Processus AUDIS

Autisme,
Déficience Intellectuelle,
Suicide

Clinical process for the prevention of suicide for autistic people or those having an intellectual disability

A set of clinical support tools to support intervention with autistic people or those having an intellectual disability with manifestations associated with suicide

2024-2025

UQÀM | Chaire de déficience intellectuelle et troubles du comportement
Université du Québec à Montréal

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

The research projects leading to the construction of the IDAS Process are directed by:

Development team and research project Associates
Cecile Bardon, Ph.D, – Director associated with CRISE, Professor in the department of psychology, Université du Québec in Montréal (UQAM)
Diane Morin, Ph.D, Scientific Director of the University Institute for Intellectual Disabilities and Autism Spectrum Disorder (ASD), holder of the Chair for Intellectual Disabilities and Behavioral Disorders (Chair DI-TC), professor in the department of Psychology, UQAM

Coordinators of the research project are:
Xénia Halmov, MA, psychoeducator, (2015-2018)
Lorraine Milette, M.S. candidate in Psychology (2018-2023)

The projects were conducted with the scientific support of:
The Chair DITC, UQAM : https://www.chaireditc.ca/
The Lanovaz Lab, School of Psychoeducation, Université de Montréal : https://lanovazlab.com/
The Center for Suicide Research and Intervention, Ethical and Practical End-of-Life Issues (CRISE), UQAM : https://crise.ca/
The University Institute in Intellectual Disabilities and Autism Spectrum Disorder : http://institutditsa.ca/

Research assistants
Louis Philippe Coté, PhD candidate in psychology, UQAM. Research intern (2015-2016)
Mélina Boulé, cand. PhD candidate in psychology, UQAM. Research assistant (2018-2019)
Geneviève Lord, PhD candidate in psychology, UQAM. Research assistant (2018-2019)
Sarrah Thomas Persechino, PhD candidate in psychology, UQAM (2019-2023)
Nadia Moussa, PhD candidate in psychology, UQAM (2020)

Research projects and partners:
- 2013-2014 – ”Consensus of experts on suicidal risk assessment in people having an intellectual disability or autistic spectrum disorder,” Bardon, C., Morin D., Ouimet AM, Financial beginning of CRISE project.
- 2014-2017 – “Understanding and estimating suicidal risk in people presenting and intellectual disability or autistic spectrum disorder (ASD)” Bardon, C. Mishara B., Weiss J., Grant from the Canadian Institutes of Health Research (CIHR).
–2016 - ”Developing intervention strategies for suicidal people presenting an intellectual disability or autistic spectrum disorder (ASD),” Postdoctoral grant CIHR-Office of handicapped people (OPHQ)
- 2018-2020 – Innovative knowledge mobilisation strategy for suicide prevention in people with Intellectual disabilities or ASD: Collaborating with the network to improve services.” Bardon, C., Morin, D. Grant “Determinants of Social Participation for people having an intellectual disability or autistic spectrum disorder.” Research grant CIHR-OPHQ.

- 2018-2023 – Empirically validating the operational concept of “the suicidal option” to understand suicidal behaviors in people having an intellectual disability or on the autistic spectrum disorder” - Bardon, C., Morin, D. Saïas, T., Research grant from the Social Sciences and Humanities Research Council (SSHRC) Knowledge Development.

The following places of practice participated in different projects leading to the development of the IDAS Process.

Directions DI-TSA-DP of CISSS and CIUSSS[1]	
Bas-Saint-Laurent	Montérégie-Ouest
Chaudière-Appalaches	Centre-Sud-de-l’île-de-Montreal
Côte-Nord	Ottawa
Estrie	Québec
Laurentides (Centre du Florès)	Saguenay–Lac-Saint-Jean
Laval	Est-de-l’Île-de-Montréal
Mauricie–Centre-du-Québec	
Hospitals	
Hôpital Rivière-des-Prairies	Institut universitaire en santé mentale de Montréal (IUSMM)
Hôpital Louis-H.-Lafontaine	
Suicide Prevention centers and Crisis Services	
Suicide Action Montréal	Tel-jeune
University Institute of Geriatrics–Sherbrooke	Québec Association of Suicide Prevention Centers (RCPSQ)
Réseau national d’expertise en troubles envahissants du Développement	Société québécoise d'excellence en troubles graves du comportement (SQETGC)

[1] Direction Déficience Intellectuelle – trouble du spectre de l’autisme – Déficience physique – Centre intégré de santé et services sociaux and centre intégré universitaire de santé et services sociaux – health and social services organizations

To cite the IDAS Process: Bardon, C., Morin, D. (2015-2023) IDAS Process – Support process for clinical decision-making for suicide prevention for Autistic people or those having an intellectual disability or those on the autistic spectrum. CRISE, Chair DITC, Montreal, Québec, 136 p.

English version

Translation of the IDAS process has been done by Edward Prindle
With the financial and organisational support of Portland public Schools

Version last updated 2023 – translation into English in 2025
C. Bardon, CRISE, Chair DITC

Table of Contents

List of tables

List of figures

Section 1 - Practical foundations of the IDAS Process and General Structure

The IDAS Process aims to support the clinical judgement of caregivers in the prevention of suicide for people with Autism or those presenting an intellectual disability, and who have manifestations associated with suicidal (MAS).

It aims to support care workers in rehabilitation, in community settings, in mental health and in the field of suicide prevention.

> Every clinical decision always depends on the judgement and the interpretation of caregivers who are present at the moment that suicidal behaviors become evident, but also on the process and tools used at the time of evaluations–from the manner of gathering information and the perceptions and interpretations of those consulted (other caregivers, friends and family). The clinical judgement must rely on the best knowledge and practices possible, but it will still stay at the heart of the work of assessment and of intervention for the prevention of suicide. No other tool can nor must replace it.

As illustrated in Figure 1, the IDAS Process includes:

A dynamic model of suicide for autistic people or those presenting an intellectual disability (ID).

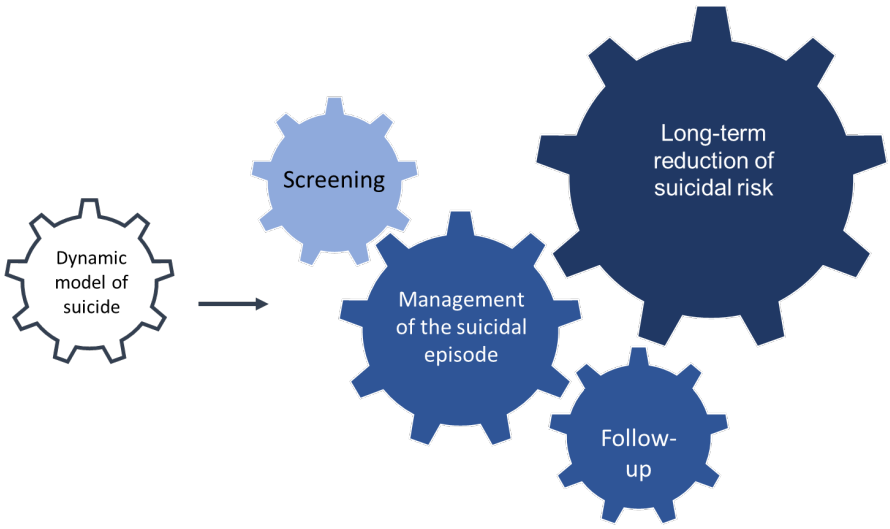


Figure 1 - IDAS Process - Overview

A process of support for the evaluation and intervention at three complimentary levels of suicide prevention. These levels have been separated so that different actors can apply them according to the needs of the clientele and the characteristics of their environment:

- Screening of the person at risk
- Management of the suicidal episode (assessing the danger, analyzing the situation and needs, taking action to reduce the danger and distress), including follow-ups
- Reduction of the suicidal risk (factors relating to risk and protection, suicidal options and patterns of suicidal behaviors)

Clinical tools are therefore described with relation to these three levels throughout this document.

Understanding the suicidal risk – Dynamic model of suicide for people with Autism or intellectual deficiencies (ID)

The dynamic suicidal model illustrated in Figure 2 was developed from a study carried out between 2015 and 2017 with 100 people with Autism or ID by the specialized services of 12 Integrated health and social services centers (CIUSSS and CISSS) in Québec, and validated in the context of a qualitative study with 23 service users experiencing MAAS (2022-2024).

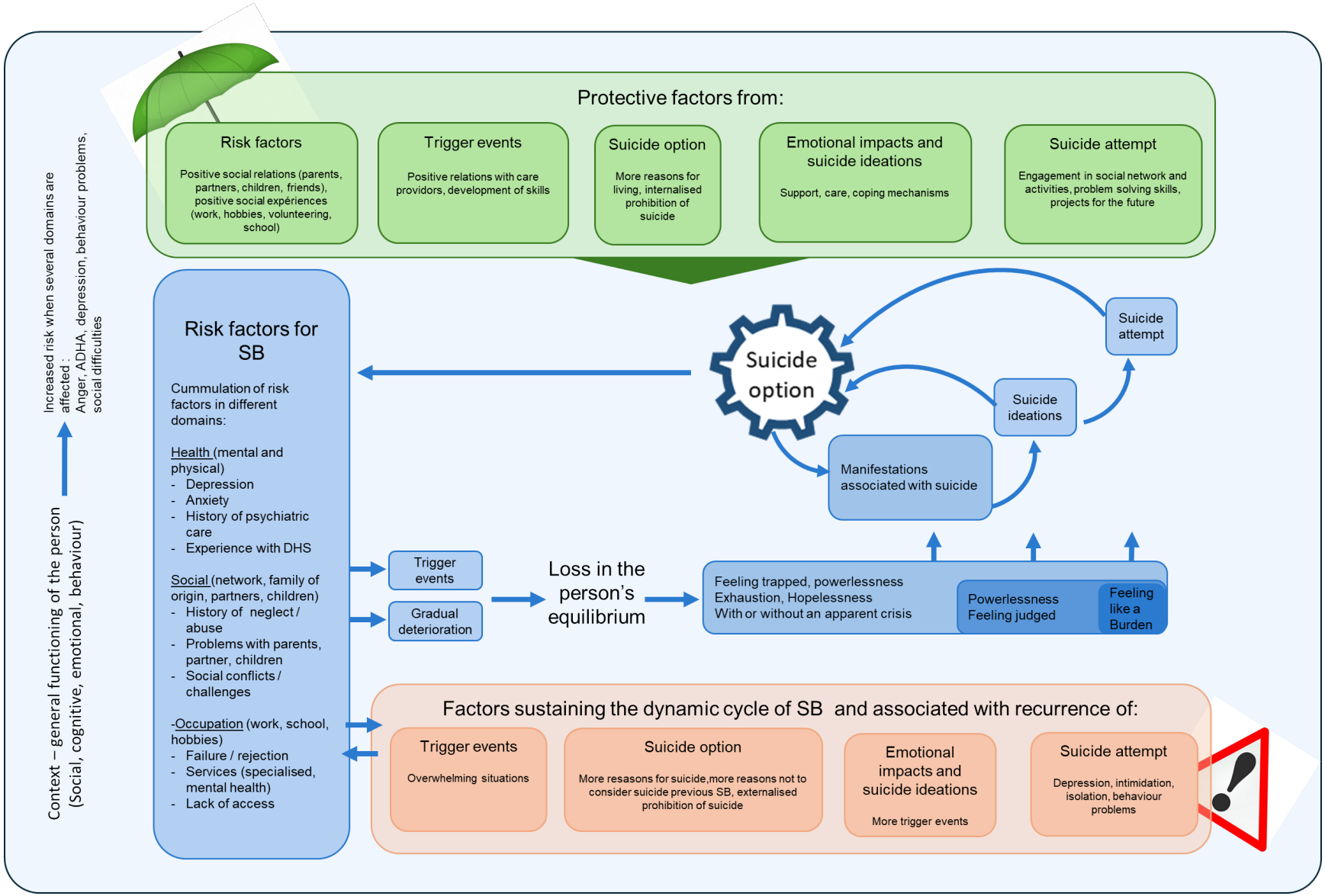


Figure 2 - Dynamic model of suicide

This model serves and the foundation for the indicators of the analysis of suicidal risk proposed in the IDAS Process. Its components are described in the sections below.

Manifestations Associated With Suicide (MAS)

The term Manifestations Associated with Suicide (MAS) was chosen to reflect the variety of behaviors–verbal, non-verbal, direct and indirect–which can express suicidality for the autistic or those presenting intellectual disabilities. Table 1 describes several of these MAS. It is not exhaustive, and people can present different MAS.

Tableau 1 - Manifestations associated with suicide (MAS)

Type of MAS	Examples
Thoughts (non-observable or non-communicated)	• Thinking about your own death when sad • Thinking to hide a knife in your bedroom • Having suicidal flashes or seeing yourself dead • Thinking about the reaction of your loved ones if you died or disappeared
Direct verbal communication	• “I want to die”; “I want to commit suicide”; “I have dark thoughts”
Indirect verbal communication	• “I want to join my grandmother in the cemetery”; “I would like to be dead”; “You would be better without me”; “I want to go far away and not come back”; “I want to be with the birds”; “I want to do like… did (the person who committed suicide)”
Direct or indirect communication by text or social media	• In the form of phrases (affirmations, questions), images, “likes” on publications talking about death or suicide, etc.
Non-verbal Communications	• Drawings representing a violent act or a suicidal action, gravestones, suffering, objects used for suicide • Gestures: strangling, cutting
Non-injurious self-harm behaviors	• Trying to stick an unsharp object (a branch) through the skin (into the stomach, arm or leg)
Injurious self-harm behaviors causing wounds or death	• Swallowing pills or substances having toxic potential (drugs) • Hurting oneself with a sharp object • Strangling oneself or hanging oneself with a belt towel or cord • Jumping from a window or from a high place • Throwing oneself in front of a vehicle • Jumping into water (without knowing how to swim, without looking)

	• crossing the street during a red light or crossing Metro tracks
Indications associated with MAS These indications can help to screen a person at risk who does not verbally express their distress and their suicidal ideations They are also present with more direct suicidal behaviors	• **Cognitive**: confusion, difficulty concentrating, indecision • **Emotional**: changing moods, mood swings, Manifestations of sadness, of anger, of irritability, increased worry due to future events, anxiety, Increased aggressivity, dissatisfaction, disappointment, fears or insecurity about a situation, feelings of incompetence • **Psychiatric**: increase in symptoms • **Loss of knowledge and difficulties in adapting to the current situation:** stagnation or regression • **Behavioral**: changes of behavior (for better or worse, agitation or lethargy, Amplification of Habitual Behavior, increase in the consumption of substances or compulsive behaviors, isolation, increased need of help, absenteeism • **Somatic**: The appearance or worsening of physical or digestive troubles, back pain, headaches, etc. • **Neurovegetative**: Degradation of sleep, of appetite, of the level of energy • **Signs of despair:** Negative talk about the future, discouragement, resignation, devaluing of the self, cessation of Treatment, refusal of follow up or absences, refusal of offered help

General Considerations on the IDAS Process

General Approach

The IDAS Process integrates common clinical approaches used in the literature on autism and intellectual disabilities (in particular the functional behavior assessment). In addition, it is compatible with the suicide prevention tools developed for the general population which support collaboration between professionals in different fields.

The IDAS Process does not replace clinical judgment; it completes and supports it. It establishes a framework to identify relevant information and orient clinical decision-making about levels of danger, risk and needs and in order to identify necessary interventions. It establishes a way to document information and knowledge acquired during the management of suicidal episodes in order to share that information, work in teams and implement adapted Suicide Prevention Plans (SPP). The clinical process is reflected in the PPS documents:

- Screening (SPP-S, Screening) – identify the presence of distress and suicidality
- Episode (SPP-E, Management of the suicidal episode) – assess the needs and reduce the distress

- Follow-up (SPP-F, Follow-up) Watch over the evolution of MAS and ensure the adaptation of the intervention plan to changes.
- Risk (SPP-R, Reduce suicidal risk, understand and reduce the option of suicide, understand and reduce the repetition of suicidal behaviors, reduce the distress) – Contribute to spacing out the episodes of MAS and reducing their severity.

The IDAS Process is neither a standardized tool producing a danger score, a replacement for expertise and clinical judgment, nor a worksheet to fill in after the fact in order to compile information irrelevant to the intervention. The assessment tools do not aim to establish a score or a grade of danger or risk. Instead, they form a process to support clinical decision-making as it relates to suicidal risk in people with Autism or an ID and of identification of intervention needs appropriate to each situation.

The management of suicidal risk is a collaborative process involving stakeholders and professionals who know the patient well and professionals who know the process of suicide prevention well.

The principles which have guided the development of these tools are the following:

- The assessment of suicidal danger and risk must be collaborative. It must be based on the analysis of the current situation and the needs of the person.
- Suicidality fluctuates rapidly in time and the assessment of intentionality does not always constitute an effective indicator of suicidal risk, particularly in people with Autism or intellectual disabilities.
- Once the management of the suicidal episode is complete, it is important to understand the more distal risk factors as well as the underlying circumstances of the MAS episode. An evaluation of middle and long-term risk is therefore an integral part of the process of suicide prevention and of the development of a intervention plan seeking to reduce distress and to limit the risk of recurring MAS.

Target clientèle

The tools for suicide prevention proposed in the IDAS Process can therefore be used with all autistic persons or those presenting intellectual disabilities whose care workers[2] and caregivers[3] worry about the presence of MAS.
The way of approaching MAS varies according to the cognitive and communicative capacities of the person. In our current state of understanding (2020), it is impossible to know if specificities must be provided for children compared to adults or for people with Autism who do not present an intellectual disability.

[2] We use « care worker » to talk about people whose job it is to provide care and services to clients with autism or ID. They include psychologists, social workers, educators and others.
[3] We use « caregiver » to talk about non-professionals who provide support to people with autism or ID. They include close persons, friends and family, community members.

Collaborative use of the IDAS Process

Many people may gather information at different moments according to their abilities, their bonds of confidence, the availability of care workers and caregivers, and the time available. A longitudinal perspective of the assessment of danger and of risk also requires the regular collection of data. Note-taking is therefore an integral part of assessment and communication between care workers and caregivers around the person.

Note taking in documents associated with the IDAS Process can be done after the intervention to keep a transmissible paper trail of what happened. It is obvious that note-taking is not done during a critical suicidal episode or during emergency interventions. The tools proposed in the IDAS Process are above all a guide for remembering relevant points to explore with the person in order to manage an episode of MAS and to reduce the risk.

A large part of the necessary information can usually be available in the person's clinical file or from caregivers and care workers. The triangulation of information is therefore important in order to support the clinical process of suicide prevention.

