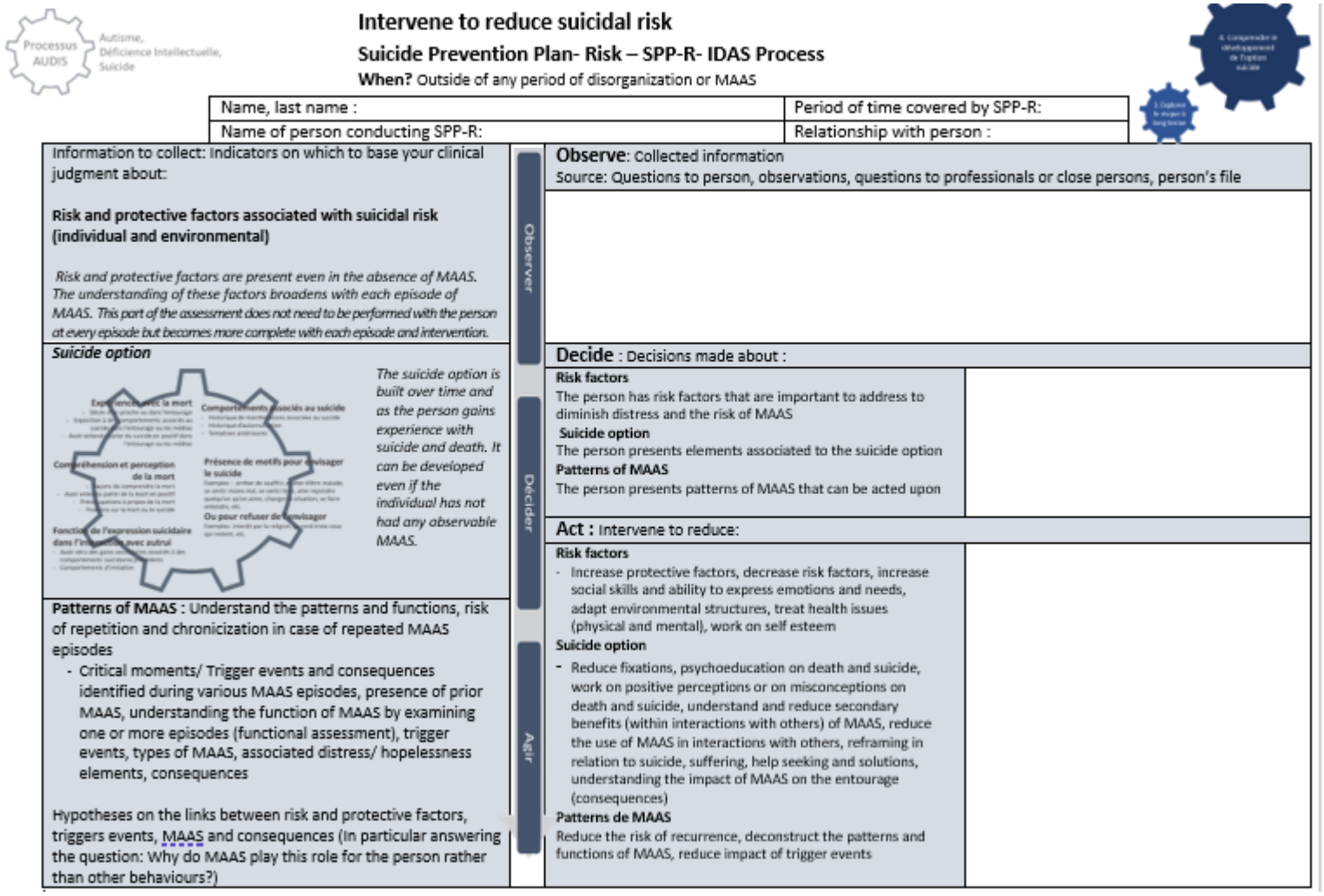
Section 5 – Reducing the Long-Term Suicide Risk - Suicide Prevention Plan – Risk (SPP-R)

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:



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)

- 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.

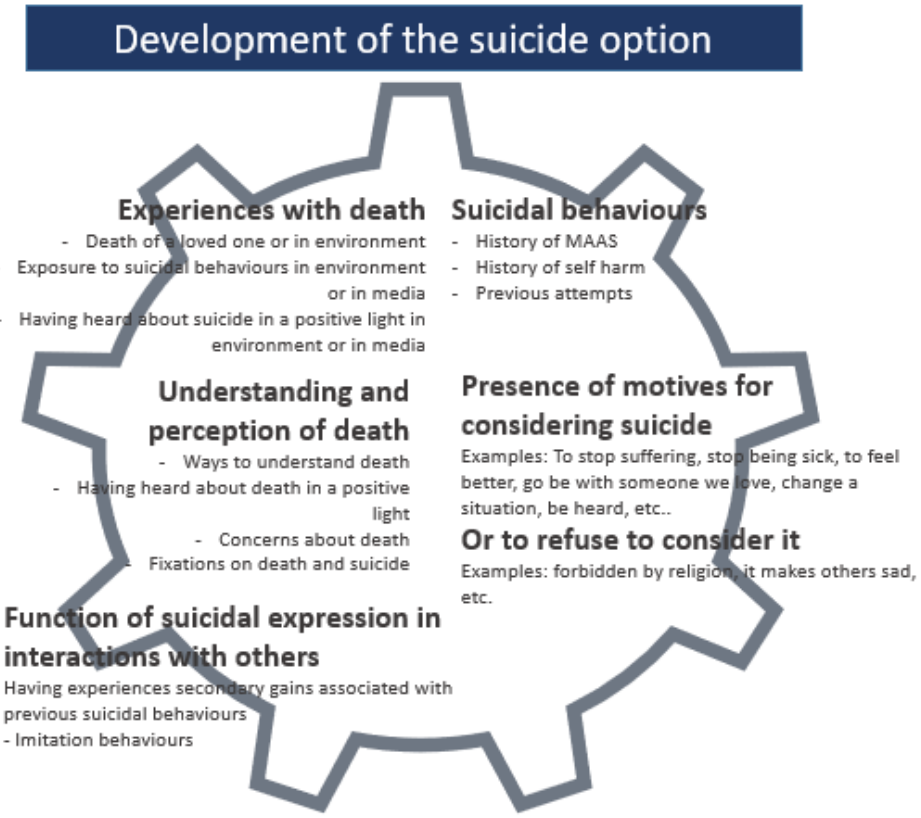
The exploration of the suicide option aims to understand a person's understanding of suicide and how it came to be seen as a solution to problems encountered by the person or by others. It addresses cognitive and social components of suicide, its acceptability, as well as the role suicidal behaviours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

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.

