision taken from the observations made.</td><td></td></tr>
</table>

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)-

- 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.

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?”)

- 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.

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.

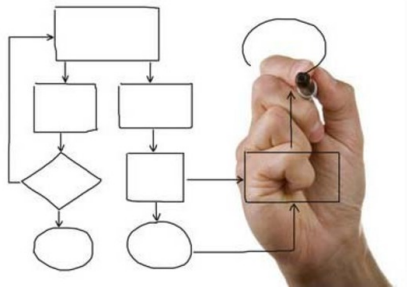
Reassure the user: when you think of something, it does not mean that you are going to do it.

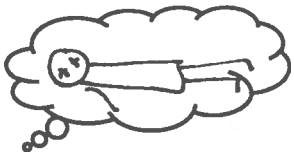
Exploring the presence of MAAS takes place in continual dialogue.

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?

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

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.

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.	

	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?

	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).

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.