Clinical process of suicide prevention for people with Autism or ID

The objectives of the IDAS Process are:

- **To understand:** The Manifestations Associated with Suicide (MAS) is part of a dynamic process that stems from the person's history, their vulnerabilities, their current situation and the cognitive and interactional construction of suicidality. Suicidality is a complex process care workers need to understand in order to adequately intervene (IDAS Model – figure 2).
- **Screening a person at risk:** This first crucial stage in the management of suicidal risk aims at adequately identifying a person living with distress **and** MAS in order to take them seriously and develop an intervention adapted to his needs.
- **Management of a suicidal episode:** This phase consists in analyzing the situation, assessing the danger for a suicide attempt and identifying the person's needs, then intervening to reduce the episode of distress and MAS. More precisely the assessment aims at qualifying the danger of a suicide attempt, identifying the presence/ nature/ intensity of suicidal ideations, identifying the proximal risk and protective factors, identifying the trigger-events, documenting the individual and familial story of MAS, describing the level of hopelessness, understanding the impulsivity of the person, understanding what happens for the person without preconception. The objective is specifically **to orient the intervention (allocate the right services at the right moment with the right intensity).** As for the intervention, it aims to ensure safety, prevent a suicidal attempt, reinforce hope, diminish the risk of a future suicide attempt, reinforce protective factors, reduce risk factors associated with the current situation, depending on the result of the assessment.
- **Follow-up:** This step, often neglected, supports the recovery of the person after an episode of MAS. It aims to reevaluate the MAS and the needs in order to adjust the

SPP-E, according to its effects and the evolution of needs. As such, a SPP that is not adapted to the progression of the person can do more harm than good.

- **Reduction of the suicide risk:** This last step aims at understanding the construction of the suicidal process and intervening for the long term. More precisely, it aims to complete the collected information (identifying more distal risk and vulnerability factors, and protective factors working on the long term in the construction of suicide risk), understanding the person's suicidal process (cognitive, emotional and social), making decisions about the suicidal risk, determining interventions aiming to reduce risk factors, reinforcing protective factors and modifying the suicidal process (identifying and implementing pathways of intervention aiming at improving the well-being of the person and reducing their distress).

The phases of assessment and intervention are interdependent at all levels of the management of suicidal risk. The IDAS Process is, therefore, based on the sequence Observe– Decide– Act (illustrated in Figure 3). All actions must be founded on informed decisions. This decision must be based upon observation and a rigorous analysis of the situation.

Figure 3 - Foundational principles of the clinical process

Figure 4 illustrates the interdependence of the four phases of the clinical process and the specific assessment and intervention objectives of each phase.

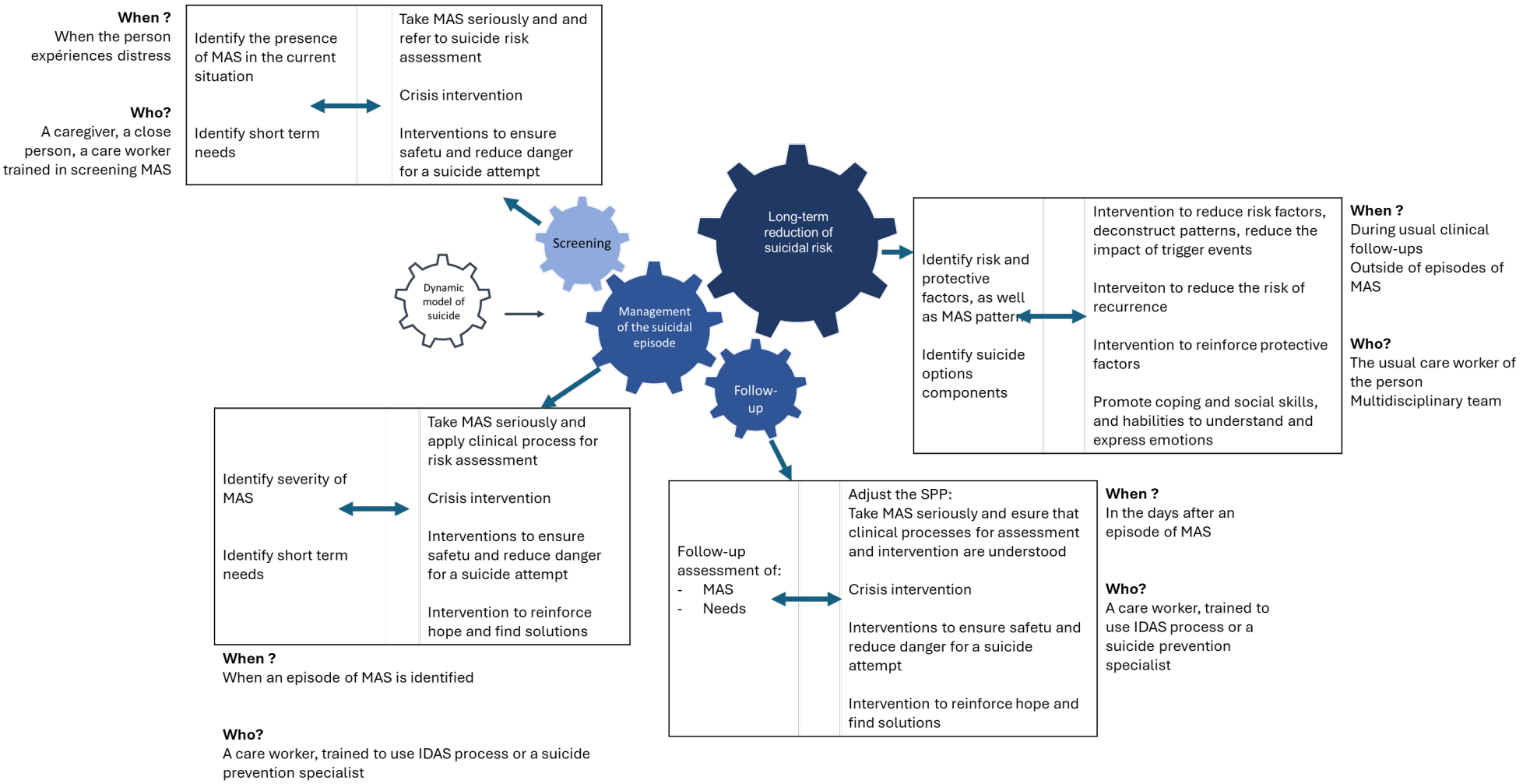


Figure 4 - Overall clinical process

Integration of the IDAS Process into usual intervention protocols

Suicide prevention should not be separated from other intervention implemented with the person. That's why the IDAS Process aims to integrate into usual care and support practices used to respond to the needs of the person. Therefore, IDAS process's framework emphasizes the necessity of understanding suicidality within the understanding of the overall domains of the person's life (cognitive, emotional, social). For example, if the distress of the person is mainly exacerbated by his lack of control over his daily life, it can be useless to work on her ability to express her emotions to reduce suicide risk.

No intervention should be ad hoc, and no ad hoc intervention will reduce current and long-term risk for MAS for a person. The suicide prevention strategies proposed in the context of the IDAS process should therefore be integrated into a systematic support strategy based on the rigorous evaluation of the person and of his environment.

Simultaneously, the IDAS Process follows a structure compatible with usual support practices implemented in rehabilitation services, such as Multimodal Analysis, intervention plans, action plans, active prevention plans, etc. It is therefore possible to integrate the various phases of suicide risk management into clinical processes known and already used with the person.

Finally the integration of clinical tools and the note-taking associated with IDAS Process in clinico-administrative case files facilitates their use. This integration should be planned upstream of the implementation of the IDAS process in care structures.

General description of the structure of IDAS process assessment and intervention tools

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

The interventions proposed as part of the AUDIS Process are suggestions. They can be modified and adapted to the needs of clients and care workers. For example, a story can be transformed, accompanied by images or summarily staged using roleplay. Objects can also be used to illustrate a concept (for example, using a pan balance to facilitate understanding of the concept of ambivalence). The option of an individual or group activity can always be considered. Many interventions have also already been developed for other purposes and can be adapted to work on different aspects of suicidality. However, **before using them, it is necessary to clearly identify the clinical objective of the intervention and to discuss as a team the adequation between this intervention and the needs and specificities of the person.**

Within the framework of the IDAS Process, interventions are presented according to their objectives for suicidal risk management and described in detail using the structure below:

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

2. **Justifications/ Explanations:** a) Present theoretical foundations, if they exist, to support the intervention; or b) Describe the process by which the intervention can contribute to reduce suicidal risk.
3. **Process:** Describes how to use the intervention. This section can also contain examples.
4. **Presentation of intervention tools:** Where necessary, when the intervention uses written or drawn material, the intervention tools are included in the dedicated section.

Structure of clinical decision support documents

Each stage of the clinical process is presented in a table similar to the illustration in Table 2. The colored sections present information to guide the clinical decision process. The white zones are left open for note-taking about observations, decisions and interventions put into place.

Tableau 2 - General Structure for phases in the IDAS Process

Information to collect: Indicators for basing your clinical judgement as to the stage of suicidal risk management concerned (spotting, episode management, risk reduction) Clues and elements to observe when making a clinical decision about a person's suicidal process		Observe: collected information Source: Questions to the client, observations, questions to caregivers or loved ones, client file
		Decide: Decision as to screening, danger, risk, protection
		Decision criteria are worded in the form of questions for care workers
		Act: Intervene to prevent suicide
		Intervention strategies possible at this stage and adaptable to the decision made from observations

The overall PSS is made of the accumulating note-taking documents that build the understanding of MAS and effective actions.

Gathering information on suicide and its prevention

The exploration of suicidality with an autistic person or one presenting an ID can be done verbally in a direct or indirect way, by pictograms or drawings, by using social scenarios or through various activities. Some suggestions are made in the section below. It is important to vary the sources of information and not neglect observation of emotion as well as observable

changes in physical and verbal expression. Furthermore, remember that it is important to clarify ambiguous information even if this can be stressful, in order to make an informed decision.
In this context, the question of the validity of verbalizations made by the person comes up often. When a person says that he wants to kill himself, what constitutes a “valid expression of MAS”? The IDAS Process tries to respond to these preoccupations through different methods. The triangulation of sources of information helps to validate information (close persons, caregivers, the person themself). Furthermore, combining strategies of information gathering can reinforce the quality of information (observing and questioning). Questioning a third party about the behaviors of the person and about changes observed in their functioning is a good strategy but it should not be used alone, because close persons often have a biased perception of the emotions of the person. Knowing the usual functioning style for the person is an important asset because MAS often represent changes in this functioning. Finally, the IDAS Process indicates elements to explore in order to establish the nature and scope of suicidal danger and risk, in order to define the targets of intervention.

Attitude of the care worker towards the client

More than the precise methods of questioning and of exploration, the general attitude of the care worker has a decisive impact on the suicide risk management process. We emphasize here some key elements which can help you to adopt an attitude that favors the exploration of risk and intervention in the prevention of suicide.

Favorable attitudes

- A kindly, warm, reassuring, patient, welcoming attitude is essential.
- Showing that you are open to listening and understanding is crucial (welcoming and establishing of a trusting relationship).
- It is important to be quite directive with the person (ex: “It’s important, we're going to sit down and take the time to talk about it.").
- Adapt to the emotional level of the person, by taking into account their understanding of their emotions and of their current level of disorganization.
- The ideal person to do an assessment is a familiar care worker with whom the person has a good relationship (This can mean that the meeting includes two care workers: The assessment specialist and the specialist on the person.).
- Begin with what the person says/understands, without putting words in his mouth, especially at the beginning. Take into account their cognitive and social capacities while asking unequivocal questions.
- Note the terms used by the person to talk about his distress and MAS, then reuse them (ex: “When you (term used by the person), come tell me.”).
- Use a neutral tone in the questions.
- Pay attention to nonverbal cues (those of the care worker and those of the person).
- Start from the person's own words. If you reformulate, use simple terms.
- Reassure the person that you are not looking to punish him, but to understand to better help him.

- Stay open in order to understand without changing the person's train of thought with too many questions.
- Tolerate silence, be patient.
- Encourage the expression of distress which leads to suicidal ideas, listen to the person's story according to his own perception, whatever your own analysis of the situation.
- Use familiar modes of communication.

Behaviors to avoid

- Avoid putting words in the mouth of the person.
- Avoid suggesting answers / asking leading questions (ex: Did you think about suicide in order to stop suffering?).
- Avoid transmitting an impression of disapproval about suicidal ideations (ex: I hope that you're not thinking of suicide?).
- Avoid interrupting the train of thought of the person by asking too many questions.
- Be careful not to orient the questions with interpretations, since the person can have difficulties remembering what he wanted to say.
- Avoid stigmatizing and blaming (ex: Have you thought of the pain that you would cause if you committed suicide?).
- Avoid too many questions about suicidal intention. (This isn't a trustworthy indicator of risk and can change very quickly).
- Avoid giving special favor because of MAS, or inversely, taking away an activity from the person. (This could be perceived as a punishment and harm the expression of his needs in the future.).
- Avoid calling into question the answers of the person (ex: “Are you sure?”). This can endanger the potential for assent and can hinder, rather than help or clarify a problem.

Validation of the help request

It is important to always validate the person for asking for help (ex: “You were right to say that you wanted to talk to me. It’s important to say it when things aren’t going well.”) This constitutes the first necessary step in every suicide risk management process (assessment and intervention).

Collaboration with the person

It's important to have the collaboration of the person who had the MAS in order to truly understand what happened, to clarify the MAS and their triggers. On the other hand, in certain cases, once calm has returned and the crisis has dissipated, the person refuses to return to what happened and does not collaborate easily in the evaluation of danger and long-term risk.

Multiplying sources of information is therefore a useful strategy. However, it is necessary to stay prudent with the perceptions and analysis of close persons and caregivers. In effect, studies show that parents do not perceive the MAS of their youth in the same way as care workers and care workers can be at risk of wrongly interpreting the MAS that they observe.

The analysis of certain components of suicidal risk can be done without the direct collaboration of the person (observation of the person in his environment, data collection from close persons and caregivers, from their file, etc.), but other components require having access to the interior life, behaviors and emotions of the person.

The approach and establishment of a favorable context are therefore two important elements so that the person feels confident and is willing to talk about the MAS episode.

Returning to the situation or follow up
Waiting for the person to be in a calm and secure space in order to return to the situation can help. You can also bring up the discussion by talking about your perceptions and about your needs related to the situation that occurred.

- For example: “I know that you don't feel like talking again about what happened (at the moment of the crisis). I'd like us to see together how you’re doing now, what happened that has helped you to feel better. I would also like us to look at what we can do so that it doesn't come back. What matters now is that you're better.”

Asking questions to collect information from a person about the presence of MAS
It can feel scary or uncomfortable to ask questions about suicidal behaviors. However, it is vital to be clear and precise on this topic in order to assure good analysis and interventions which are adapted to the needs and to the level of danger and the risk to the person.

Example 1: The person presented direct suicidal communication
In this case, the suicidal elements must be addressed frankly and directly, without judgment and without detours, preferably starting by using the same terms than the person.

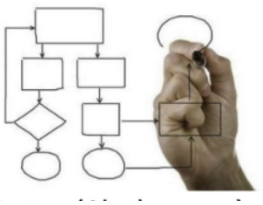
Example 2: The person did not present direct or evident suicidal communication
In this case, exploring the distress and the thoughts is essential in order to find avenues to address the issue of suicide. When questions about suicide are asked, mention that questions of this type are asked to all people who are experiencing difficult situations, to ensure their well-being and their safety.

Reassure the person: For example, “when we think about something, it does not mean that we are going to do it”. Exploring the presence of MAS is done throughout continuous dialogue.

Vignettes
As with other subjects and if this method is known by the person, it is possible to construct and use vignettes to approach different aspects of MAS. Some examples are given below.

Presence of suicidal thoughts		
Image	Text: (Alex) is very frustrated. He/She does not	Questions: ● Do you feel like (Alex)?

	know what to do for things to change. He/She would like to die to stop being frustrated. He/She is thinking of finding a way to kill him/herself.	• What thoughts do you have? • Why do you feel like (Alex)? • Why don't you feel the same as (Alex)? • Do you still feel that way?

Planning for a suicide attempt	
Image  Text: (Alex) is thinking about dying, like you. He/She found a means to kill (or to hurt) him/herself.	Questions: • Have you thought of a way to kill/hurt yourself, like (Alex)? • What way did you think of to kill or hurt yourself? • Do you think you will die if you do that?

Suicide attempt	
Image  Text: (Alex) is very sad. He/she is so sad that he/she tried to hurt themself, to kill themself.	Questions: • Do you feel like (Alex)? • Have you tried to kill yourself or to hurt yourself? • How did you do it? • Did you think that you'd die by doing …? • Do you want to try again? • Why would you try again?

Using simple questions with a choice of answers
The person can point to what they are feeling and what happened or fill in by writing. Explain that all the answers are correct and that there is no a bad response. Some examples are written below.

Exploring the objective of the behavior	
When you did (description of the suicidal behaviour), what did you hope would happen? Did you want to hurt yourself? Did you want to die? Do you want me to help you? Did you want me to know that you were sad (or upset)?	
Exploring suicide ideations	
Do you think sometimes of being dead? At this moment, are you thinking of being dead?	
Exploring ambivalence	
Are you happy to be alive at this moment? Are you angry to be alive at this moment? You tried to kill yourself and now you are alive. How does it feel to be alive?	 

Integrating the exploration of MAS into a non-verbal activity
The objective here is to promote the expression of emotion and of behavior in a way that emphasizes the nonverbal, for people experiencing difficulties in expressing their lived experiences orally.

Examples:

- “I would like us to discuss what happened because I want to understand in order to help you better if you feel down again when you have (restate the issue).”

Sit down Next to the person and make a drawing;

- “It's hard and if you cannot do it it's okay, but can you draw how you felt when…”
- “Draw what you were doing when you were angry, sad…”
- “I'm going to draw what I understand that you're telling me. you'll tell me if I made a mistake.”
- “Show me what happens in your body when you feel down and you want to die.”
- “Show me what you want to do to hurt yourself or kill yourself.”
- “When you put a knife in your room, what was that for? What did you want to happen?”

Suggestions for direct and indirect questions

The IDAS Process does not include specific items or questions to ask the person since the questions must all be adapted to their level of communication. However, we offer some examples in Table 3.