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.**

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

- 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

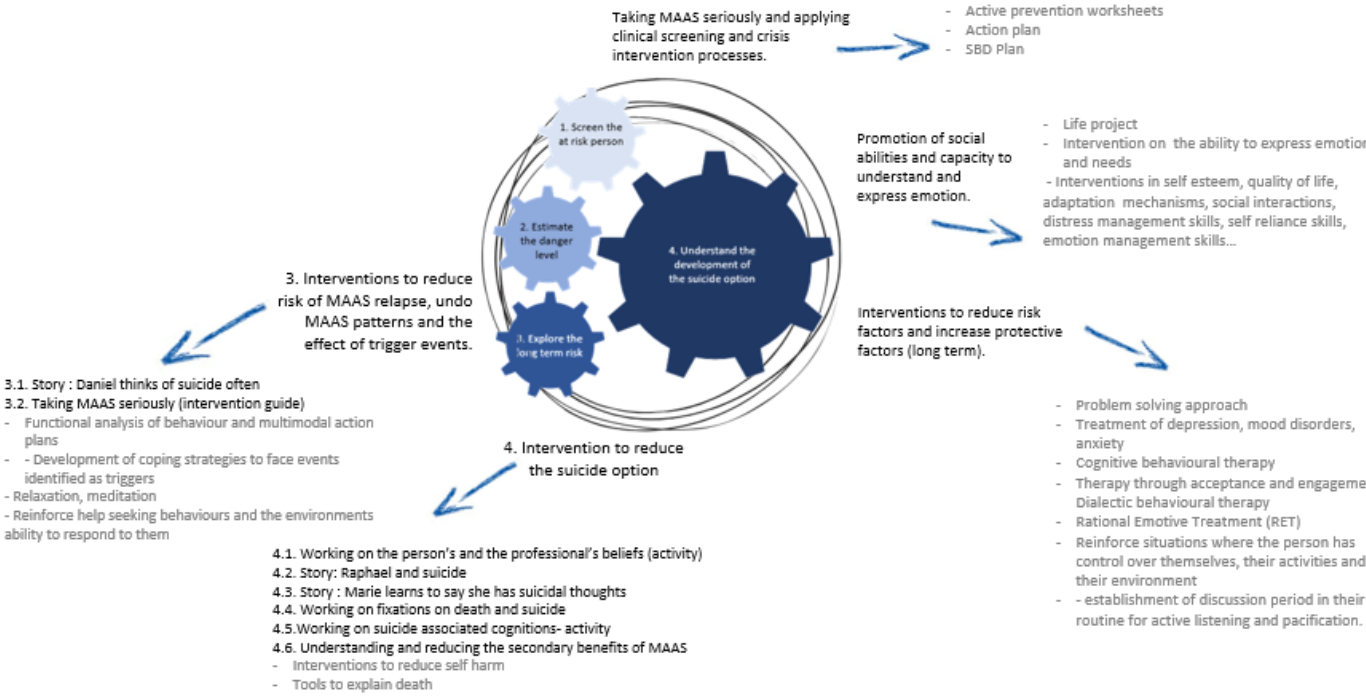


Figure 10 - Strategies for suicide risk reduction

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

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.

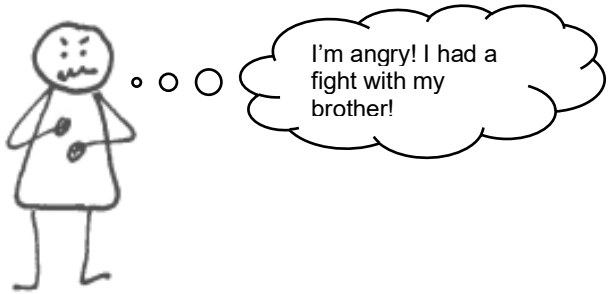
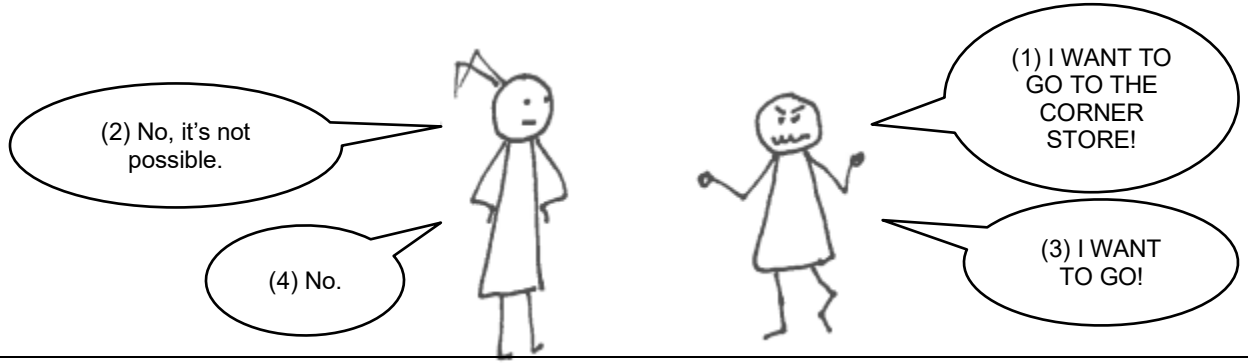
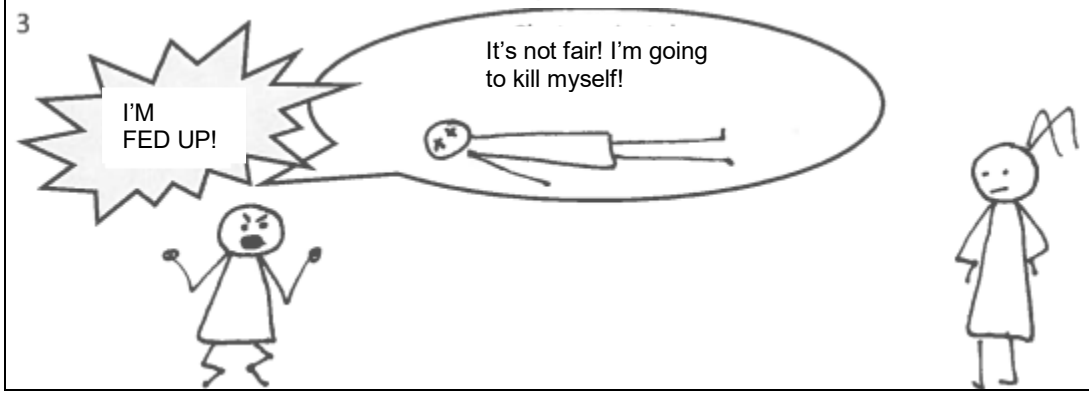
Boxes 4 and 5 describe Daniel's resistance in discussing the situation and the distraction strategies that can be used to lead to healing. The intervention aims to address this resistance with the person who experiences it as well ("you're also like Daniel sometimes, and you don't want to talk about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

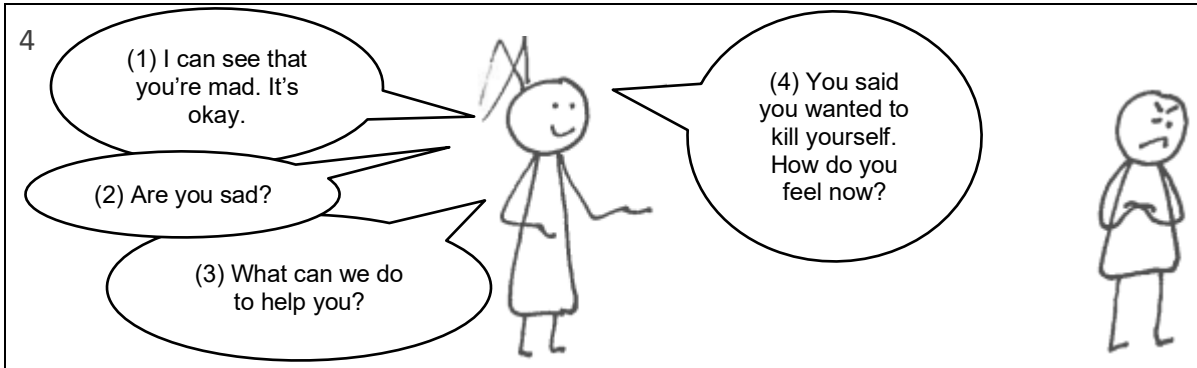
Boxes 6 and 7 describe the professional's feedback in relation to Daniel's resistance to discussing the suicidal episode. The intervention's objective is to show that MAAS are taken seriously and commands the professional's attention, without necessarily leading to obtaining something. MAAS are subjected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

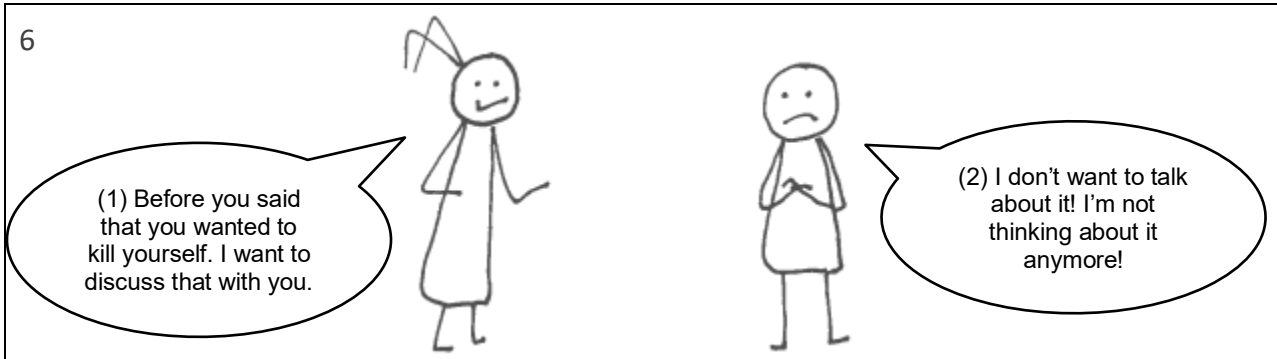
Boxes 8 to 10 describe Daniel's MAAS patterns. The intervention aims here to describe the person's MAAS pattern, if they have one.

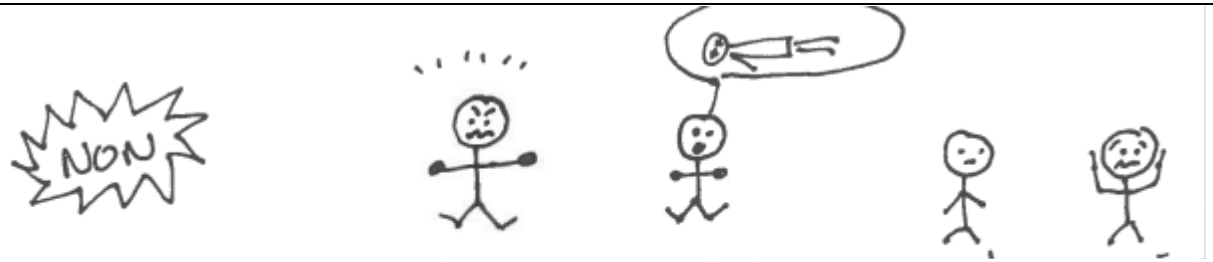
Boxes 11 and 12 allow to validate and normalise Daniel's experiences so that he will be more receptive to intervention. The objective is to show the person that it can be advantageous to accept working on alternative means of expressing their needs when they do not feel well. Once this step is started, 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.