Tableau 3 - Possible questions and formulations to explore the risk of suicide: Collecting important information from the client about the presence of suicidal ideations

Field of exploration	Intervention	
Expression of distress and thoughts	Use of gestures, images representing emotions and other pictograms familiar to the person that represent their environment to help them express their distress, suffering, the things that create malaise in the moment, their wishes, their desires.	
Recognition, validation and acceptance of distress, whatever its form of expression (frustration, anger, aggressivity, crying, sadness, etc.)	I see that you have a lot on your mind. You said (...), you did (...). Usually, you do that when things aren't going well. Is that right? It's OK, you need to let it out. I am listening.	
	The client presented direct suicidal communications	The client did not present evident or direct suicidal communications
Search for clues of the presence of suicidal ideations and exploration of suicidal ideations.	–You told (...) that you wanted (to kill yourself, die, etc.), does that mean that you are thinking (about suicide, about taking your life)? –When you think about dying, what's it like? How does that happen in your mind? (Open question, exploration) –Do you mean to say that you are thinking about killing yourself? (Closed question) –When you think of dying, what's it like? –What are you thinking of doing? Assess suicide plans by asking the person to tell: –Tell me what it's like when	–Normalization question: It can happen that people who experience [name the difficult situation experienced by the client] think about killing themselves. Do you think about that? Have you ever thought about it before? –When someone feels very down like you feel right now, it's possible to have all sorts of ideas in mind, I understand that. –Sometimes, people feel like they want to hurt something when they are angry and in pain. Sometimes, they might feel like hurting themselves. If that happens to you, you can talk to me about it.

	you think about taking your life, what ideas do you have? Where did you find these ideas (for the suicide option)? What else comes to your mind? –When the answer is yes, verify the suicide plan directly.	–Are you in so much pain that you think about… Dying? Taking your life? (closed question) –When you feel (reflect), does it happen to you sometimes to think of dying? –I see that you are feeling really bad–mixed up–lost–discouraged–etc. –I would really like to know how you're feeling inside, what ideas you have when you feel like this (exploration of suffering and suicidal ideations). –Do you feel so frustrated–angry–sad–upset–that you would feel like dying–disappearing–killing yourself?
Validation of observed elements	–I noticed that you did not enjoy (doing some activity) like before, you said that your life was not worth the trouble, you don't seem like you are feeling well, I would like to confirm some things with you. When you say that life is not worth living, what do you really mean? Do you mean that you are thinking about dying? Are you trying to say that you are thinking about killing yourself?	–I noticed that you did not enjoy (doing some activity) like before, you don't seem to feel well, I'd like to confirm some things with you. It happens sometimes when people aren't feeling so well, some people think about dying. And you, are you thinking about that?
Inclusion of elements of validation and of understanding of client's discourse and behavior	–You seem very upset and you told (...) that you wanted (to kill yourself, die, etc.). Sometimes, there are people who say that when they are down. Are you feeling down? –Tell me what's not going well? (...) Is that what's making you say that (repeat	–You seemed really upset and you told (...) that you wanted it all to stop. Sometimes, people say that when things are going badly. Are things going badly for you? Tell me what's not going well. (...) Is that what made you say that (repeat their

	their words, or name what he/she drew). –What does that mean for you? (...) Does that mean that you are thinking (about suicide, about taking your life), or does it mean something else?	words, or name what he/she drew). What does that mean for you? (...) Does that mean that you are thinking (about suicide, about taking your life) or does it mean something else?
Towards solutions and the action plan: Opening to action aimed at working with the person to support their collaboration and begin to reduce their distress	–You'll see, we're going to talk about it, and together, we are going to find some 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 lessened – increased your ideas about dying?	
Follow-up (a few hours or days) post-episode: reevaluating the presence of suicidal ideations and distress	–How are your ideas about dying–suicide–compared to last time? Less strong/more strong/the same (use the image of a scale/ thermometer)? What has made them decrease/increase?	How do you feel today? Compared to the other time? Do you remember when you were having doubts about your suicidal thoughts? Have you thought about that again? –How did you feel when you thought about it again? –You haven't thought about it again? That's good (change the subject).

Construction of a social scenario for the development of distress, the situation which leads to suffering

Social scenarios are common tools used with autistic people and those presenting an ID. They can also be applied to the exploration of MAS and to the process of suicide prevention. The social scenario can be written, drawn or illustrated. It can allow the person to describe the process that led them to think of suicide or to have suicidal behaviors. It also allows us to identify moments in the process where we can intervene to interrupt it. On the other hand, it's important to avoid drawing or describing the suicidal act in a social scenario so as not to introduce ideas as to how to do it, for example. One might instead use a symbol for the person's distress, or the effects of the suicidal impulse (such as grief, pain). Another social scenario can describe the intervention and the manner in which the suicidal process was interrupted by actions that led to collaboration with the person.

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

The first phase in the management of suicidal risk consists in identifying distress and the potential presence of MAS in a person. This screening is done in the context of daily interactions with care workers, caregivers and close persons who can help to identify the distress.

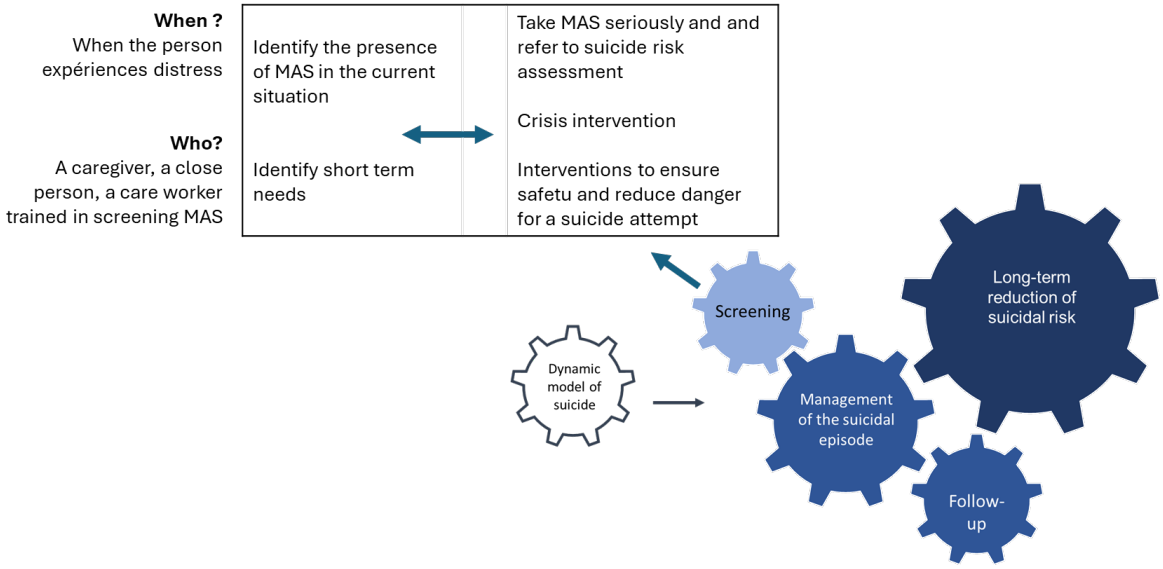
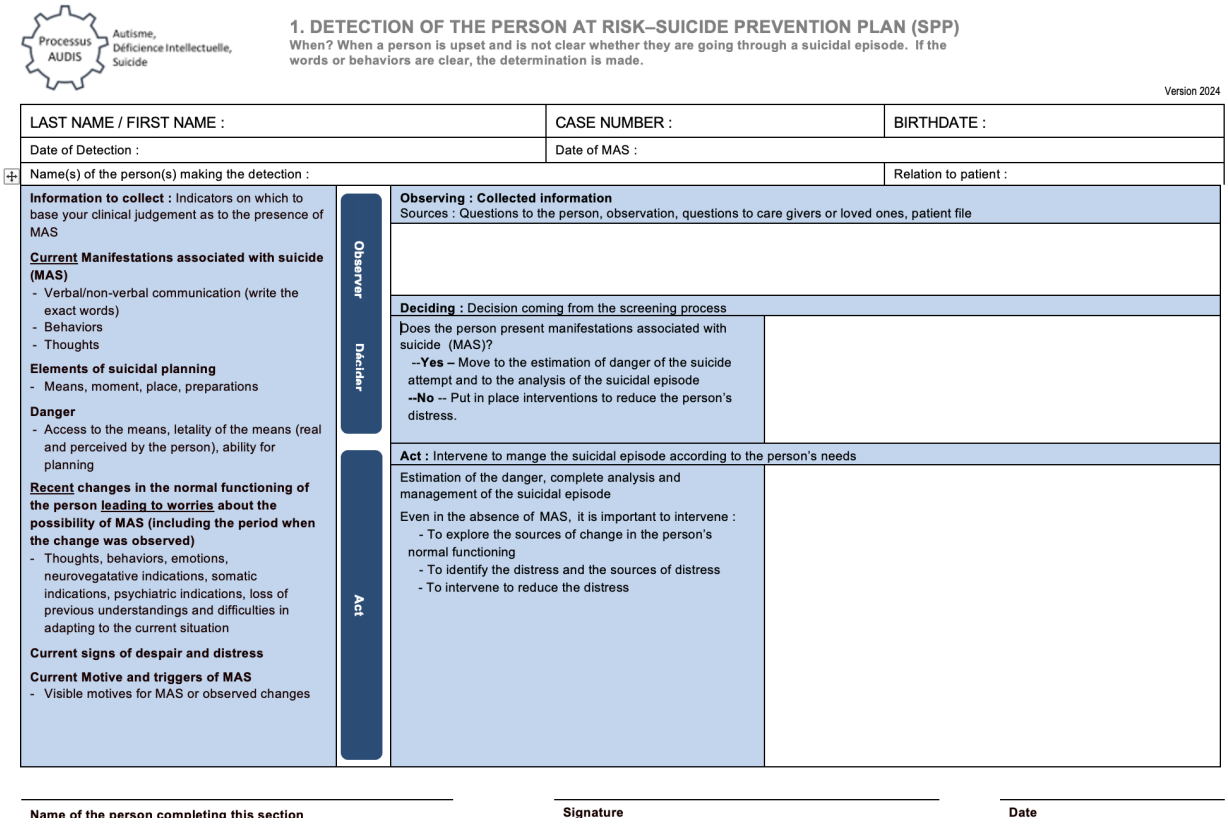


Figure 5 - Screening role in the IDAS process

1. General structure of the screening process

The screening step is actualized as follows in the IDAS process' clinical decision-making and data collection document:



Processus AUDIS — Autisme, Déficience Intellectuelle, Suicide

1. DETECTION OF THE PERSON AT RISK–SUICIDE PREVENTION PLAN (SPP)

When? When a person is upset and is not clear whether they are going through a suicidal episode. If the words or behaviors are clear, the determination is made.

Version 2024

LAST NAME / FIRST NAME :	CASE NUMBER :	BIRTHDATE :
Date of Detection :	Date of MAS :	
Name(s) of the person(s) making the detection :		Relation to patient :

Information to collect : Indicators on which to base your clinical judgement as to the presence of MAS

Current Manifestations associated with suicide (MAS)
- Verbal/non-verbal communication (write the exact words)
- Behaviors
- Thoughts

Elements of suicidal planning
- Means, moment, place, preparations

Danger
- Access to the means, letality of the means (real and perceived by the person), ability for planning

Recent changes in the normal functioning of the person leading to worries about the possibility of MAS (including the period when the change was observed)
- Thoughts, behaviors, emotions, neurovegatative indications, somatic indications, psychiatric indications, loss of previous understandings and difficulties in adapting to the current situation

Current signs of despair and distress

Current Motive and triggers of MAS
- Visible motives for MAS or observed changes

Observer

Observing : Collected information
Sources : Questions to the person, observation, questions to care givers or loved ones, patient file

Décider

Deciding : Decision coming from the screening process

Does the person present manifestations associated with suicide (MAS)?
--**Yes –** Move to the estimation of danger of the suicide attempt and to the analysis of the suicidal episode
--**No** -- Put in place interventions to reduce the person's distress.

Act

Act : Intervene to mange the suicidal episode according to the person's needs

Estimation of the danger, complete analysis and management of the suicidal episode

Even in the absence of MAS, it is important to intervene :
- To explore the sources of change in the person's normal functioning
- To identify the distress and the sources of distress
- To intervene to reduce the distress

Name of the person completing this section | **Signature** | **Date**

Figure 6 - PPS-S - screening of a person at risk for MAS

2. Objectives of screening

Screening aims to answer the following questions:

- Does the person present MAS?
- What must I do to go further in my analysis of suicidal risk and what actions should I implement?

Screening can be done independently or in combination with the management of a suicidal episode (phase 2). Different people can be in charge of screening and suicide risk assessment in different contexts and work environments. For example, people in the areas of life, work, or recreational activities can be trained in screening persons under their care and to refer persons in distress to professionals with whom they collaborate.

Simultaneously, people trained in the management of suicidal episodes can screen in the context of a complete intervention of suicide prevention.

This phase enables us to identify the presence of suicidal ideas and the short-term danger and cannot be used to categorize a person as suicidal or not suicidal in the medium to long term.

A detailed screening is not necessary in the case where a person clearly and directly says that she wants to kill herself, when she makes a suicide attempt or where she has immediate access to a suicide method and indicates the desire to use it. In that context, MAS are clearly present and assessment is required by a trained care worker.

In addition, a screening is also useless when the person is doing well at the moment. Indeed, the screening does not aim at identifying past MAS, but only current MAS. The screening is very useful in less clear situations, when the person has ambiguous communications, makes ambiguous behaviors or lives through a rapid change in habitual functioning. It's worth clarifying the presence of MAS before beginning a more complete process of suicidal episode management.

A person who, after being screened, does not present MAS can still experience difficulties or distress. This distress must be explored, understood, recognized and an appropriate intervention must be provided.

Observe: Sources of information and indicators of MAS

Many sources of information can be used to screen MAS. The behaviors and actions of the person are the principal source of relevant information, but this information can be completed by observations, questions to caregivers or family members, reading the person's clinical file, etc. Table 4 suggests indicators to observe in a person in order to complete the screening.

Tableau 4 - Screening observation

Information to collect	Description and instructions
Manifestations associated with suicide	
Types of MAS	Direct and indirect verbal expressions, communication through various means, changes in observed behaviors, preparations for death, letters, finding or accessing a suicide means, etc. (see details in Table 1) Any type of MAS must be immediately considered relevant to a suicidal risk. When words are ambiguous or indirect, it is important to clarify with the person. Describe words and behaviors in note-taking and in communications in a precise way to reuse the words that the person used at the time of subsequent interventions.

Suicide planning	A plan that is not comprehensive can still be dangerous for autistic people or those with an ID. Planning is the fact of having thought of a means (no matter its lethality) and of a way to use it or put it to work.
Danger	Access to the means, lethality of the means, perceived lethality of the means by the person. The inability to plan a suicide or to identify a lethal means does not take away the distress of the autistic person or the person with an ID. An intervention is still necessary. In addition, there is always a risk of underestimating the ability to kill oneself or to suffer severe injuries.
Recent changes in signs associated with MAS	
Cognitions	Confusion, difficulty concentrating, indecision, state of intoxication, semblance of addiction, dissatisfaction/frustration, inability to adapt to a situation, catastrophic thoughts, loss of limited interests, rigidity or fixations increased on an object, person or idea
Behaviors	Changes in behavior (worse or better), agitation or exhaustion, amplification of habitual behaviors, increase in the consummation of substance or compulsive behaviors, isolation, absenteeism, new or increased demands for help, attention seeking, aggressive behaviors towards other or objects
Emotions	Changing mood, mood swings, manifestations of sadness, of anger, of irritability, increased disquiet vis-à-vis future events, anxiety, increased aggressivity, dissatisfaction, disappointment, fears or insecurity vis-à-vis a situation, breech in one's self-esteem, feelings of abandon, feelings of incompetence, of blockage, mourning one's normal life, etc.
Neurovegetative signs	Degradation of sleep, appetite, level of energy, pains, fatigue, aggravation of psychiatric symptoms, loss of interest in known restricted interests
Somatic signs	Development or aggravation of physical troubles, digestion, back pain, headache, etc.
Psychiatric signs	Aggravation of symptoms
Associated Context	
Loss of abilities	Stagnation or regression, difficulties adapting to the current situation
Hopelessness	Negative discourse as it relates to the future, discouragement, resignation, self-deprecation, ending treatment, refusal of follow-up care or absences, refusal of help offered
Apparent motive for MAS or observed changes	The identified motive can differ depending on the source of the information and the real motive may not be the one that appears in the first place. It is one of the tools to assess the behavior's function. The motive can help us to understand the function of the suicidal behavior

	but is not enough. It should be completed with the exploration of the situation to possible solutions to diffuse a crisis and build the action plan.
This information is not exhaustive. Please note all that seems relevant to the understanding of the distress situation.	

Decide: Decisions stemming from the observation in the screening

The following question is key to translate observations into decisions regarding MAS: Doest the person present manifestations associated with suicide?

- Yes – move to the current danger and MAS episode assessment
- No – put in place interventions to reduce the person's distress

Act: Intervention to put in place in the context of a screening

If the person is presenting MAS, it is important to continue to the assessment of the current situation and the management of the suicidal episode. However, even in the absence of MAS, it is important to intervene if the person presents signs of distress. In this case the interventions then aim to:

- Explore the sources of change from usual functioning
- Identify the distress and its sources
- Intervene to reduce the distress

Documenting

It is important to note the observations made, the decisions and the actions undertaken to support the management of the suicidal episode, if necessary. It is also important to rigorously note the exact actions and behaviors of the person in order to be able to refer to them and analyze them in a larger context.

Section 3 – Managing the suicidal episode

Once the screening is complete and it is determined that the person currently experiences distress accompanied by MAS, it is possible to analyze the current situation and needs, assess danger for a suicide attempt, and implement SPP-E (suicide prevention plan – Episode). This management of the suicidal episode can be completed by the same care worker who did the screening if she is adequately trained and equipped. If the screening has been done by a close person, the suicidal episode can be managed by a different professional. However, in all cases, it must be done very quickly after the screening in order to ensure the person's safety and to properly take charge of the current distress, since its intensity can change quickly over time.