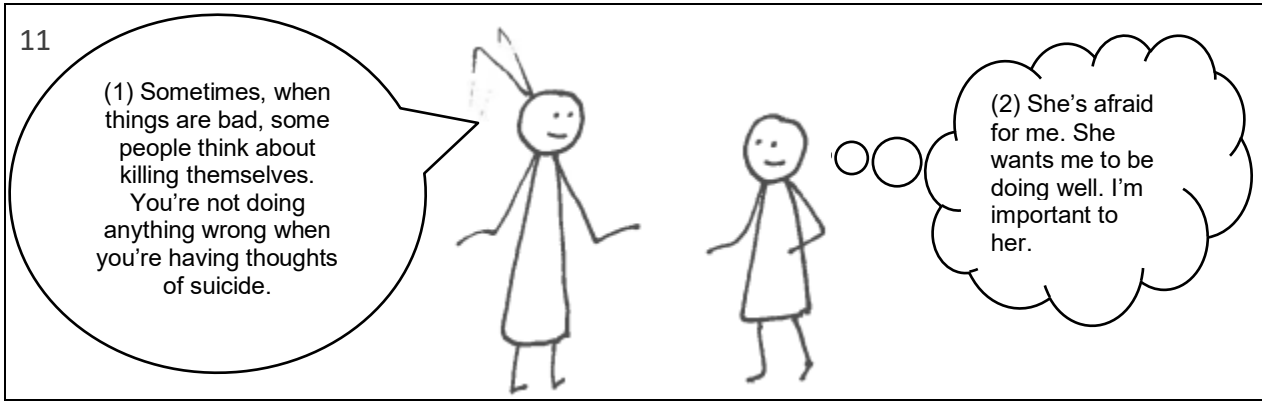
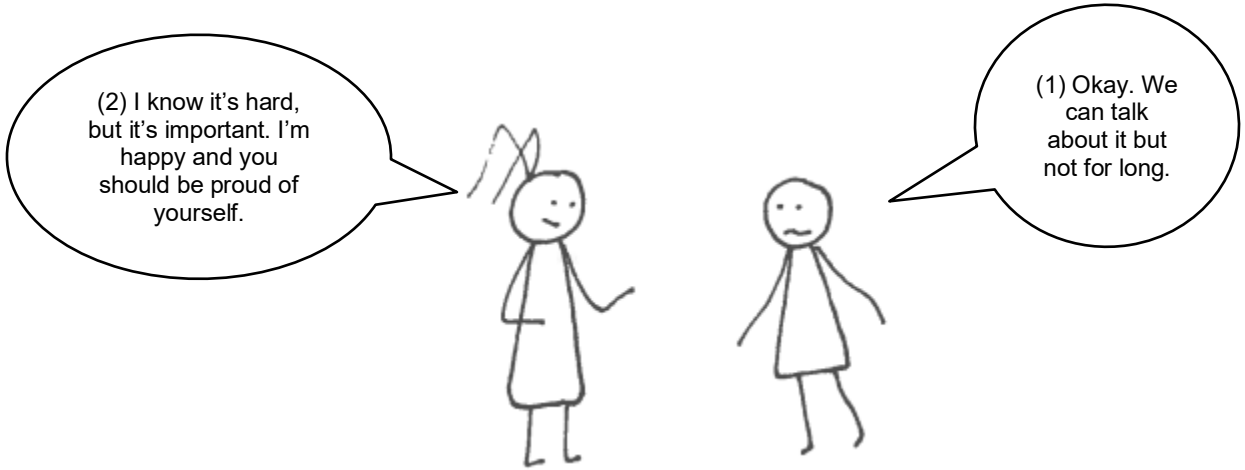
Daniel often thinks of suicide- Daniel often says he wants to kill himself

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

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.

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.

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 Punishment → Frustrated! → Angry! Wanting to kill yourself →Calmed down →Embarrassed	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.

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.

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

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.

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**

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**

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

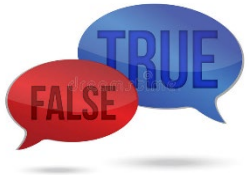
When a person experiences MAAS or when they are confronted to someone else's MAAS, their beliefs in relation to suicide, if they are false, can harm the intervention or create cognitive fixations that can be damaging to them. Being aware of these beliefs and intervening to correct them can help reduce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

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.

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.

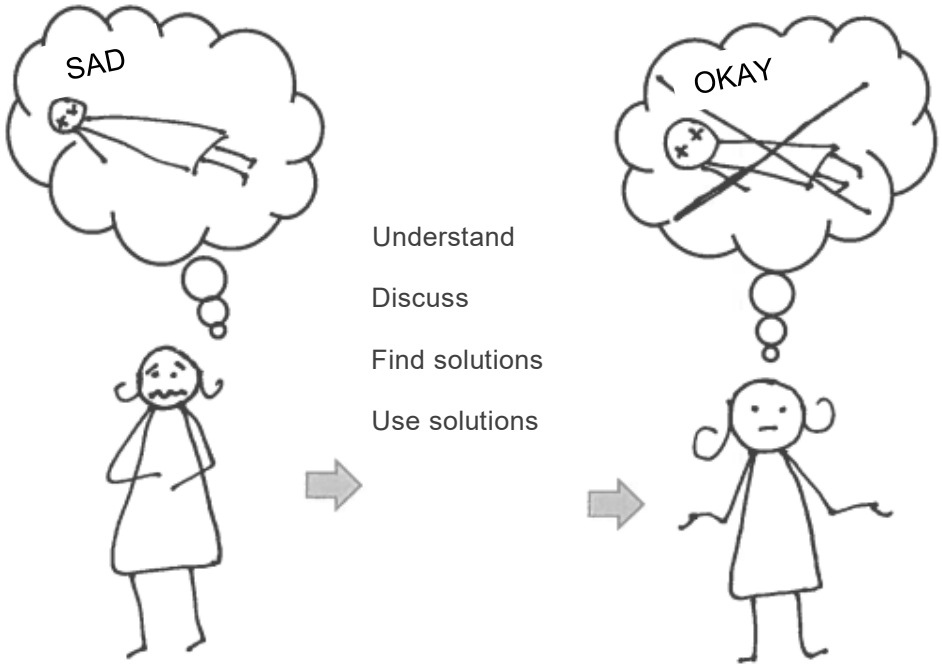
People who think about killing themselves often change their minds. They find other solutions and later they feel better.

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.

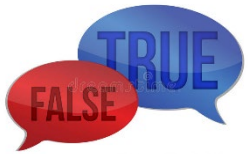
Heather's sister sees that she is very sad. She chats with her. Discussing what is wrong makes Heather feel better.

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.



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.

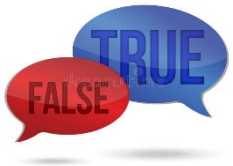
Have you ever thought of killing yourself after seeing another person do it? Tell me what happened.

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.



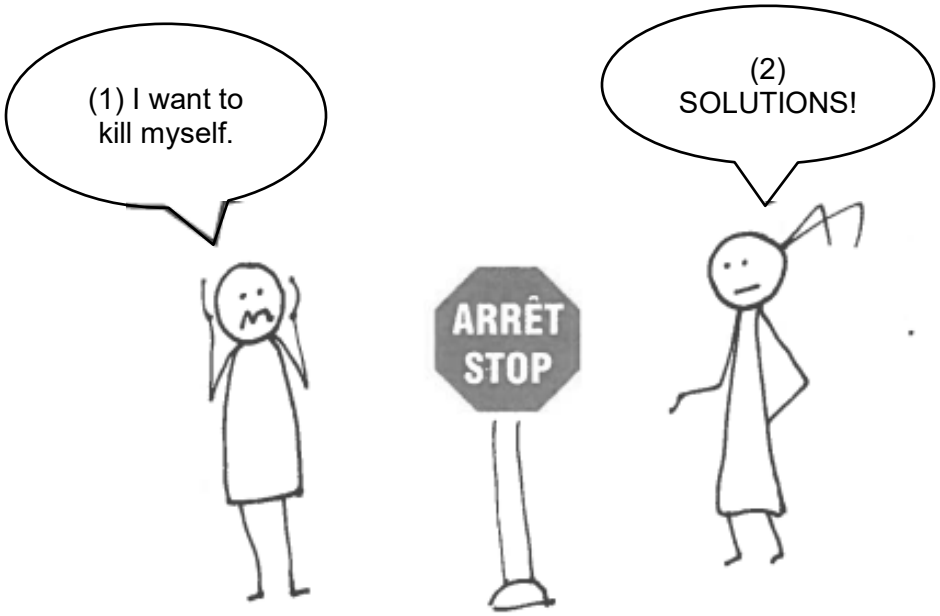
I agree I do not agree

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

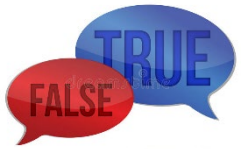
Have you ever tried to kill yourself and someone kept you from doing it? Tell me what happened.

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.



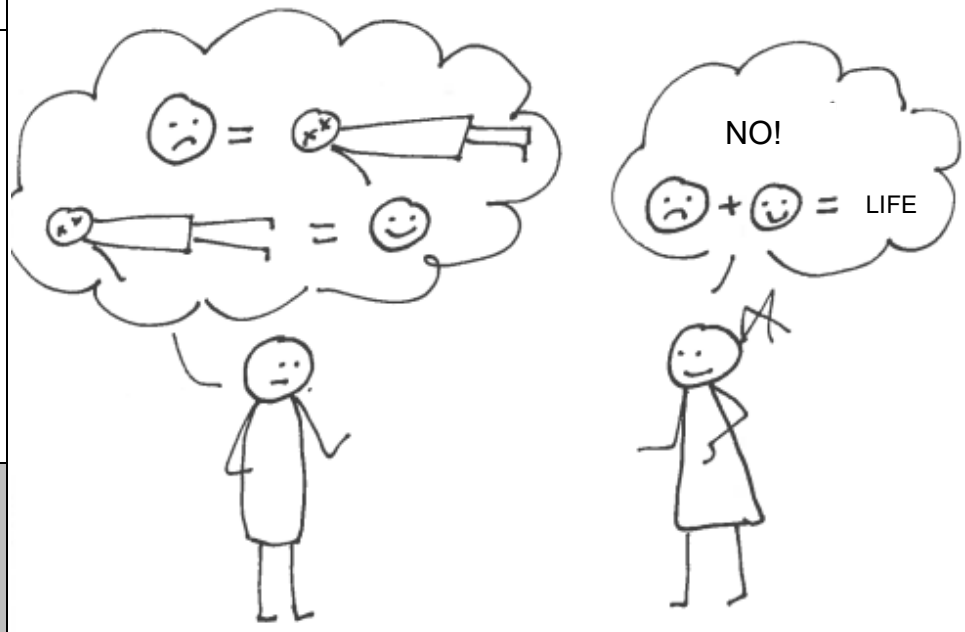
I agree I do not agree

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.



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

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.	

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?"

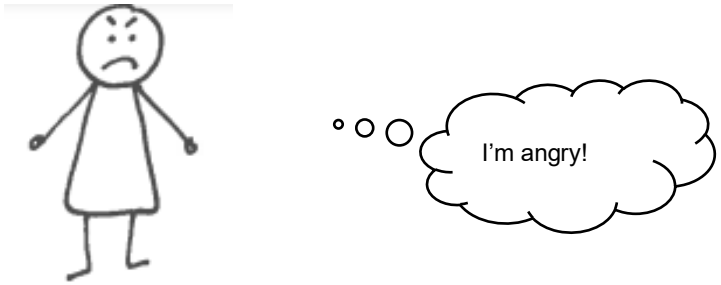
In box 3, Raphaël expresses suicidal thoughts. The intervention aims to explore the person's ideations as well as their reasons for considering suicide (Suicide option). For example, a counselor might say: "Raphaël thinks that if he killed himself, he wouldn't feel so bad. What do you think? Have you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

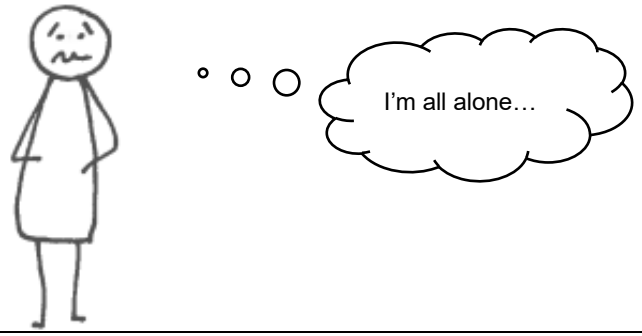
Boxes 5 to 7 present the sequence of events around Raphaël's suicide attempt and its effects on himself and on others. The intervention's aim here is to show the consequences of the attempt. However, the method used to attempt suicide must never be described. The intervention aims to discuss the consequences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

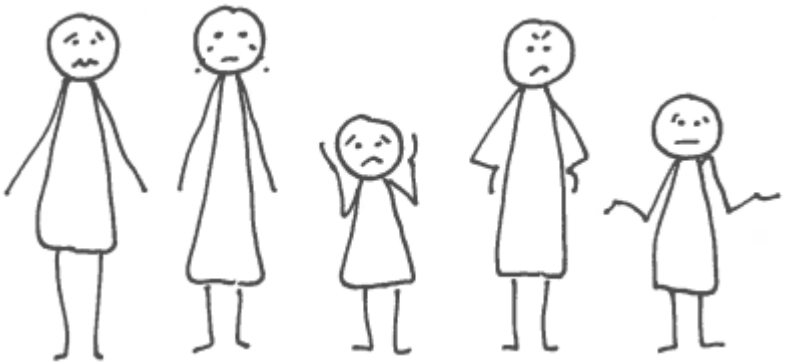
Box 7 describes the negative effect of the attempt on Raphaël's loved ones. The intervention aims to bring the person's attention on the people in their environment for whom they are important, in order to reinforce reasons for living and social support. The goal is not to blame, but rather to help the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