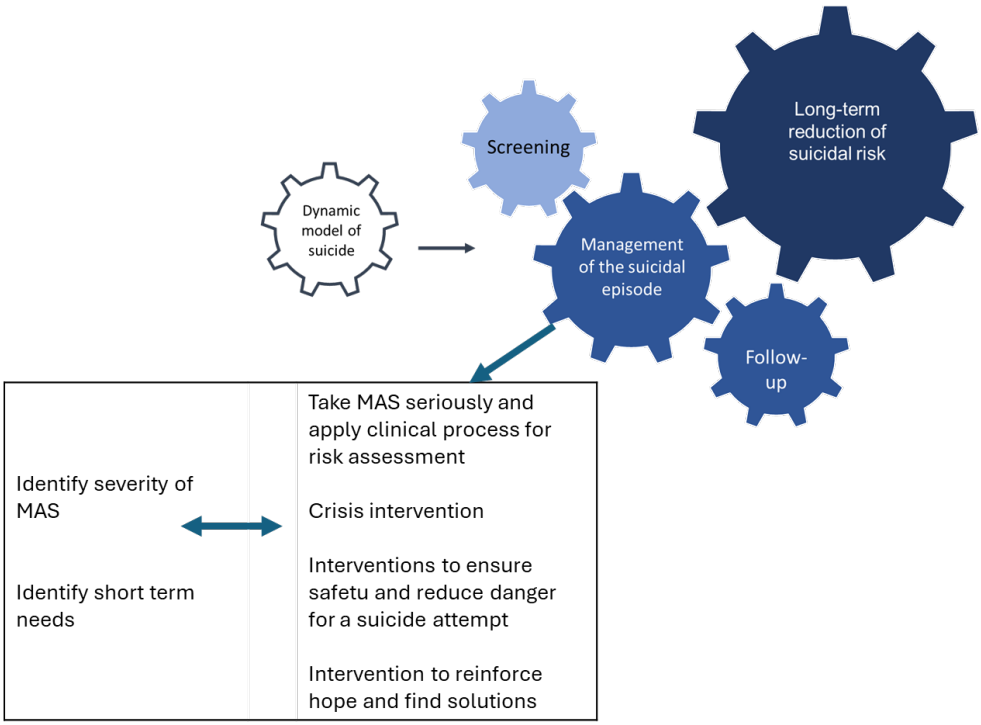
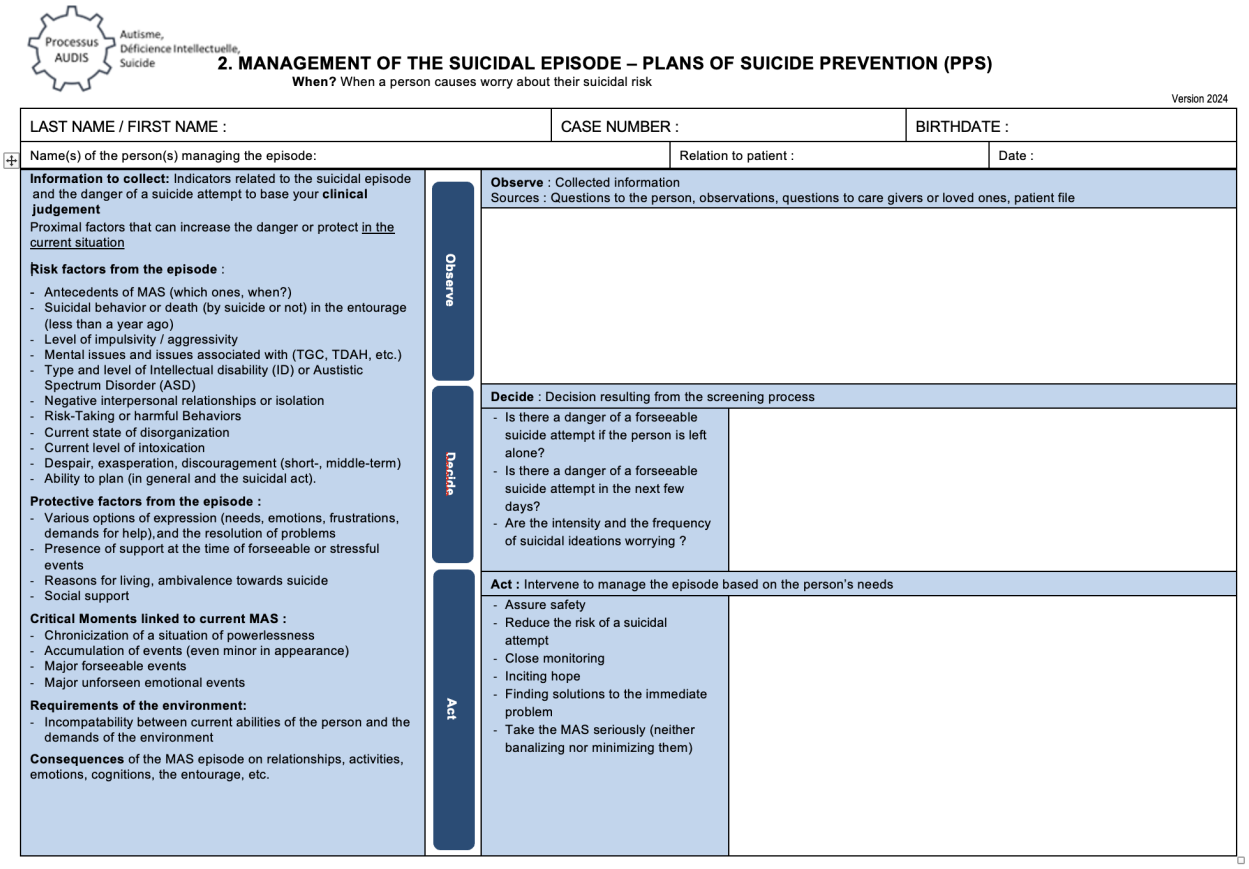


Figure 7 - MAS episode management role in the IDAS process

1. General structure of the management process in a suicidal episode

The management of a suicidal episode is based on the structure presented in figure 8.



Processus AUDIS — Autisme, Déficience Intellectuelle, Suicide

2. MANAGEMENT OF THE SUICIDAL EPISODE – PLANS OF SUICIDE PREVENTION (PPS)

When? When a person causes worry about their suicidal risk

Version 2024

LAST NAME / FIRST NAME :	CASE NUMBER :	BIRTHDATE :
Name(s) of the person(s) managing the episode:	Relation to patient :	Date :

Information to collect: Indicators related to the suicidal episode and the danger of a suicide attempt to base your **clinical judgement**

Proximal factors that can increase the danger or protect in the current situation

Risk factors from the episode :

- Antecedents of MAS (which ones, when?)
- Suicidal behavior or death (by suicide or not) in the entourage (less than a year ago)
- Level of impulsivity / aggressivity
- Mental issues and issues associated with (TGC, TDAH, etc.)
- Type and level of Intellectual disability (ID) or Austistic Spectrum Disorder (ASD)
- Negative interpersonal relationships or isolation
- Risk-Taking or harmful Behaviors
- Current state of disorganization
- Current level of intoxication
- Despair, exasperation, discouragement (short-, middle-term)
- Ability to plan (in general and the suicidal act).

Protective factors from the episode :

- Various options of expression (needs, emotions, frustrations, demands for help),and the resolution of problems
- Presence of support at the time of forseeable or stressful events
- Reasons for living, ambivalence towards suicide
- Social support

Critical Moments linked to current MAS :

- Chronicization of a situation of powerlessness
- Accumulation of events (even minor in appearance)
- Major forseeable events
- Major unforseen emotional events

Requirements of the environment:

- Incompatability between current abilities of the person and the demands of the environment

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

Observe

Observe : Collected information
Sources : Questions to the person, observations, questions to care givers or loved ones, patient file

Decide

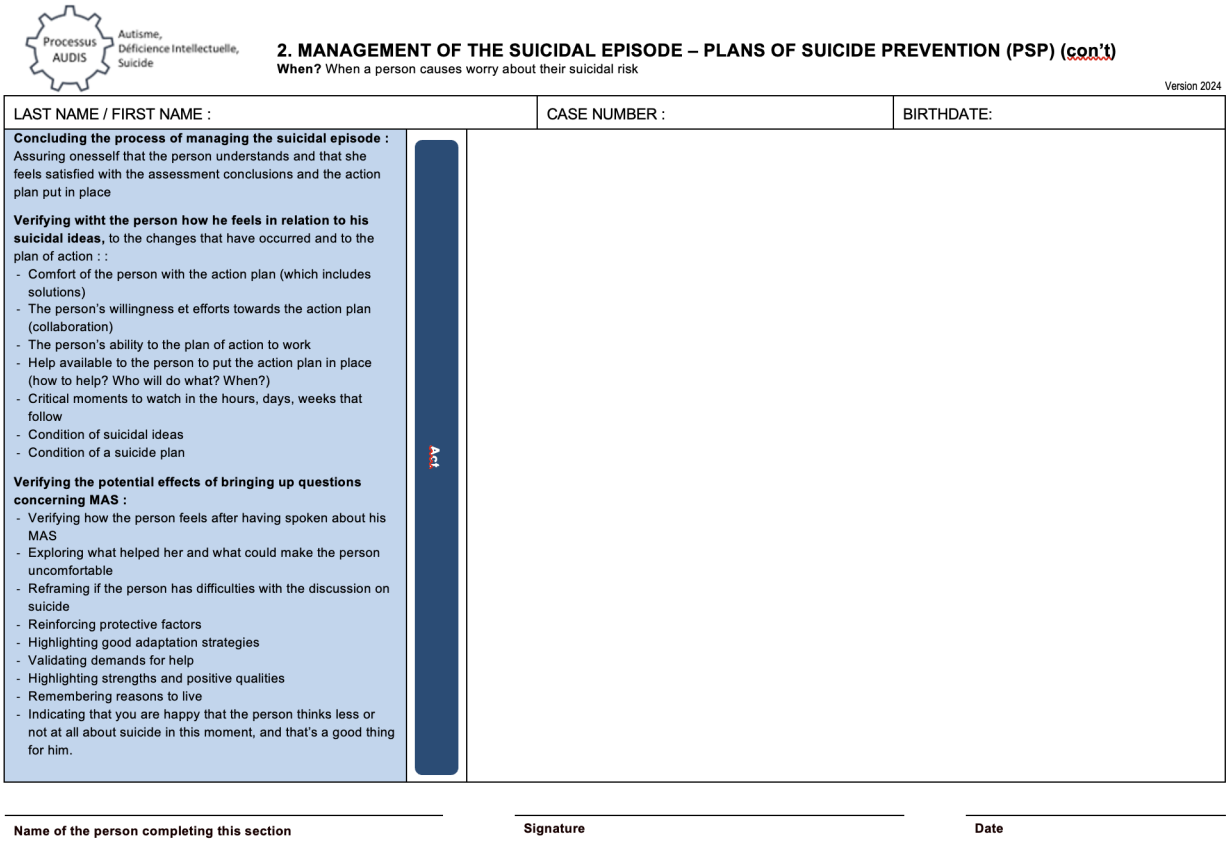
Decide : Decision resulting from the screening process

- Is there a danger of a forseeable suicide attempt if the person is left alone?
- Is there a danger of a forseeable suicide attempt in the next few days?
- Are the intensity and the frequency of suicidal ideations worrying ?

Act

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

- Assure safety
- Reduce the risk of a suicidal attempt
- Close monitoring
- Inciting hope
- Finding solutions to the immediate problem
- Take the MAS seriously (neither banalizing nor minimizing them)



Processus AUDIS — Autisme, Déficience Intellectuelle, Suicide

2. MANAGEMENT OF THE SUICIDAL EPISODE – PLANS OF SUICIDE PREVENTION (PSP) (con't)

When? When a person causes worry about their suicidal risk

Version 2024

LAST NAME / FIRST NAME :	CASE NUMBER :	BIRTHDATE:

Concluding the process of managing the suicidal episode : Assuring onesself that the person understands and that she feels satisfied with the assessment conclusions and the action plan put in place

Verifying witht the person how he feels in relation to his suicidal ideas, to the changes that have occurred and to the plan of action : :

- Comfort of the person with the action plan (which includes solutions)
- The person's willingness et efforts towards the action plan (collaboration)
- The person's ability to the plan of action to work
- Help available to the person to put the action plan in place (how to help? Who will do what? When?)
- Critical moments to watch in the hours, days, weeks that follow
- Condition of suicidal ideas
- Condition of a suicide plan

Verifying the potential effects of bringing up questions concerning MAS :

- Verifying how the person feels after having spoken about his MAS
- Exploring what helped her and what could make the person uncomfortable
- Reframing if the person has difficulties with the discussion on suicide
- Reinforcing protective factors
- Highlighting good adaptation strategies
- Validating demands for help
- Highlighting strengths and positive qualities
- Remembering reasons to live
- Indicating that you are happy that the person thinks less or not at all about suicide in this moment, and that's a good thing for him.

Act

Name of the person completing this section | **Signature** | **Date**

Figure 8 - structure of the SPP-E

2. Objectives for the suicidal episode management

As is described in table 5, the management of the suicidal episode has two complimentary objectives: assessment and intervention.

Tableau 5 - objectives of SPP-E

Assess the danger for a suicide attempt	Intervene during the episode of MAS
• Qualify the danger of a suicide attempt • Identify the presence/nature/intensity of suicidal ideations • Identify proximal risk and protective factors • Identify the triggers events • Document the individual and family history of suicidal behaviors • Describe the level of hopelessness	• Ensure safety • Prevent the suicide attempt • Reinforce hope • Diminish the risk of a future suicide attempt • Reinforce protective factors • Reduce risk factors

• Understand the impulsivity of the person • Understand what happens for the person without preconceptions • **Orient the intervention (allocate the right services at the right moment with the right intensity)**	

Observe: Sources of information and assessment indicators of danger during a suicidal episode

The relative weight of different observed factors varies according to the level of ID or of autism, the life history of the person, his cognitive, social and emotional capacities, and on their living conditions. It is established by the care worker making the assessment, beginning with her clinical judgment, her understanding of the usual functioning of the person and her interdisciplinary collaborators.

The process of managing the suicidal episode aims to support the exploration of factors associated with the development of suicidal ideations and of danger for a suicide attempt, with the goal of deploying an intervention with an intensity adequate to ensure the safety of the person and to respond to his immediate needs.

In addition, it is important to recognize the fact that the assessment of danger is mainly relevant in the short-term, based on the current situation. An assessment of danger done at a certain moment is no longer valid when the conditions change for the person, for example, or after an intervention has been put into place.

Beyond the short-term danger of attempting suicide, this phase also allows us to assess the form and intensity of suicidal ideations. It is important to understand what can trigger suicidal ideations and to put into place appropriate interventions. Suicide prevention is not limited to the prevention of suicide attempts. The reduction of ideations and of distress must be among the objectives of the suicide episode management. This section provides some clues for making an assessment of the danger and an analysis of the suicidal episode, to adequately support your interventions.

Tableau 6 - SPP-E observation

Information to collect	Description and instructions
Risk factors	
- MAS antecedents (which ones? when?) - Suicidal behavior or death, by suicide or not,	These risk factors can complete the information collected at the time of screening.

in one's entourage (less than 1 month ago) - Level of impulsivity / aggressivity - Mental disorders and associated disorders (serious behavioral disorder, ADHD, etc.) - Type and level of ID and of autism - Negative interpersonal relationships or isolation - Risk-taking or harmful behaviors - Current state of disorganization - Current state of intoxication - Hopelessness, discouragement (short or middle-term) - Ability for planning (in general and for suicide)	They are essential for assessing the level of danger and complete information about suicide planning elements, which are important but insufficient for clinical decision-making. Even more so for autistic people or those having an ID, planning is often very vague. They allow us to consider areas of vulnerability when establishing an action plan and assuring safety and for short-, medium- and long-term follow-up.
Protective factors	
• Various options for self-expression (needs, emotions, frustrations, asking for help), and for problem-solving • Presence of support at the time of predictable stressful events • Reasons for living • Ambivalence towards suicide • Social support	Protective factors are key levers of intervention. The absence of protective factors increases risk. The absence of certain risk factors can be considered a protection, but there must also be positive protective factors such as the presence of reasons for living that are clearly identified by the person, bonds of trust, and/or the presence of a responsible person who is aware of the suicidal ideations.
Triggers events and Critical Moments	
Chronicization of a situation of powerlessness: increased reactivity to a situation in which the person experiences emotion, autonomy or self-esteem issues.	These types of critical moments seem to be the most common at the time of suicidal episodes for autistic people or those presenting an ID. A critical moment observed once during a suicidal episode may not necessarily be present during a subsequent episode.
Accumulation of events (even minor in appearance): social failures, constraints of one's freedom, mourning or loss of objects	
Major foreseeable events: changes, recurrent annual events	
Major unforeseen emotional events: (mourning for a person, conflict, rejection)	These critical moments can be identified and anticipated for prevention. Other types of critical moments exist in addition to those mentioned here.
Inadequacy between the person's current capabilities and the demands of the environment	We can note changes in the person's functioning as it relates to the demands of the environment that they frequent: either 1) they

	are no longer able to do the things they used to do before or 2) they get bored or the expectations are too low.
Impact of the episode	
Impact of the MAS episode on the activities, cognitions, environment, close persons, and personal relationships	We can note what has changed in the person's life routine or relationships after a MAS episode, for the better or the worse. From the perspective of a functional evaluation of behavior, we explore here the component "consequence" in the ABC sequence.

Decide: Decision based on observations

The analysis of the episode and the assessment of suicidal danger begin with by gathering information. These are founded on clinical judgment of care workers, taking into account the person's abilities and level of collaboration to assure his security and the abilities of his environment to protect him.

Clinical decision-making can be based on the following questions:

- Is there a danger that the person will attempt suicide if left alone now?
- Is there a danger of suicide behavior in the next few days?
- Does the person have serious suicidal ideations?
- Could the situation change rapidly for the person?

Answers to these questions guide the suicide prevention plan.

Act: Intervention to manage the suicidal episode

The answers to questions of assessment supports the evaluation of the person's needs so as to decide on an intervention plan whose intensity is adapted to his needs and characteristics. Section 3 describes in details various interventions tools that can be used to construct the SPP-E.

Adequately concluding the process of managing the suicidal episode

This conclusion is necessary to ensure that nothing has been forgotten and that everyone understands the situation and the SPP-E well. Some avenues to conclude the management process for an episode (evaluation and intervention) in an inadequate manner are listed below.

- Assure yourself that the person understands and feels comfortable with the conclusions of the assessment and with the action plan put in place. **Verify with the person how he feels towards his suicidal ideations,** towards changes that have happened, and towards the action plan.
- Verify the comfort of the person with the action (including solutions) the willingness and efforts of the person towards the action plan (collaboration), the ability of the person to put to work the action plan, the support required by the person to put in place the action plan (how to help him or her, who will do what? when?).
- After the SPP-E has been completed, identify the critical moments to watch over during the following hours, days and weeks, the level of suicidal ideations and the suicidal plan. The level of danger for attempting suicide should be reassessed at the end of the SPP-E process. Indeed, the danger can have changed during the session, and it is important to keep track of this change in order to inform future interventions.

Finally:

- Verify the potential effects of having brought up questions concerning MAS
- Verify how the person feels after having spoken about MAS
- Explore what helped the person and what could make him uncomfortable
- Reframe the situation if the person encountered difficulties with the discussion on MAS
- Reinforce protective factors, highlight effective coping strategies, validate asking for help, underline strengths, remind of the reasons for living
- Indicate that you are happy that the person no longer thinks or thinks less about suicide for this moment, that it's a good thing for them.

Documenting

It is important to rigorously record the clinical decision-making process used so as to share and support the understanding of the pattern of MAS in time. The SPP-E described in figure 8 can be helpful at this stage.

3. Intervention tools for the management of the suicidal episode

The following tools of intervention can be used as they are or adapted according to the needs and abilities of the person. They are presented in the order of Figure 6. The interventions in black are found in this document and the interventions in gray are generally available in the work environment. These tools of intervention are suggestions. You can develop others according to your needs, keeping in mind, however, that each intervention must respond to a precise objective that comes from the analysis of the episode and the assessment.

All interventions are presented following the same structure:

- Objectives – to ensure a close adequation between intervention objectives and used tools.
- Justification / explanation – describe the theoretical and clinical foundations of the intervention
- Process of intervention – describe the modalities proposed to use the intervention in the context of MAS with a person with autism or ID
- Illustration of intervention tools – provides examples and blank versions of the instruments proposed to support intervention

3.1 intervention to ensure safety and to reduce the danger of suicide attempt

This first series of interventions can be used at the time of a suicidal episode or when the person's situation is worrying family or caregivers, after a screening and an assessment of danger.

A. Safety plan for a person having MAS

Objectives

- Ensure the safety of the person who has MAS in order to avoid moving toward a suicidal attempt
- Suggest appropriate ways for the person to act and ask for help during episodes of distress in order to reduce the appearance of suicidal thoughts or the risk of a suicidal attempt

Justifications / Explanations

When a person is suicidal (ideations or behaviors) they can experience difficulties in using strategies to diminish tension or mitigate the crisis. A safety plan allows the person to use strategies that he knows to be effective for him, in order to face the situation without immediately resorting to extreme measures. A safety plan can help the person to regain control over the crisis process by giving him the opportunity to apply solutions that have been pre-identified by him and within his reach.

An autistic person or someone presenting an ID can however experience more difficulties than other people in evaluating his emotional state. Alone, he might not know when or how to use his safety plan. It is therefore important to properly explain and support the use of the safety plan.

The safety plan includes solutions that have been developed in collaboration with the person. It proposes actions that are graduated according to the intensity of support necessary to diffuse the crisis process. At the lower level, we find actions that the person can do by himself. If these actions prove to be insufficient, we find strategies involving outside resources such as caregivers' support and at the higher level, we find specialized services. The inclusion of this gradation of solutions is particularly useful for people who may call 911 immediately when they are in crisis. In a safety plan, the person is encouraged not to use the higher level of intensity as long as he has not used the one from the preceding level. The goal is to help the person to develop a feeling of empowerment and self-confidence and in his own coping mechanisms and problem solving, all the while reducing the unhelpful recourse to Emergency Services.

The safety plan is applied in collaboration with caregivers and service providers typically associated with the person. It requires good communication between partners to allow for its optimal use over time. For example, in the fictitious safety plan of Lea, she must call her sister before communicating with her care worker. If Leah didn't call her sister but reached out to her care worker, the care worker could encourage her to do it, accompany her when she calls and then make an intervention if her sister is not available at that moment.

In its classic form, the safety plan is intended for a relatively autonomous clientele, who is able to identify moments when they experience a crisis or psychological disorganization. However, the care worker can guide the person through different stages of his safety plan, but it is generally expected that the care worker's help fades away progressively. In the case of less autonomous people, each stage of the safety plan can be deployed with the support of a caregiver or family member.

The safety plan fits into the same category of tools with active prevention plan to help reduce disruptive behaviors. All these tools reflect a progression of intensity of interventions and include a group of actions that the person can do alone in order to find an acceptable level of well-being. The safety plan specifically addresses the prevention of MAS by applying interventions of increasing intensity to reduce the risk of MAS.

Intervention process

Elaborated with the person, the safety plan requires the identification of:

- Triggers and critical events of suicidal episode and the type of MAS which the person experiences, including associated emotions and alarm signs specific to him (for example, level of agitation, of disorganization, or of confusion).
- The actions that the person can do himself to reduce the effect of the trigger event, highlighting the benefits of using identified strategies (to reinforce the person's motivation).

- Actions that involve the help of an external person (caregiver, close person, family member) and key sentences allowing others to recognize that the person is having suicidal ideations and that they need help in the context of the safety plan.
- People who have a role to play in the safety plan. These people need to be aware of the plan and key sentences which indicate that the plan is in use. They should be equipped to respond to the person based on the role that they agreed on in the plan: helping to explore the situation, providing distraction, disarming the crisis or calming the person. The role of each person must be well defined, according to their abilities and resources.

Each action identified must be achievable for the person and clearly planned and described. It should be designed in a social scenario, written or illustrated with the help of gestures or objects.

We can also write down things not to do, if the person is able to refer to them. For example, actions that the person has already done which increase the risk of MAS and reduce the capacity of the person to feel better can be identified in the safety plan.

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

It can be important to conduct regular role-playing activities with the person to allow him to familiarize himself with his safety plan and to practice ways that have been identified to help calm his distress.

Illustration of intervention tools
What follows presents the safety plan of Raphael (Table 7), an example of a safety plan that the autistic person or one presenting an ID can use alone or with the support of a caregiver.

Tableau 7 - Raphael's safety plan

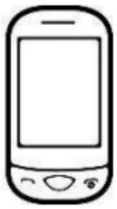
Things that make me think of suicide or that make me unhappy (emotional or behavioral indicator that can be associated to a MAS episode): I argue with a person at school and that makes me unhappy.		
	Actions that I can do to no longer think of suicide and why it's useful for me to do them.	Actions that I must avoid because they make me think even more of suicide.
		
By myself, alone	• I breathe deeply 3 times, then I do my relaxation exercises. • I draw how I feel. This helps me to feel stronger, to decide for myself. I can be proud of myself.	• Think about the argument all alone in my room.
Ask a friend for help	I feel unhappy. I tried to do my relaxation exercises alone. I still feel unhappy. • I ask my friend for help by saying: "I am unhappy, can I talk to you to distract me?" That lets my friend know that I need help and he knows how to help me. I am capable of saying that things aren't going well.	• Become upset because my friend can't help distract me. • Drink alcohol. • Stay all alone.
Ask for help from my sister, who is not next to me. I call her on the telephone.	I feel unhappy. I tried talking to my friend. That didn't work (he wasn't available because he was busy or maybe we chatted but I still feel unhappy). • I ask my sister for help by calling her on the phone and saying "I am unhappy, can I talk to you about what is happening?"	• Yell at my sister. • Yell at others around me.
Ask the care worker for help	I feel unhappy. I tried to ask my sister for help. That didn't work, she didn't answer her phone. I still feel unhappy. • I ask the care worker for help by saying: "I am unhappy, can I talk to you about what is going on?"	
Ask the crisis center for help	I feel unhappy. I talked to my care worker, but I still feel unhappy. My suicidal ideations are still there. • I ask the crisis center for help by	

	calling (telephone number)	
Ask the paramedics/ emergency services	I am really thinking seriously about killing myself and I tried everything that is in my plan. Nothing works. • I call the paramedics/emergency services with my care worker or with the crisis center.	• Call the paramedics all by myself.

Certain actions in the safety plan can be more detailed. For example, the action *Ask my friend for help* presented in Raphael's plan can include a simple written procedure on a card, such as the one Illustrated below:

 John	John's number 514-333-2211	Phrase to say to John: "I'm unhappy, can I talk to you to distract me?"

A card of the same type can be used for the action *Ask for help from the crisis line:*

  Suicide crisis line that I can call	Crisis Line Number 514-333-2211	I call with my care worker Julie

If possible, it may be interesting to organize a visit to the local crisis center with the person, in order to show him the service, introduce the crisis team and explain to him what the care workers do there. The person can become familiarized with the procedures of intervention and with the questions that are asked by care workers when a person calls their service. These steps allows the person to better understand what to expect, if he asks the Crisis Center for help. This visit can also be the opportunity to explore different ways of contacting the crisis center (telephone, text message, Online chat, email, visits in person), certain modalities working better depending on the person.

Table 8 presents another example of a safety plan. It's Dominique's plan; her functional limitations are more significant than Raphael's. The safety plan is very simple, schematic, and visual.

Tableau 8 - Dominique's safety plan

I want to go away, I feel sad, I'm hitting myself hard	
I stop what I'm doing.	
I give the caregiver my distress token.	

A safety plan can also be developed to predict an episode of MAS. It can then take a form more resembling a de-escalation plan, which identifies alarm signals and levels of disorganization, with actions to put in place to defuse agitation or distress.

B. Ensuring the safety of a person in danger

Objectives

- Ensuring the immediate physical safety of the person and others
- Stopping an imminent suicidal attempt if verbal interventions are not enough to reduce the danger (prevention) or take charge of a person in order to reduce the effects of a suicidal attempt (care).

Justifications / Explanations

This type of intervention must only be done when the life of a person seems to be in immediate danger. The intensity of safety measures depends on the level of danger and therefore on the assessment of danger made from observations made with the person. An intervention to ensure an individual's safety must be followed up by interventions to induce hope, to reduce the risk of MAS recurrence and of secondary benefits and to decrease the suicidal option.

There can be a gradation in the intensity of interventions to ensure safety. It is important to adapt the intensity of the intervention to the person's safety needs, and not to overreact because of an elevated level of stress for caregivers or close persons. An "excessive" or disproportionate reaction relative to the needs of the person may have adverse effects, such as discouraging the person to talk about his suicidal ideations and plans in the future.

The intervention should be based on relevant information about the person, his usual level of impulsivity, his current impulsivity and the ability of the people around him to physically control the person.

Removing the object or mean by which a person thought to kill himself is a good strategy to prevent a suicidal attempt since the suicidal person thinks often of a specific means in their plan. Reduce access to this means offers the opportunity to intervene to reduce distress and risk.

Process of intervention

Take away dangerous objects

The removal of dangerous objects can have two objectives:

- Stopping the action which puts a life in danger when the assessment of danger reveals that suicidal ideations are accompanied by a sufficiently elaborated plan (ex: The person hid a knife in his room and wants to cut himself)
- Reducing the risk of a suicidal attempt when the person presents an elevated level of danger, regardless of the real lethality of the planned action, lowering the tension and opening space for an intervention centered on the reduction of risk for a suicidal attempt, hope and problem solving (ex: a person thinks that some multivitamins can be used to commit suicide. It therefore becomes important to take them away from the immediate environment, despite the absence of true lethality).

Alone, the presence of suicidal ideations without an in-depth assessment of the danger is not enough to take away objects considered dangerous from the person's environment. The removal of dangerous objects from the person's environment must be done with caution and in collaboration with the person. It is important to understand what the person considers dangerous before removing objects and not stopping at what the caregiver or the family member considers as such.

The removal of objects considered dangerous can be experienced as a punishment by a person without much control over his life. If the person does experience it as a punishment, this may reduce the chances that he will talk about his ideations and suicidal plans in the future. If the reaction of family members or caregivers seems “excessive” (disproportionate compared to the danger perceived by the person), the removal of dangerous objects can have a counterproductive effect and must not therefore be a systematic intervention.

In this sense, the removal of a means (whatever the level of lethality), either contemplated or used by the person, must be immediate and accompanied by a clear explanation. For example, it is important to clarify that the person is important, that we are worried about them, that we don't want them to hurt themselves, that we want to be able to take the time necessary to talk, and to find solutions to problems and to feel better. A care worker could therefore explain: “ My job is to do all that I can to ensure your safety and taking away these dangerous objects is part of that.” Or: “I will willingly give back (the object in question) as soon as things are going better. I just want to be sure that you're safe now.”

Be careful not to take away dangerous or potentially dangerous objects if they are not related to a suicide attempt (planned or in process). If these objects have not been identified as part of a suicide plan, taking them away risks giving the person the idea of a more dangerous means of suicide they may not have thought about before. For example, if a person says that he's thinking of killing himself and we immediately take away his shoelaces and his bathrobe and pants’ belt, he can identify strangulation as a good way to kill himself.

Before returning the objects that were removed because of a danger of suicide attempt, a follow-up assessment of danger should be done. The returned objects must be presented and experienced by the person as a clinical success: this person successfully passed through a difficult moment. It should be before all else the opportunity to remember what was put into place to help him not to feel suicidal, to remember the available resources that the person can use and make a review of actions to do to ask for help, including the safety plan.

When a person refuses to give up an object which is considered dangerous by caregivers and he presents an elevated level of immediate or imminent danger according to the danger assessment, the situation can rapidly become complex. It is important here to know the person well, the way in which he becomes disorganized, his triggers, his alarm signals and ways to calm him down. It's possible that calling emergency services is the most appropriate option. Nevertheless, an approach using basic principles of dialectical behavioral therapy can disarm a dangerous situation:

- **Validation** consists in welcoming the person without judgment. It is necessary to reflect and to recognize that his behavior, his feelings and his thoughts are perfectly logical and normal in the circumstances.
- **Orientation** consists in describing what you know of the person's situation, what you would like to do and why you think could help, in clear terms and respectful of his autonomy.
- **Engagement** consists in engaging with the person in an action aimed at improving the situation and following the plan developed during the orientation phase.

Here is an example of putting these three basic principles to work. Jo is locked in his room with a belt that the caregiver tried to take away earlier when he said that he wanted to kill himself. He refuses to come out and talk, but the caregiver hears him walking back and forth and he is agitated. The caregiver can begin by breathing deeply a few times to take the time to recenter herself, calm herself a moment, regain the control of her voice and her own emotions. Then she can talk to Jo to validate what he's living by saying the following:

- "Jo, I see that you're upset and unhappy. You tried many ways to resolve the problem and it didn't work. It's normal that you are upset. I understand."

She can then orient her intervention by saying for example:

- "I understand that you argued with your mom and that you're sad. You want to stop quibbling with her. We could talk about it together if you want, a bit later. Also you want us to leave you alone in your room, because you're upset and sad. I agree with you. I really want to leave you alone, but I want you to be safe, because it's important that you are safe. So I propose that we open the door. I won't come in, you won't come out, but we'll just leave the door open so that I'm sure that you're safe. I won't take the belt and you open the door."

The caregiver can then look for Joe's engagement. she can express herself this way:

- "What do you think, shall we do that? I'll do my part and you can do yours?"

The important thing is always to validate the source of distress and the person's reaction by authentically showing that you consider him a complete person. He only acted as he was able, with the means that he had, in the situation where he was, at that moment.

Physical intervention to stop a suicide attempt

The physical interventions used to stop a suicide attempt are the same as those used to stop acts of self-harm or violent acts against others. They must be applied only when the person represents an imminent or immediate physical danger towards himself or others. These interventions must be used in a way that conforms to the directives implemented in care and support facilities and must be respect everyone's rights for dignity and safety.

They should also not be considered commonplace / banal. A security intervention in the suicidal context does not have the same objective as the same intervention aiming to reduce an undesirable / challenging behavior. It should not be experienced as a punishment. Indeed,

physical restraint must be explained as aiming to ensure the immediate person's safety and must constitute a stage of intervention aiming to reduce the danger of a suicidal attempt, kindling hope and finding solutions to the distress.

Transport to the hospital

Transporting someone to the hospital should be the last recourse in a suicide prevention intervention. Indeed this type of intervention can have important consequences for the person, his close persons and intervention settings, including:

- Stigmatization to being taken away in an ambulance;
- Removal from one's usual living setting and confrontation with a potentially anxiety-provoking environment;
- Acquisition of secondary benefits.

Danger of suicide attempt varies very quickly for a person. Therefore, acute danger may be reduced to a minimum by the time the person arrives in the emergency room and is seen by a doctor. This is why it is important for suicide prevention not to rely mainly on hospital transport and emergency psychiatric intervention.

If the person himself calls 911, without asking family members or caregivers, it will be important to make a danger assessment before letting him leave in the ambulance (unless obviously he has already made an attempt or put his life in danger). It may, however, be difficult to reconcile the perspective of the caregivers who work regularly with the person and that of the paramedics. Indeed the former have a knowledge of the functioning and of the person’s common mode of disorganization, while the paramedics judge the situation based on what they observe when they arrive on the scene. For example, the person can express words (including a suicide plan) judged worrisome for a care worker who does not know him, while using learned strategies to avoid an unpleasant situation or constraint.

After his visit to the emergency room and once the sources of distress are known and understood, an intervention can be planned with a person in order to minimize the secondary stress or benefits that can flow from hospitalization, while still showing the person that we are taking the MAS episode seriously. If secondary effects linked to hospitalization do exist, it is also possible to work with hospital personnel to identify and understand the nature of these effects. Involving members of the hospital personnel in this analysis also allows us to make them aware of the specific dynamic around visits to the emergency room and the risk of developing a damaging long-term habit for the person.

It is important to validate the distress experienced by the person, while recognizing and normalizing his emotions. Ex: “I understand that you don't feel good. That's OK. We're going to work on that and we're going to take care of you.” On the other hand, in the case where the person uses MAS to get a secondary benefit, it is very important to carefully analyze the reasons the person is using MAS and not other types of behaviors. This way, we can help the person use emergency services and hospitalization in the most appropriate manner and not for the secondary benefits that they hope to get out of it.

The follow-up tools post suicidal episode described in the SPP-Follow-up or the tools applied during a return to calm in situations encountered in other contexts can be useful to plan the return to the normal life setting, after a visit to the emergency room. This return should include discussions about what happened. The person must be encouraged to talk about his emotions, thoughts and behaviors. He may also have questions about what happened in the hospital. Finally, it is important to explore the obstacles that stopped the person from applying their safety plan and finding solutions, so they can apply it when a new crisis comes up.

3.2 Interventions to incite hope and find solutions

From the perspective of suicide prevention, it is crucial to incite hope and find solutions to distress. The interventions that target these objectives are put into place once the danger of a suicidal attempt is no longer severe or imminent. If there is no danger of a suicidal attempt in the short term or if the screening has not revealed the presence of MAS, this type of intervention should be made immediately after the screening and the assessment of danger. Five interventions aiming at inciting hope are presented in this section.

General instructions concerning interventions based on stories

Objective for the use of narration and interventions based on social scenario structure
The general objective of stories is to provide a support to explanations, to psychoeducation activities or to interventions. Stories explain different aspects of the suicidal process and of the intervention. They describe the cognitive and emotional processes often observed in autistic persons or those presenting an ID, as well as strategies for evaluation and intervention that can be used by care workers, caregivers or close persons.

Explanation/Justification
The stories use a vocabulary adapted to autistic people and those presenting an ID who can use verbal communication. They are particularly adapted to people who have basic understanding of emotions because they describe emotions. A certain ability for introspection is also necessary since these stories serve as a vehicle to explore one's own emotions. In the risk assessment and intervention process, it is important to use clear, correct, and non-ambiguous terms whose meaning is known to everyone. Talking about suicide in a clinical context does not increase the risk of suicide for a person.

General intervention process with stories
It is important to read the story with the person when he is calm. This tool should not be used in a crisis situation or when the person is agitated. It is also necessary to contextualize the use of the story (ex: It's important that we explain what happened, I sense that you have some questions about this…) while also indicating the time reserved for the activity (around 15 minutes, if the person talks a lot). The story is a prop for exchange. It can be adapted to the situation, to the person's needs and to the intervention objectives.

The caregiver can choose to tell what's happening and describe the expressions and emotions of the characters, without necessarily reading the dialogues or the narration. The person can also read the story alone, do a written exercise based on the caregiver's questions, draw what he feels, or even describe to what point he feels close to the character.

At each level following the specific instructions for each story, it is important to seize every chance to ask the person about his experience, for example by asking him in what ways he feels similar or different from the character, or by asking him questions about what others said or did, relating it to his experience or that of others. Finally, it is important to construct the intervention according to the person's situation, whether it be in a written form, orally or with the help of drawings and symbols. Furthermore, the story uses the same symbols and the same images to tackle concepts linked to suicide.

If a person does not have the capacity to identify, understand and recognize emotions, adaptations can be made with simplified scenarios and simpler emotions, according to the needs of the intervention.

Responding to direct questions on suicide, what suicide means and how to commit suicide
It is normal for people to be curious, and not responding to questions can damage one's comprehension of the process, and even increase the danger.

It is also important that people know the right terms to explain their suicidal ideations. In this way they will be more easily understood and helped in an inadequate manner.

For each story, the specific process for clinical accompaniment is described individually in the intervention document.

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

It can be necessary to discuss themes of ambivalence, particularly with people having cognitive rigidities. They can have a tendency to believe that once you want to die, no change is possible.

To reinforce the part that wants to live in a person who has suicidal ideations, we should look at the question of ambivalence and explore reasons for living.

Ambivalence is always present in the phases preceding a suicidal attempt and it is a central intervention tool. The following story provides an explanation of ambivalence, in simple and concrete terms, in a manner that supports caregivers to help a suicidal person understand this concept.