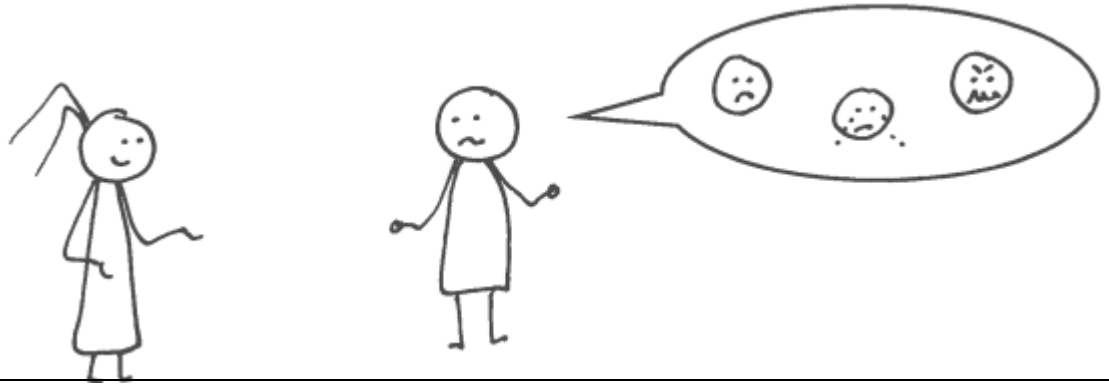
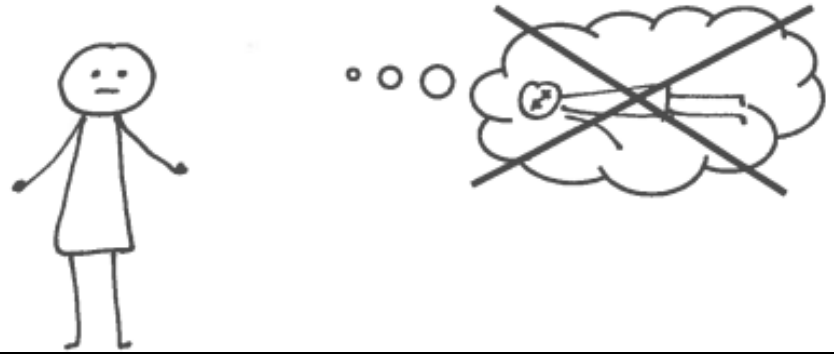
Boxes 8 to 10 show the meeting between Raphaël and the doctor, during his visit to the emergency room. We also understand that an intervention is put into place upon his return from the hospital. The story ends on a positive note of improvement. The intervention here aims to discuss what happened at 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.

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.

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.

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.

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.

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.

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).

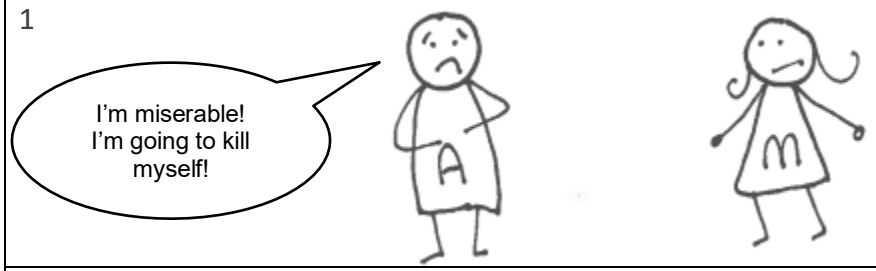
Boxes 15 and 16 allow to identify and name the methods usually used by Marie (outside of MAAS) to express her needs and emotions. The intervention aims to re-enter the person on the means of expression they usually use in order to reinforce them, without judging or punishing the use of MAAS.

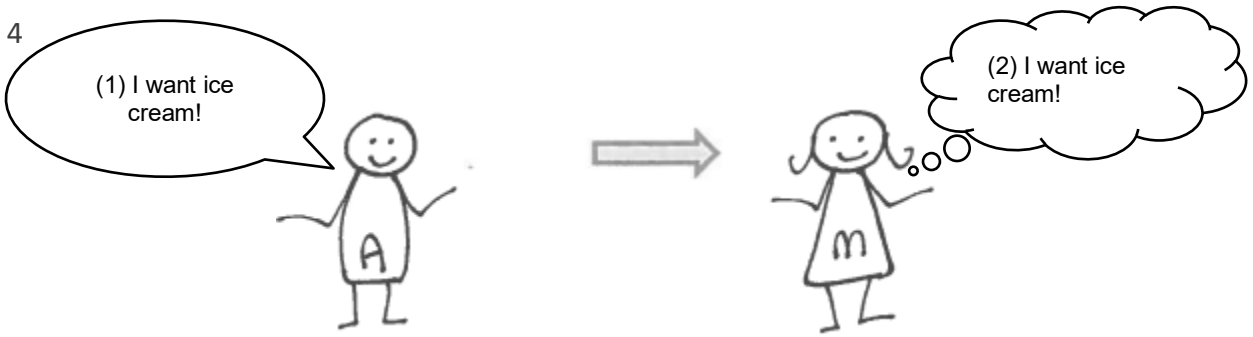
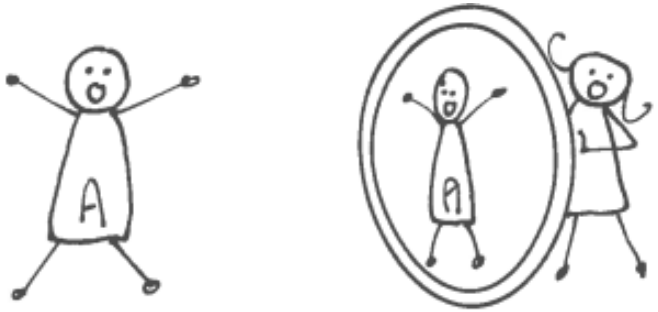
Box 17 illustrates the way the counselor reassures Marie regarding what happened with her friend who showed MAAS. The goal of the intervention is to explain that the person Marie imitated is doing better, as the case may be. If the imitated person is deceased, it is important to explain that they are 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.