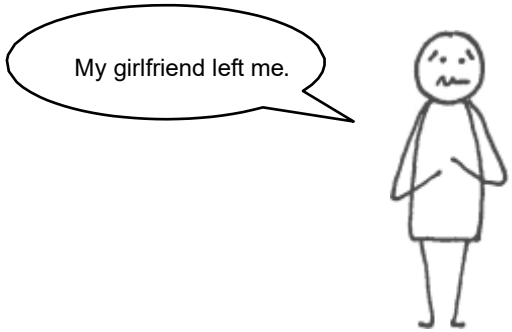
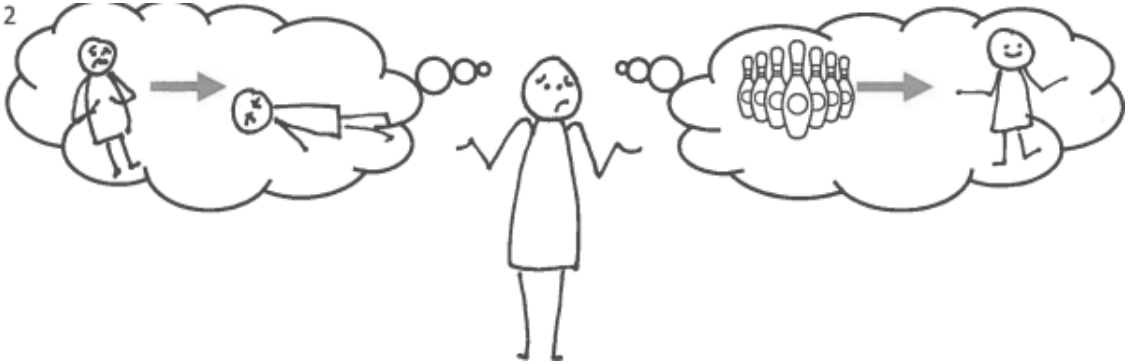
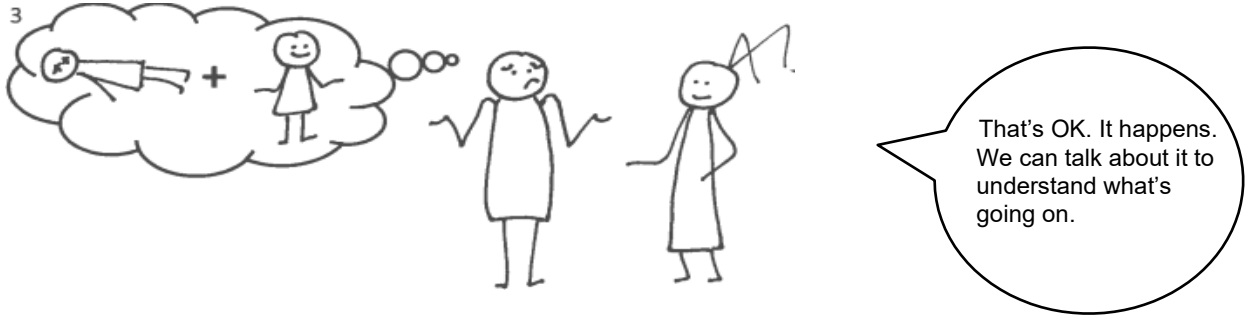
Boxes 1 and 2 expose the situation which lead Daniel to have suicidal ideations and experience ambivalence. The intervention aims here to identify the trigger events for MAS and the proximal reasons for living – in other words it seeks to identify ambivalence.

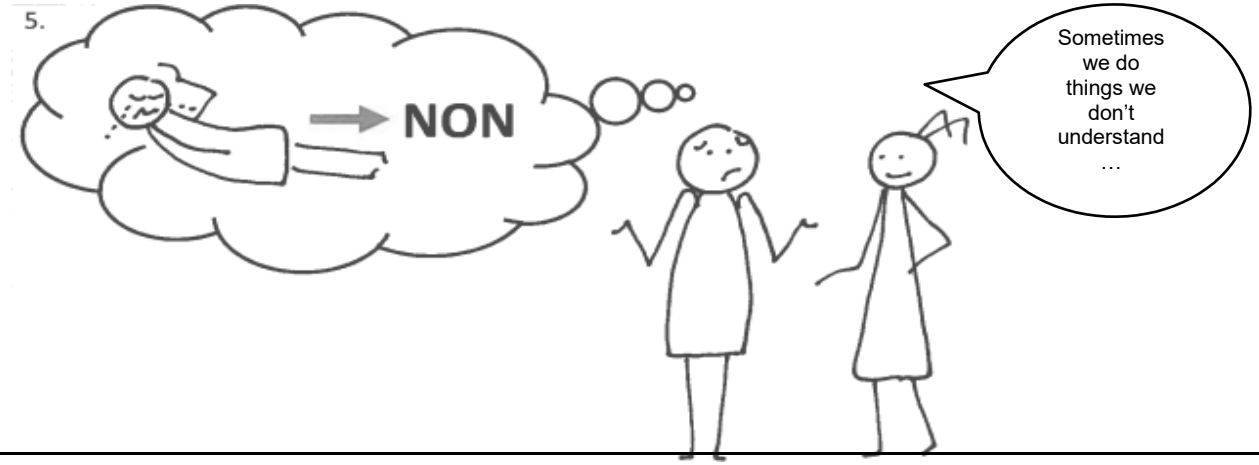
Box 3 illustrates the process of validating communication and the importance of asking questions when one feels mixed up or perturbed by events and by thoughts.

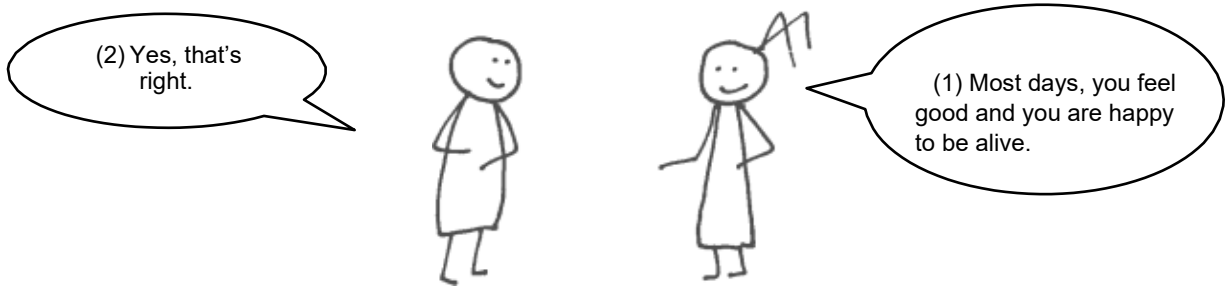
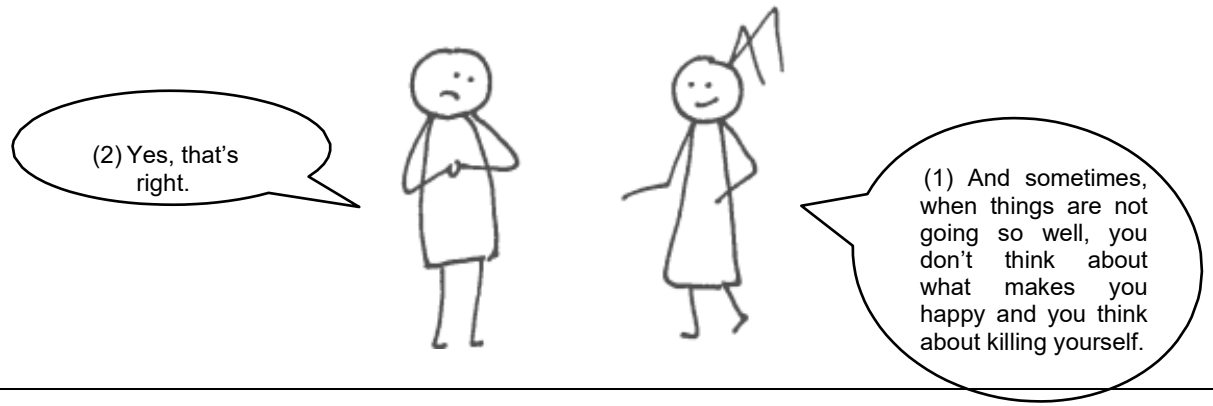
Boxes 4 to 9 provide explanations as to the different forms which ambivalence can take. The intervention aims to help the person identify ways in which he feels mixed up faced with his own MAS. It aims to help him recognize the desires to live and to die, their alternance or their simultaneous presence. The intervention normalizes this ambivalence.

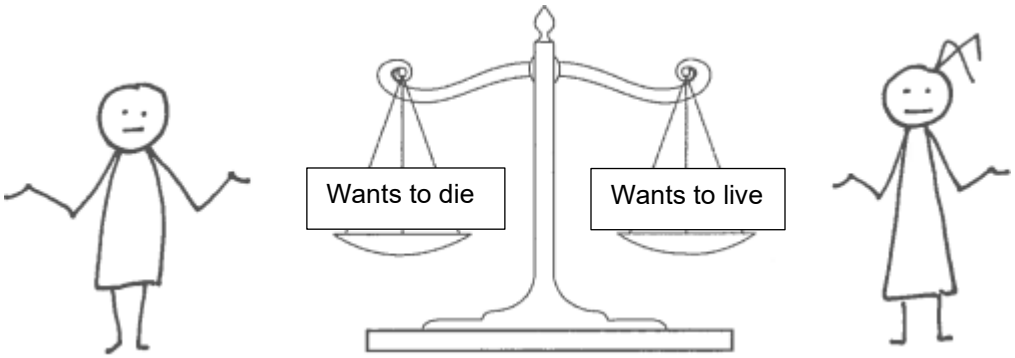
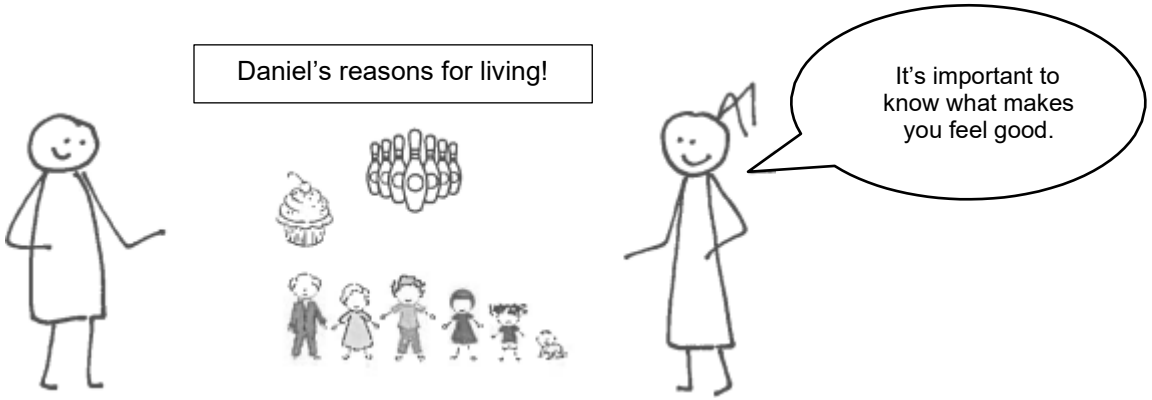
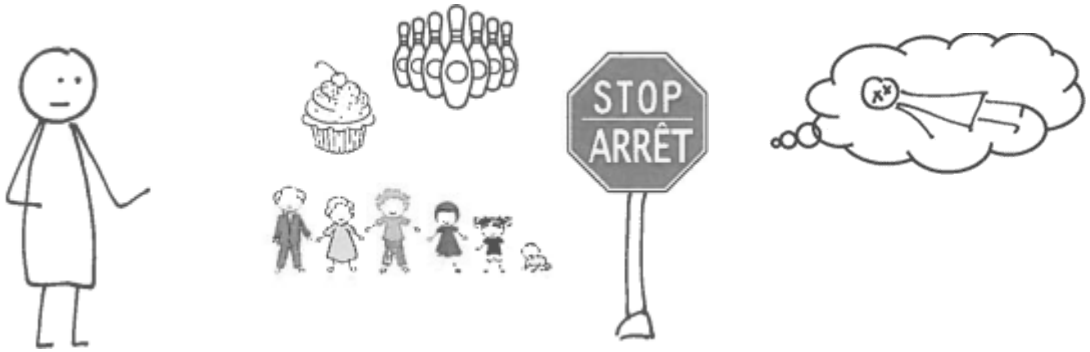
Boxes 10 and 11 illustrate the way to explore reasons for living and the way that we can use them to reinforce hope. the reasons for living are used to counterbalance suicidal ideations. The intervention enables a discussion with the person about his own reasons for living, the strategy being to help the person remember them in case of MAS. The objective is not to deny suicidal ideation or distress, but to remind the person that he also has reasons for living and that life is worth it. The intervention should equally explore sources of distress in order to reduce the risk of MAS.

Daniel wants to live and to kill himself at the same time, but finds hope

1  	Daniel had a girlfriend. She doesn't want to talk to him anymore. Daniel is sad.
2 	Daniel feels mixed up. He is thinking about killing himself because he's sad that his girlfriend doesn't talk to him anymore. He's also thinking that tomorrow, he wants to go bowling. He likes bowling with his friends.
3  	Sometimes, Daniel feels like living and at the same time feels like dying. The caregiver explains that it's normal to feel like this. It can happen to anyone.

	Sometimes Daniel feels like living and after he feels like dying, and after he feels like living. The caregiver explains that that can happen, it's normal.
	Once, Daniel tried to kill himself. But right after that, he said that he didn't want to die. He didn't know why he tried to kill himself. The caregiver explains that that can happen. Sometimes people do something without thinking because they feel bad. After, when they feel better, they no longer agree with what they did.

6 	The caregiver reminds Daniel that there are days when one feels like living and all is well.
7 	There can be days when things aren't going well. We don't think about those we love, nor about what makes us happy. On those days, sometimes, certain people like Daniel can feel like they want to die.
8 	Daniel feels a storm of emotions which confuses everything and changes the way he sees the situation. He feels really mixed up.

9 	It's OK to feel mixed up when one feels like dying. It's OK to feel mixed up when one feels like living and dying at the same time.
10 	When he feels like this, Daniel can think of his reasons for living. The caregiver helps Daniel remember his reasons for living. This helps Daniel to feel better.
11 	Daniel knows that it's possible to feel like living and feel like dying at the same time. The desire to die can come back, but Daniel combats it with his desire to live.

B. Story: Raphael finds hope again and some solutions

In the context of Autism or ID, a solutions-focused intervention is used to tackle a problematic situation that the person is going through at the present time. It is also used to diffuse the crisis, to reinforce hope and reinforce the person's empowerment in relation to this situation. It can lead the person towards solutions that they can envision to get out of the impasse and improve the situation. This intervention cannot of course guarantee the resolution of all problems. The objectives must be realistic given the situation and abilities of the person in the context of the current crisis.

Boxes 1 to 3 present the situation (risk factors, triggers, hopelessness, emotions and suicidal ideations). The intervention aims to help the person describe the situation and verbalize his ideations in his own terms. In the context of a discussion between the caregiver and the person, the caregiver could say: "Raphael says: "I want to kill myself!" And just now, you said "xxxx". What other words do you use to talk about your thoughts of suicide? Did you want to say the same thing as Raphael?" Another example that can be used by the caregiver is the following: "Raphael is unhappy and frustrated. And how do you feel when you feel like killing yourself? Just now, when you said it, how did you feel?" The caregiver can also suggest that the person draw their own emotions next to those of Raphael, the character.

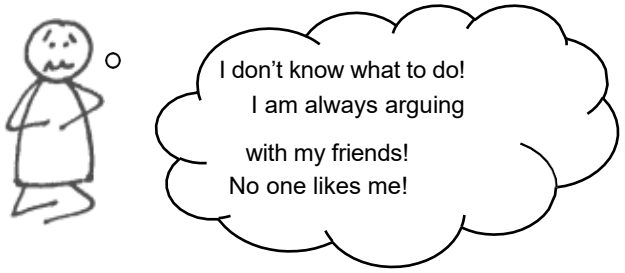
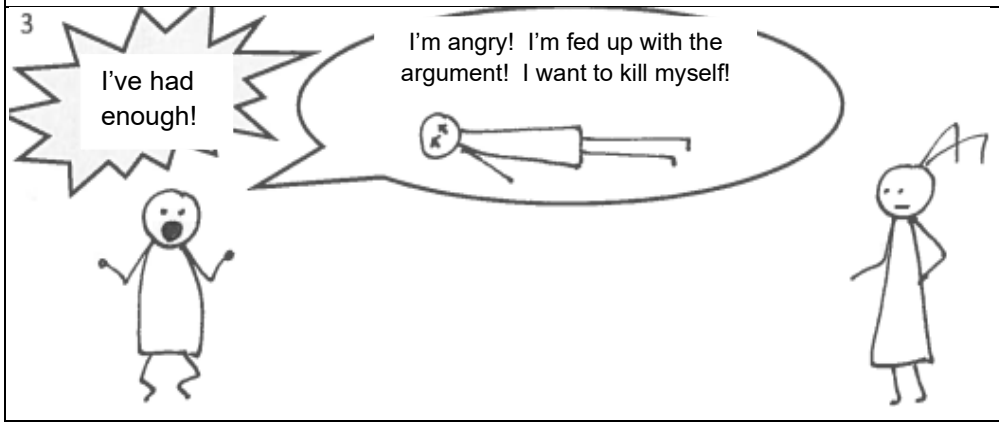
Boxes 4 to 6 explore the current problematical situation. The objective is to identify and name the triggers of the suicidal episode with the person and validate the experienced emotions. For example, the caregiver could say: "Raphael isn't doing well because he got into an argument. Is it the same for you? What happens when you don't feel good?"

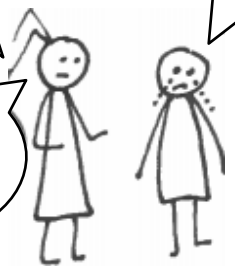
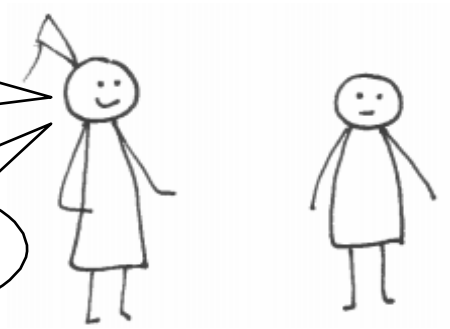
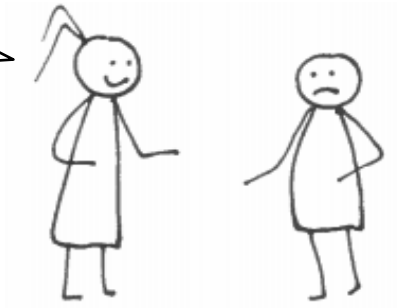
Boxes 7 to 10 bring out the reasons for living for Raphael, allowing him to find hope and reduce his distress. This exercise also reminds Raphael how he feels when things are going better, helping him to project himself into a future situation where he could indeed feel better.

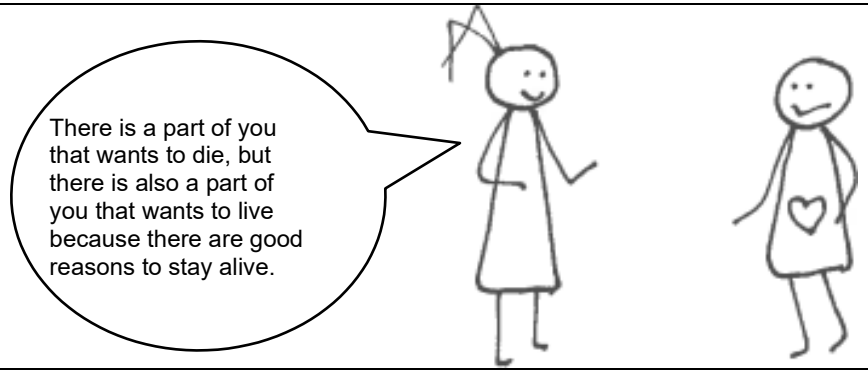
Boxes 11 to 14 illustrate the search for solutions to improve the situation. Imagined solutions must be based on the person's strengths and abilities, which we should remind them of. The caregiver can also give suggestions and accompany the person in the application of identified solutions.

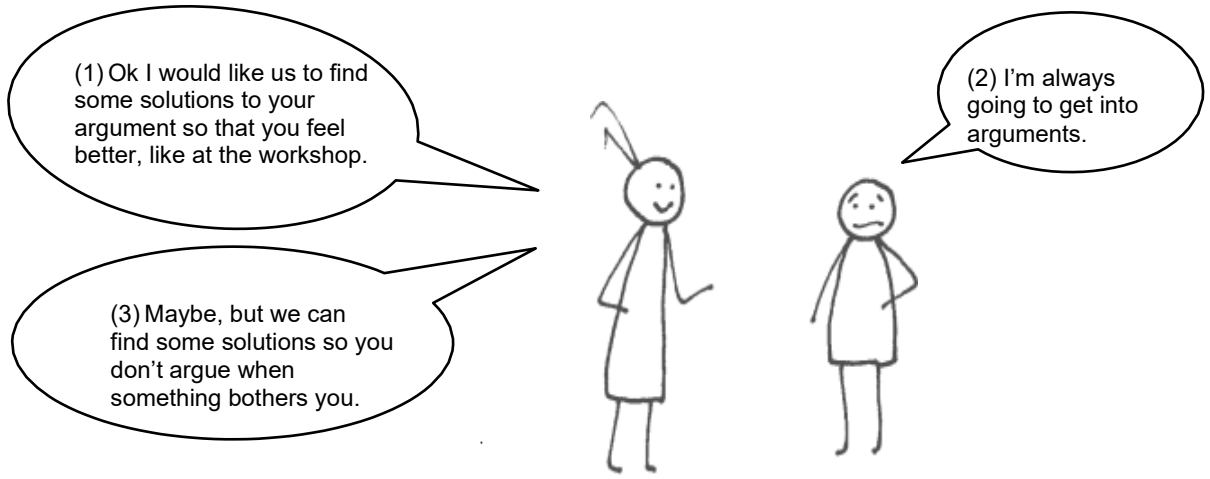
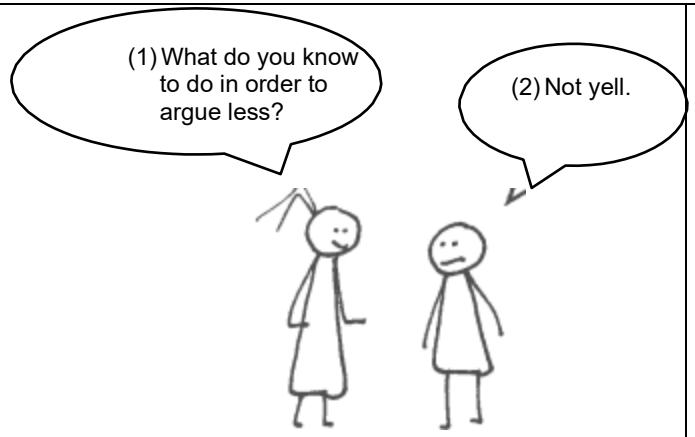
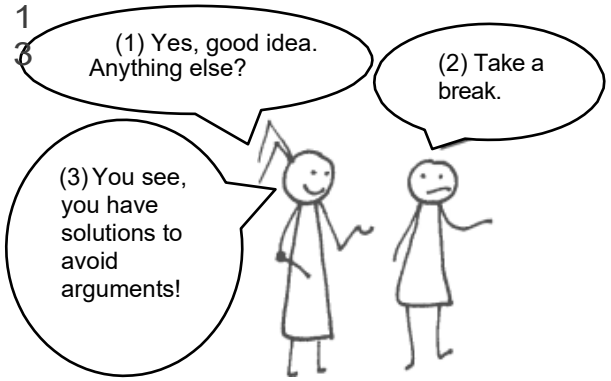
Boxes 15 to 17 demonstrate the importance of returning to emotions and recognizing observed improvements, when positive change occurs. They show the importance of encouraging the person to use developed strategies. The re-assessment of risk is also addressed.

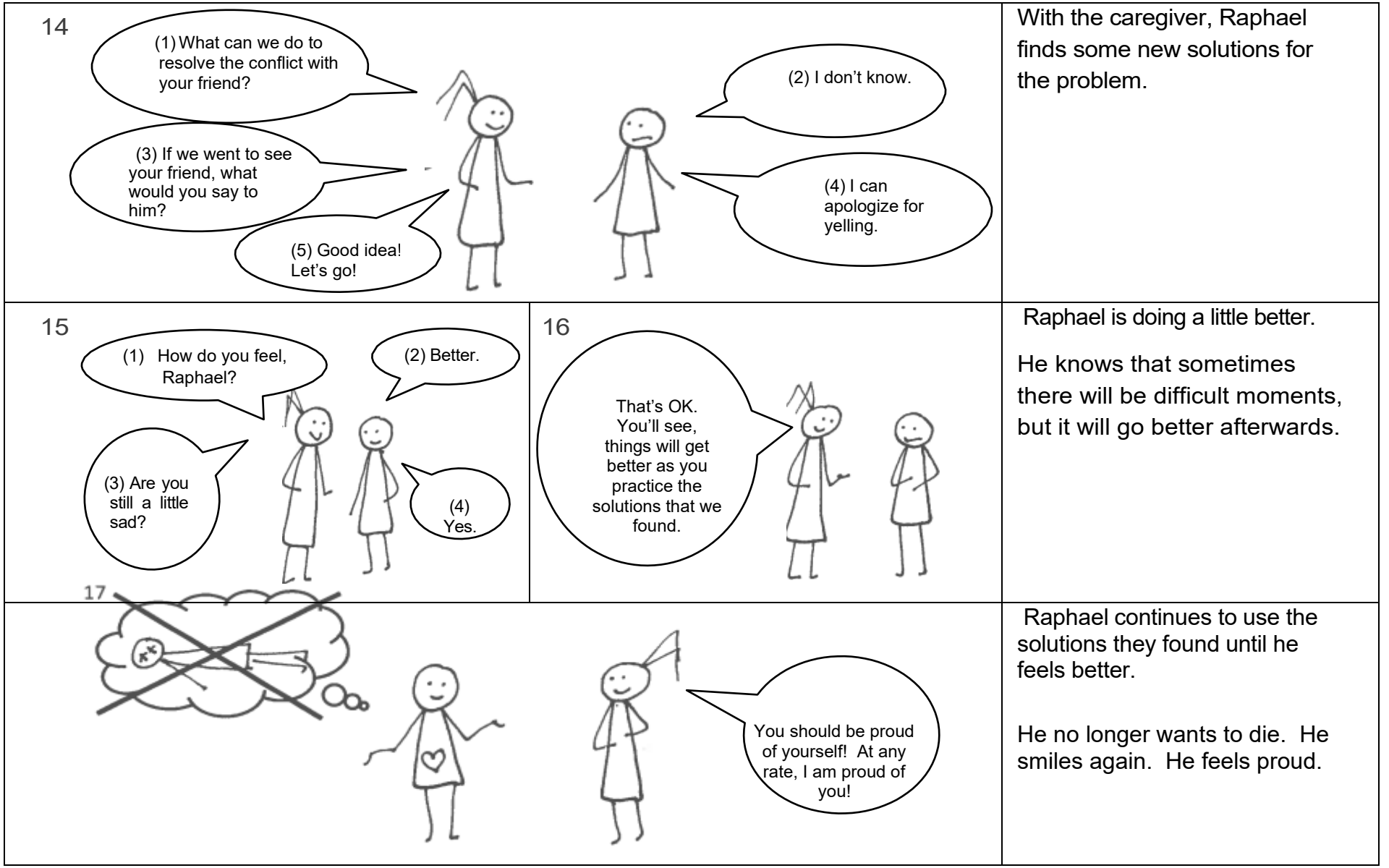
Raphael rediscovers hope and finds solution

1 	Raphael is frustrated. Too many things aren't going well for him right now.
2 	Raphael is unhappy. He doesn't know what to do to feel better. He thinks it will always be like this.
3 	Raphael talks with the caregiver. He tells her that he is upset, unhappy and that he wants to kill himself.

4 (1) What is causing you to suffer, Raphael? (2) No one likes me! I argue all the time! 	The caregiver is happy that Raphael is talking to her. She asks him questions to understand what is wrong.
5 (1) Did you argue today? (2) Yes. With my friend! (3) I understand why you're hurting! 	
6 (1) You've had enough arguing today and you want it to stop. (2) Yes. (3) OK, we are going to try to find a solution. 	The caregiver wants to help Raphael feel better. They find what is making Raphael unhappy today, what is making him think of dying. It's important to feel better.
7 (1) What's going well for you today, Raphael? (2) I don't know. (3) Do you like going to the workshop? (4) Yes. 	There are things that are going well in Raphael's life too. So, life is worth living. The caregiver asks Raphael questions to understand what is going well.

8 	It's important to also focus on the things that are going well right now. They help to feel better and to live.
9 	Also, when we think about what is going well in general, that makes us want to find solutions to bring a smile back to our hearts.
10 	Raphael and the caregiver remember reasons that give Raphael a desire to live. Raphael rediscovers the desire to live. He finds hope again.

11  	We must also find some solutions for Raphael so that he no longer wants to die. Certain problems are there for a long time, but we can find some solutions to be unhappy less often. There is always something to do to feel better.
12  13  	Raphael already knows good solutions, but he wasn't thinking about them. With the caregiver, they talk about what Raphael knows in order to avoid arguments. They remember Raphael's strengths.


14
(1) What can we do to resolve the conflict with your friend?
(2) I don't know.
(3) If we went to see your friend, what would you say to him?
(4) I can apologize for yelling.
(5) Good idea! Let's go!
With the caregiver, Raphael finds some new solutions for the problem.
15
(1) How do you feel, Raphael?
(2) Better.
(3) Are you still a little sad?
(4) Yes.
16
That's OK. You'll see, things will get better as you practice the solutions that we found.
Raphael is doing a little better.
He knows that sometimes there will be difficult moments, but it will go better afterwards.
17
You should be proud of yourself! At any rate, I am proud of you!
Raphael continues to use the solutions they found until he feels better.
He no longer wants to die. He smiles again. He feels proud.

C. Story: Dominique has suicidal thoughts without knowing why

This story aims at developing a strategy of intervention with the person when a trigger event is not present or identifiable. Sometimes, suicidal ideations come from a diffuse feeling of malaise that is difficult to clearly name. In this case, the solution-focused approach does not aim to find ways of managing a problem or an event, but more to identify the diffuse feeling of malaise and to reduce it by improving the person's general mood.

This intervention cannot of course guarantee the resolution of all problems. The goals must be realistic in relation to the situation and to the person's abilities in the context of the current crisis.

Boxes 1 to 3 expose the situation within which Dominique is thinking of suicide, without a clear reason. The intervention aims to discuss the situation with the person, who is in a similar situation.

In box 4, the caregiver explores different possible triggers in Dominique's life all the same. In the intervention, it is important to explore with the person what might have triggered ideations in the present or recent situation. Be careful however to not give examples that are too precise about potential triggers. Indeed this can worry the person or suggest to him that he should have suicidal ideations when he experiences certain events. When referring to box 4, the caregiver could say: “And you, did something happen that gives you pain, which bothers you or which makes you mad, today?”

Box 5 is an example of validating the lived experience of the person.

In boxes 6 to 8, the caregiver explores Dominique's emotions in order to identify the emotional states accompanying her suicidal ideations. This exploration can help to pinpoint, with the person, moments where he is not doing so well and when ideations crop up. Even if the malaise is diffuse, without a clear trigger, it is important to use words which represent the ideas and the emotions of the person when they have suicidal ideations. The caregiver could say: “How do you feel when you have ideas about killing yourself? Do you feel discouraged like Dominique? Different?” Box 8 also includes a validation of the person.

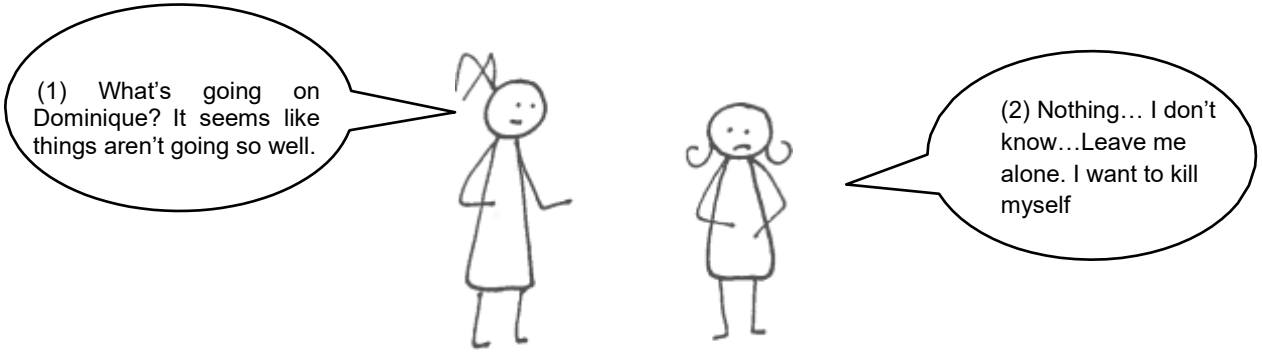
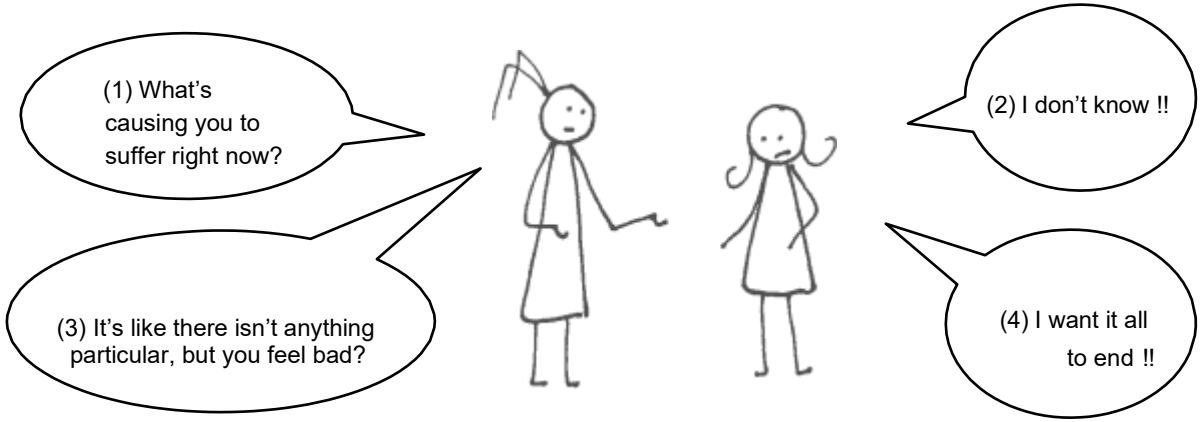
In boxes 9 to 12, the caregiver explores things that are going well in Dominique's life and her reasons for living. The objective is to remind the person that even if we feel bad it can be helpful to think about what's going well. Be careful not to minimize the distress or try to replace emotions of sadness and discouragement by others that are artificially positive. It's important to not deny the lived experience of the person nor to invalidate it. The intervention aims at showing that in the person's life, there also exist positive things which he can count on when he feels down.

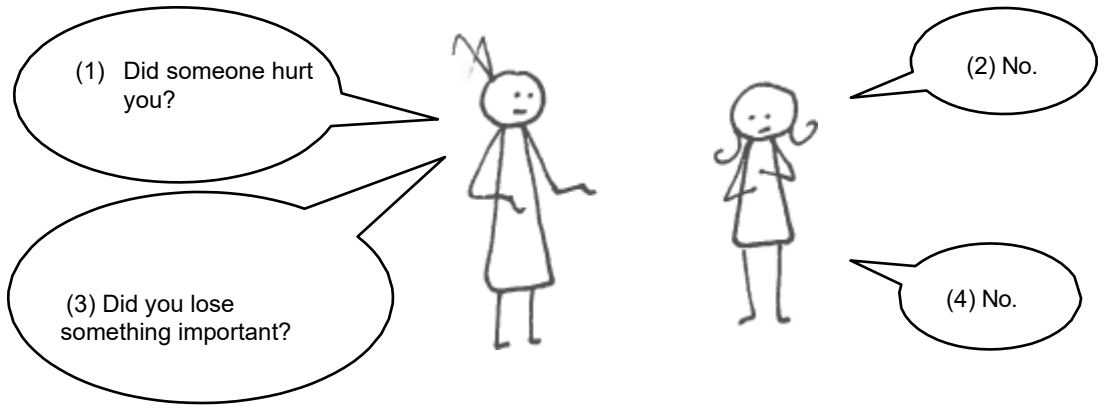
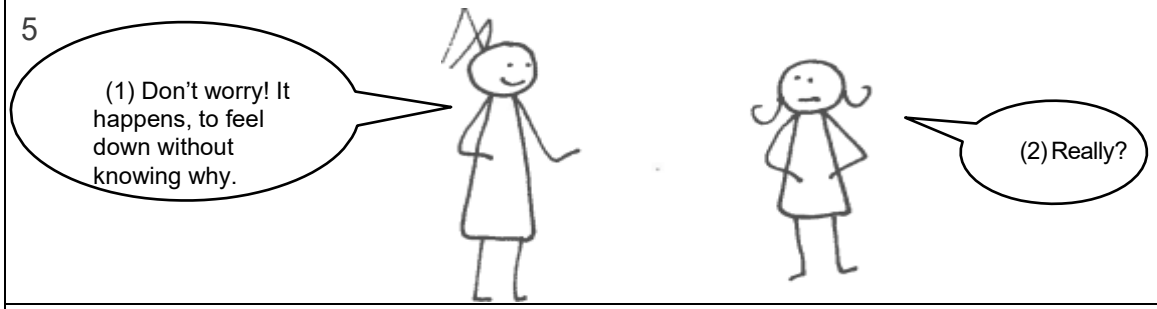
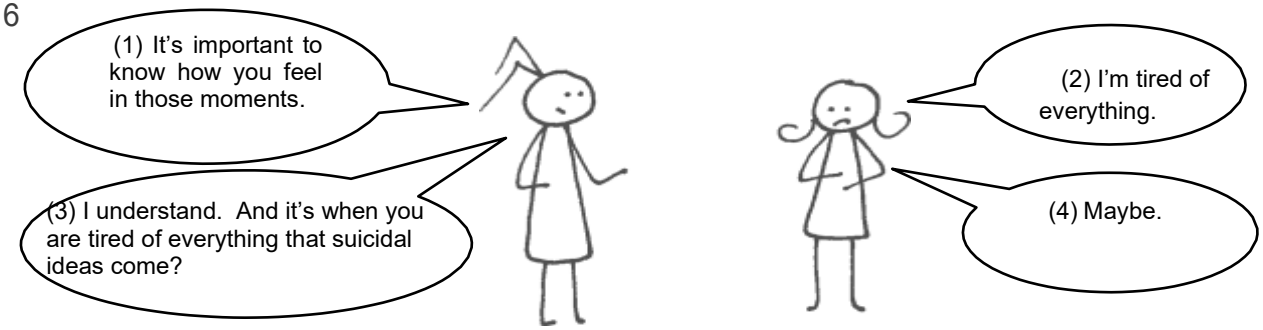
In boxes 13 to 15, the caregiver proposes to Dominique to do the Garden of Hope exercise described in following sections. Together they put in place a strategy adapted to Dominique in order to: on the one hand, identify the moments when she feels down and when she has