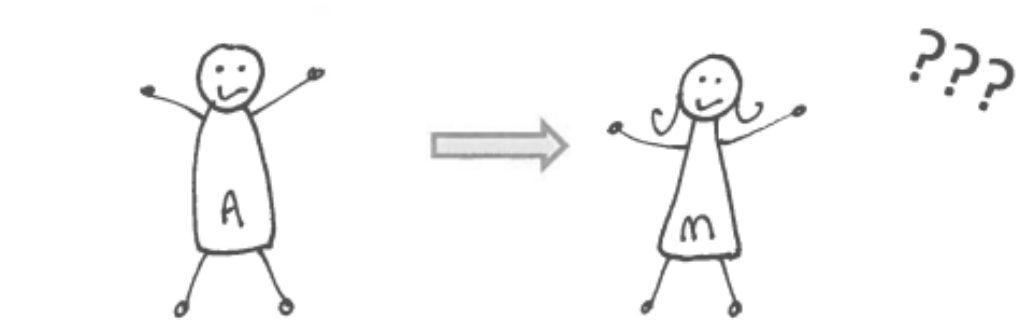
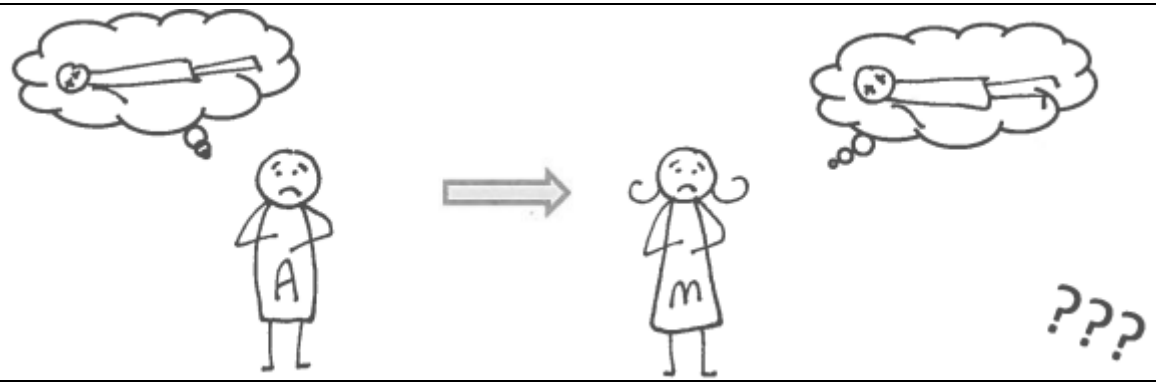
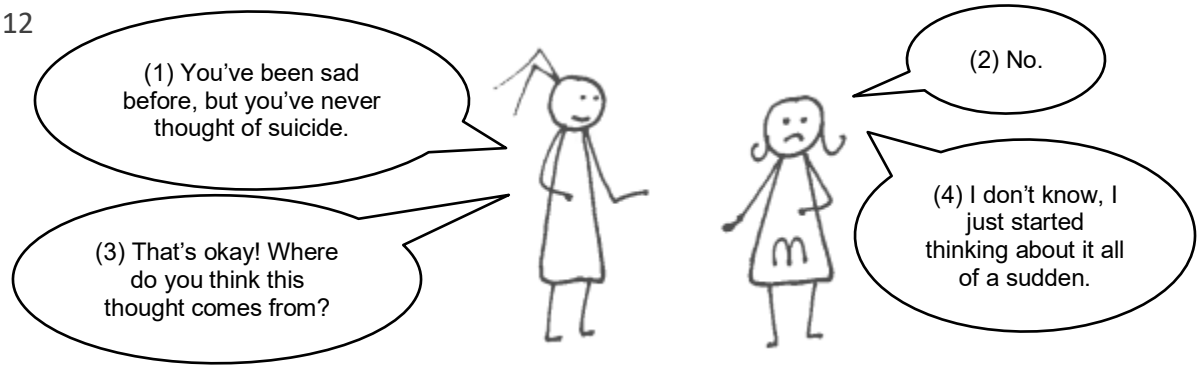
Box 18 illustrates the search for solutions to the person's situation in order to reduce distress. This step is part of the solution-oriented approach used in suicide prevention. It is therefore important to validate and emphasize the person's strengths. It is by leaning on the person's strengths that 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.

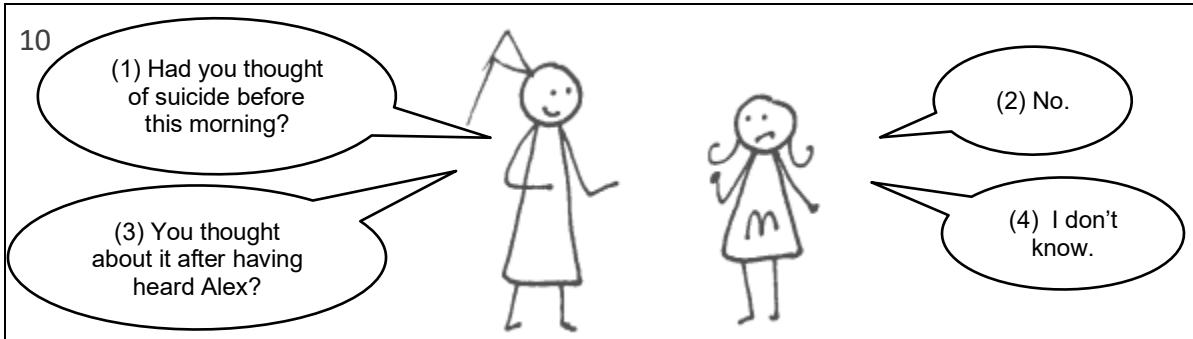
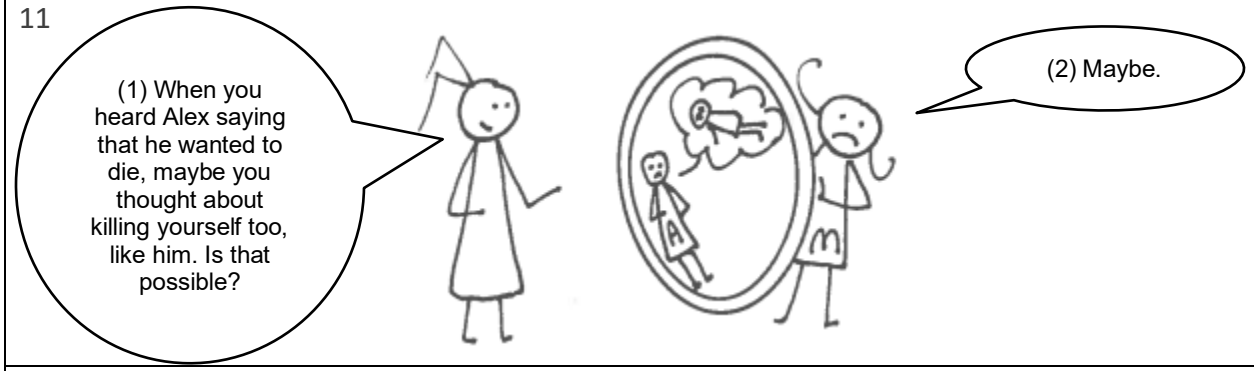
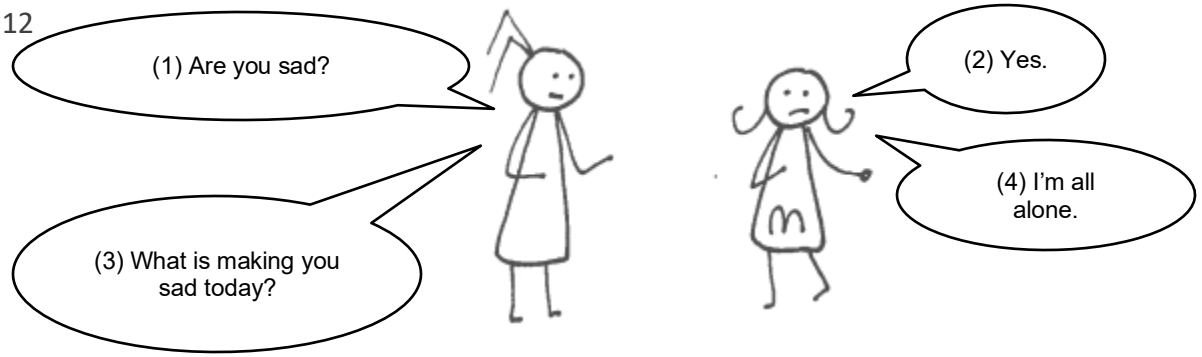
Box 19 shows how we can attempt to consciously break the vicious cycle of MAAS imitation. We can attempt to eliminate the thoughts that do not belong to the person by erasing or scratching out a drawing that represents this idea. We can also choose to use words instead.

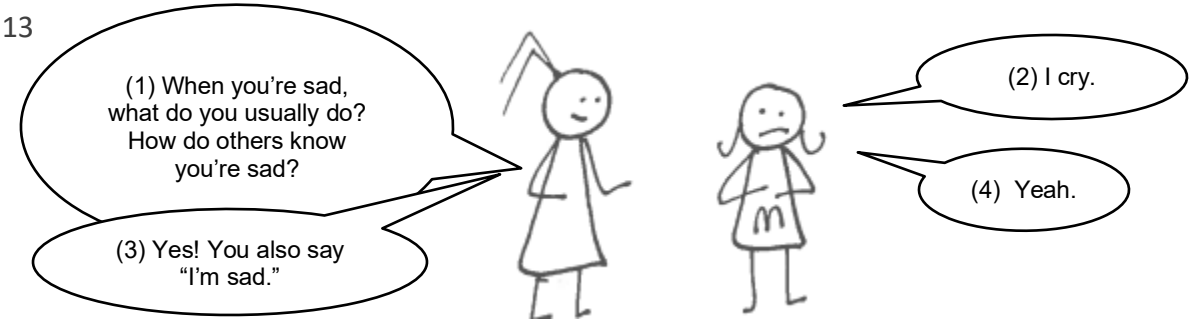
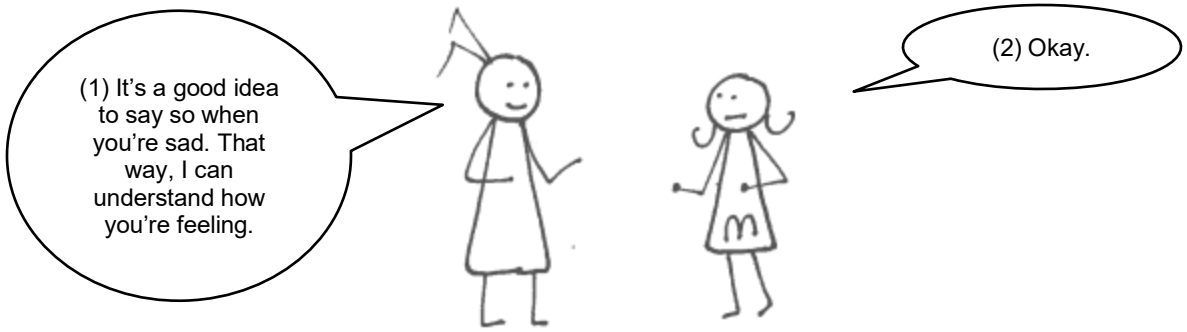
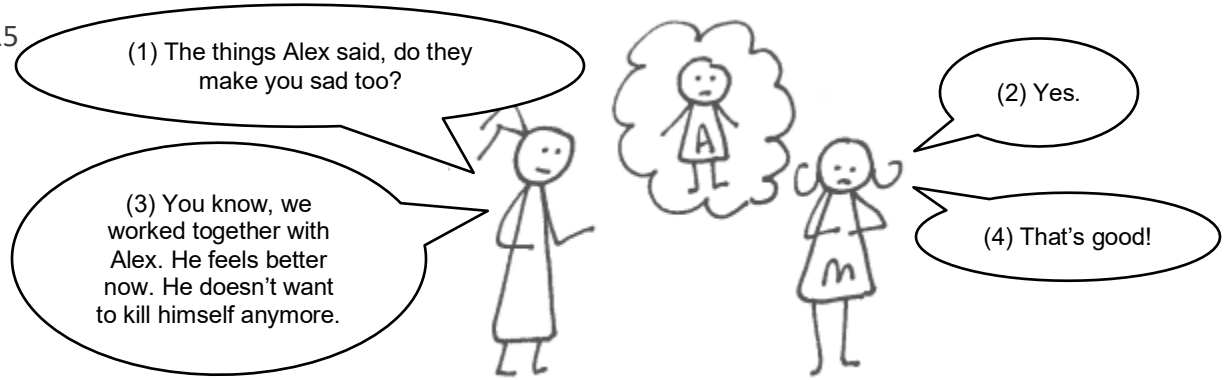
Marie learns to say that she has suicidal thoughts by observing others

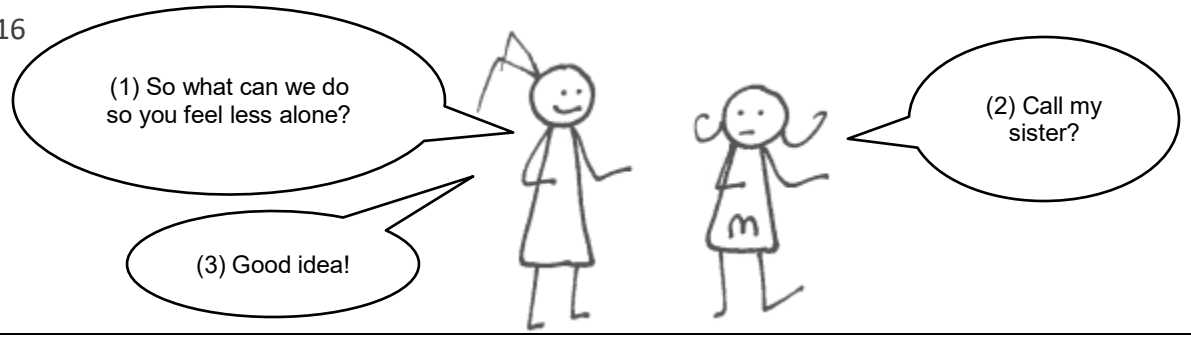
1 	Marie has a friend: Alex. Alex said that he wanted to kill himself and Marie heard him.
2 	Marie is sad. She feels bad. She starts thinking that she could also kill herself.
3 	Marie's counselor discusses with her to understand what is happening. She notices that Marie has suicidal thoughts ever since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

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.

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.

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.

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.

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.

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.)?

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

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.

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

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

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

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.

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.

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.