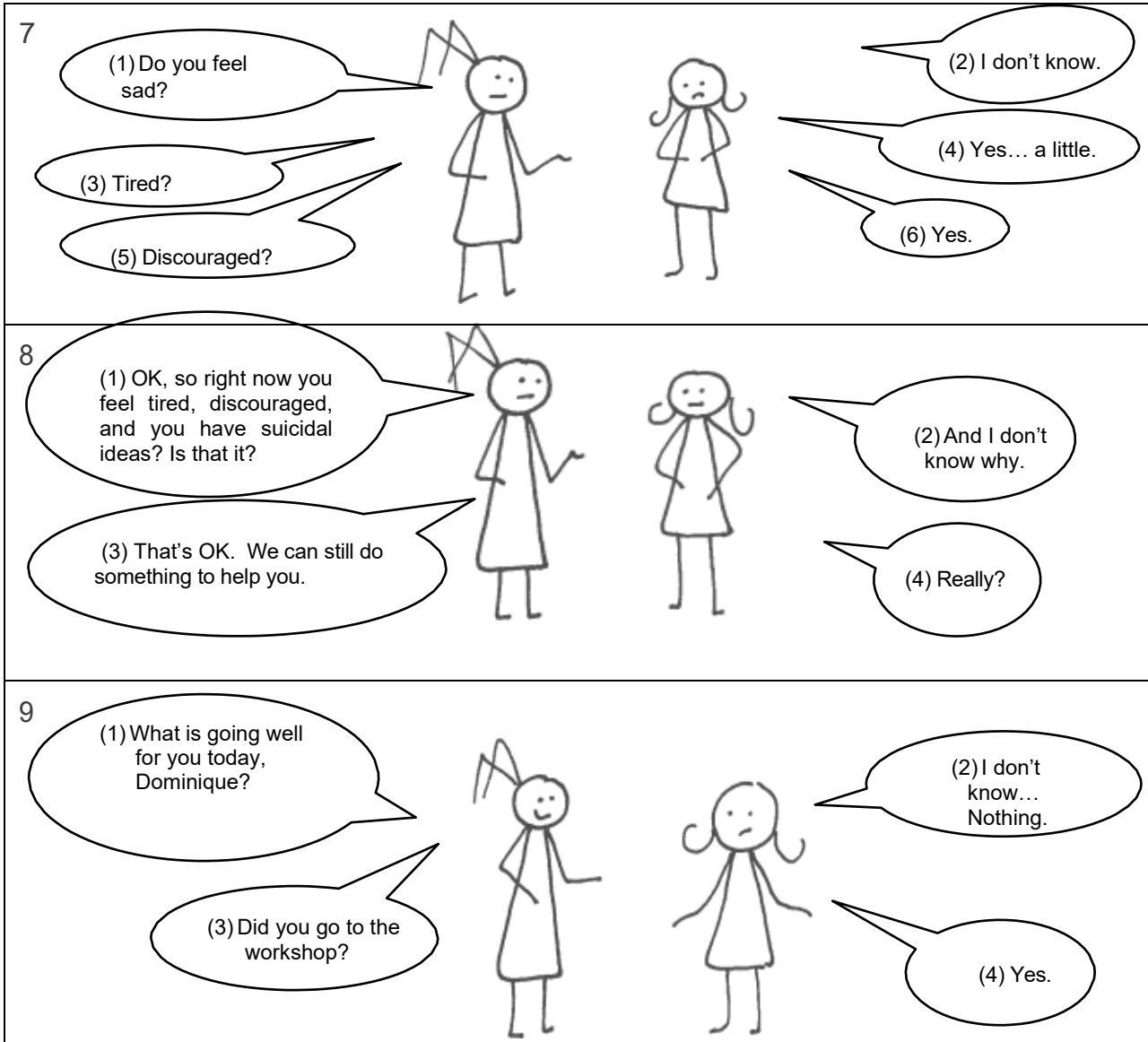
suicidal ideations without a clear reason; and on the other hand, to intervene in order to help her to positively modify his mood. In the context of intervention, it's possible to work with the person using such a strategy, keeping in mind his abilities for self-observation and communication.

In Box 16, the history closes with a validation of the person.

Dominique has thoughts of suicide without really knowing why

1 	Dominique feels bad. She has ideas of suicide.
2 	Dominique doesn't know why she feels this way. When the caregiver asks her what's going on, she doesn't know what to say.
3 	Dominique just thinks that she wants to kill herself so that all this is over…

4 	The caregiver asks Dominique questions to see if there is something in particular that is making Dominique feel down and making her want to kill herself today. They can't think of anything!
5 	The caregiver explains to Dominique that it's OK to not know why you feel down sometimes. It can happen to anyone.
6 	The caregiver also explains that it's important to talk about it to learn how to recognize the moments when you feel bad without knowing why.

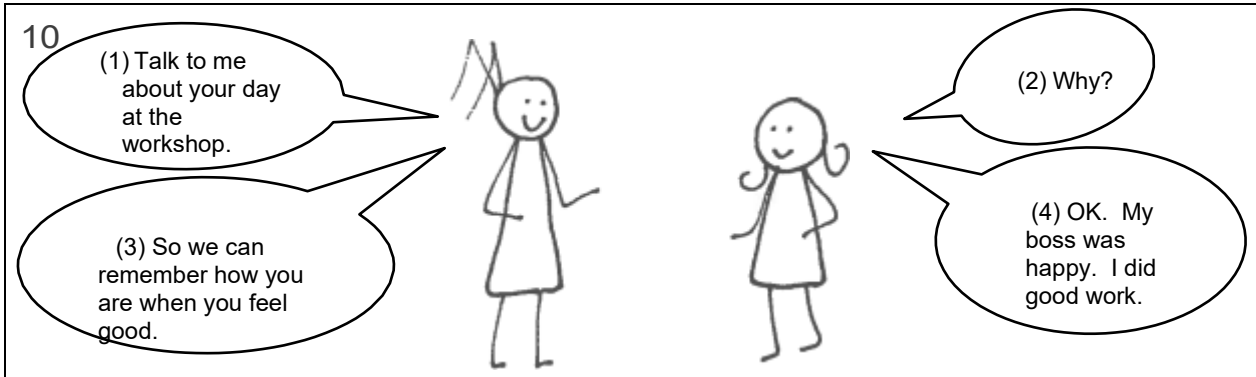


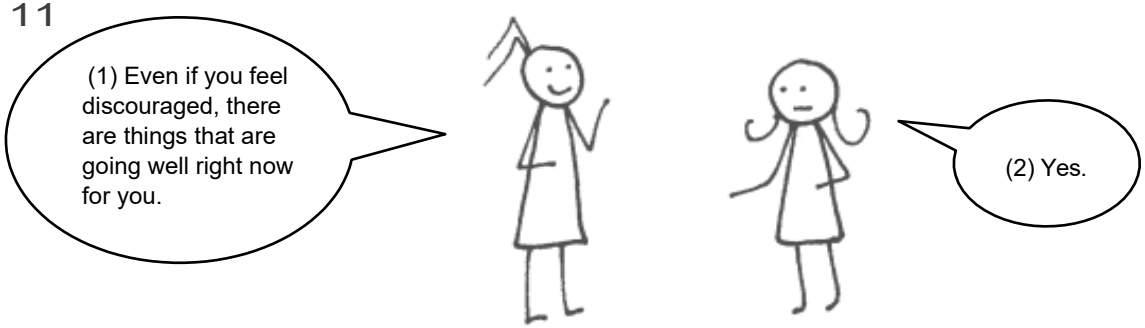
In this way, in cases like this, Dominique can still do something to feel better.

There are things that are going well in Dominique's life, too.

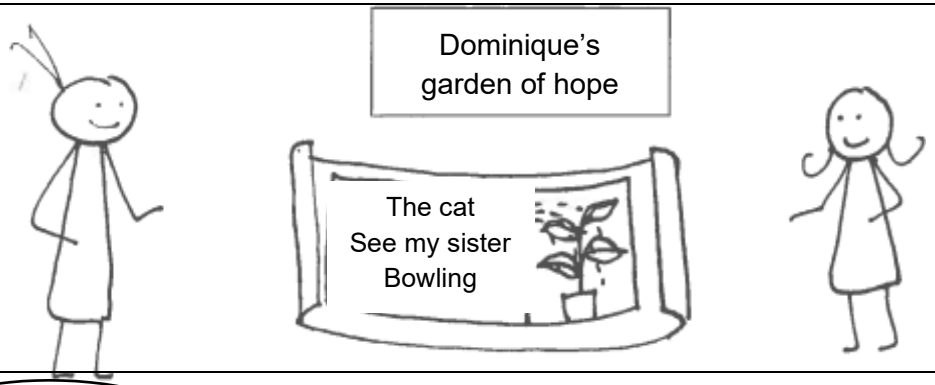
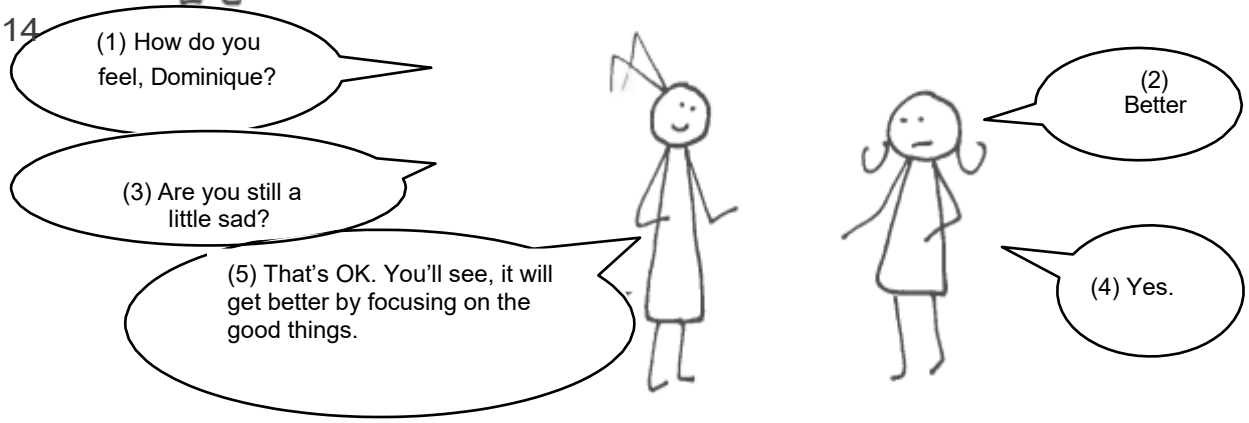
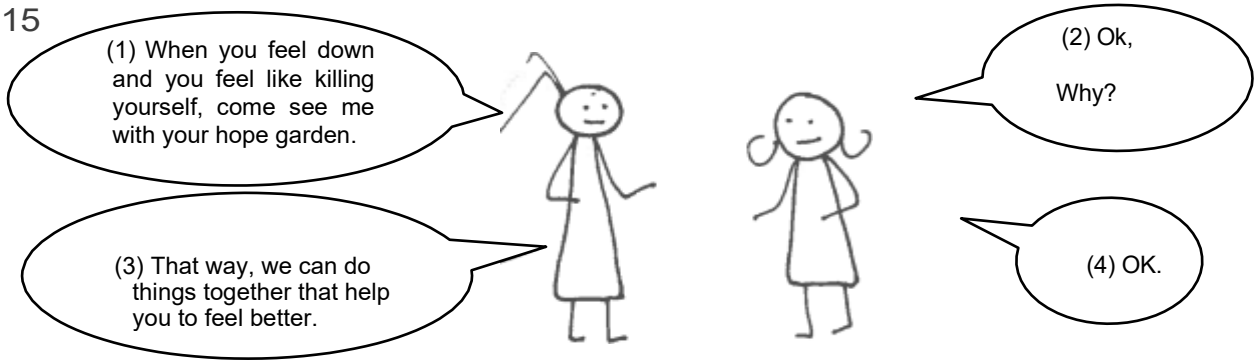
So, life is worth it.

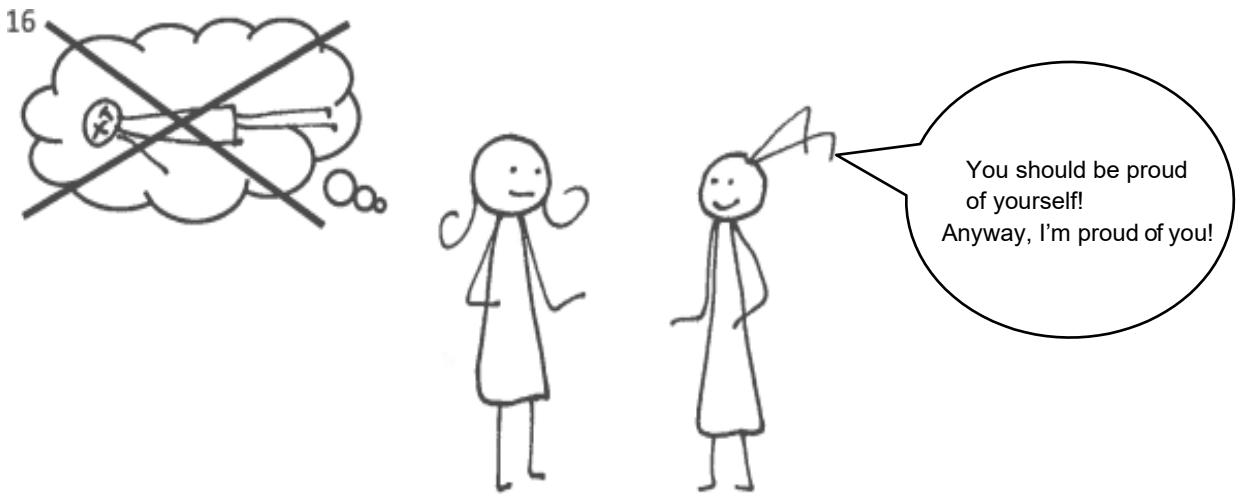
The caregiver asks Dominique questions to understand what is going well.

<table>
<tr>
<td>10
 
</td>
<td rowspan="2">It’s important to also focus on things that are going well right now.

They help to better live through moments when you feel down without knowing why.</td>
</tr>
<tr>
<td>11
 
</td>
</tr>
<tr>
<td>12
  </td>
<td>Dominique and the caregiver remember reasons that give Dominique the desire to live.

Dominique finds the desire to live again. She feels less sad and discouraged.</td>
</tr>
</table>

13 	Dominique and the caregiver make a garden of hope for Dominique. It contains everything Dominique likes and that makes her feel good.
14 	Dominique feels a little better. She knows that there will sometimes be difficult moments when she will feel down, but that she will feel better afterwards.
15 	Dominque and the caregiver make a strategy to help Dominique when she has suicidal ideas and she doesn't know why.

	Dominique is able to see how she feels thanks to the tools she learned to use with the caregiver. She practices thinking about what is going well and about her reasons for living when she feels down. And then, her smile returns. She feels proud.

D. Calendar of hope and timeline

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

D.1. The calendar of Hope

Objective

In a situation where the person has difficulties situating himself in time and is living a difficult event (even if the situation occurs multiple times), the calendar of hope can help him project himself into the future that can be more acceptable. The calendar also helps to identify possible actions the person can implement to take back control of the situation and feel better faster. This exercise is particularly adapted to people who already use a calendar to manage their daily life and those who are good at identifying their own emotions.

Justification/Explanation

The intervention focused on building hope is based on the key presence of hopelessness in the suicidal dynamic. This hopelessness has been modeled in triads such as those described below.

Suffering is perceived as:

- Interminable, inacceptable, unbearable (Shneidman)
- Interminable, unavoidable, intolerable (Chiles & Strohsahl)
- Negative perception of the suicidal person:
    - of himself
    - of his close circle
    - of his future (Beck)

In the context of hopelessness, it is important also to remember that:

- Ambivalence is always present.
- The person has reasons for living: explore reasons for living more than reasons to die.

Intervening to create a breach in these triads is an essential strategy of suicide prevention. This intervention is also based on feelings of powerlessness and not having control over oneself and one's life. The hopelessness component is a fundamental element in the suicide model for autistic people or those with an ID. Working to bring back hope, and therefore identifying things which are going well for the person and that the person can do in the near future, helps him to take back control of her situation. Understanding better what he is living through contributes to giving the person control over the suicidal process and over the actions needed for change.

Finally this intervention helps to reduce hopelessness. The calendar can help the person to visualize the resolution of his suicidal episode and the associated emotions. This can help him to project his thoughts into the future, to a moment when he will feel better, in order to identify the steps needed to get there.

Intervention process

The first step consists in validating the reality and the legitimacy of emotions felt by the person through time. Many emotions can be identified in connection with the situation as it unfolds. For example, after feeling sad, the person can be tired or feel the need to be alone. It is important to have the person understand that fatigue or the need to be alone can be present for a certain time before feeling inclined to meet other people again. It's a matter of validating that the sequence of emotions is normal and legitimate (see Table 9).

Second, the care worker works with the person to identify the moment corresponding to a return to calmness and serenity, in the sequence of emotions. For example, the care worker could say to the person: "Tomorrow you'll feel calm, after the night." It is a matter of reinforcing the fact that the person will feel well compared with how he's feeling now, while making him understand that the process takes some time. This time is illustrated in the calendar, in column 2 of Table 9.

The third stage is to identify what we can do between the present moment and the moment where the person will feel better, in order to accelerate the process and reinforce the person's feeling of control over the situation.

The expected outcomes are the following: 1) help the person to understand and reframe his lived experience; 2) anticipate and act in view of an amelioration of his current condition; and 3) for the person to regain control over what is happening.

An adaptation of the Calendar of Hope can be made where the person experiences periods of fragility throughout the year (for example during holidays or when school starts) or when a foreseeable event represents a potential trigger (for example a planned meeting with a parent who rarely visits). In such cases, when preparing the monthly or weekly calendar, it can be useful to highlight positive elements that will help the person live through the difficult period more easily.

The calendar of hope

Tableau 9 - calendar of hope

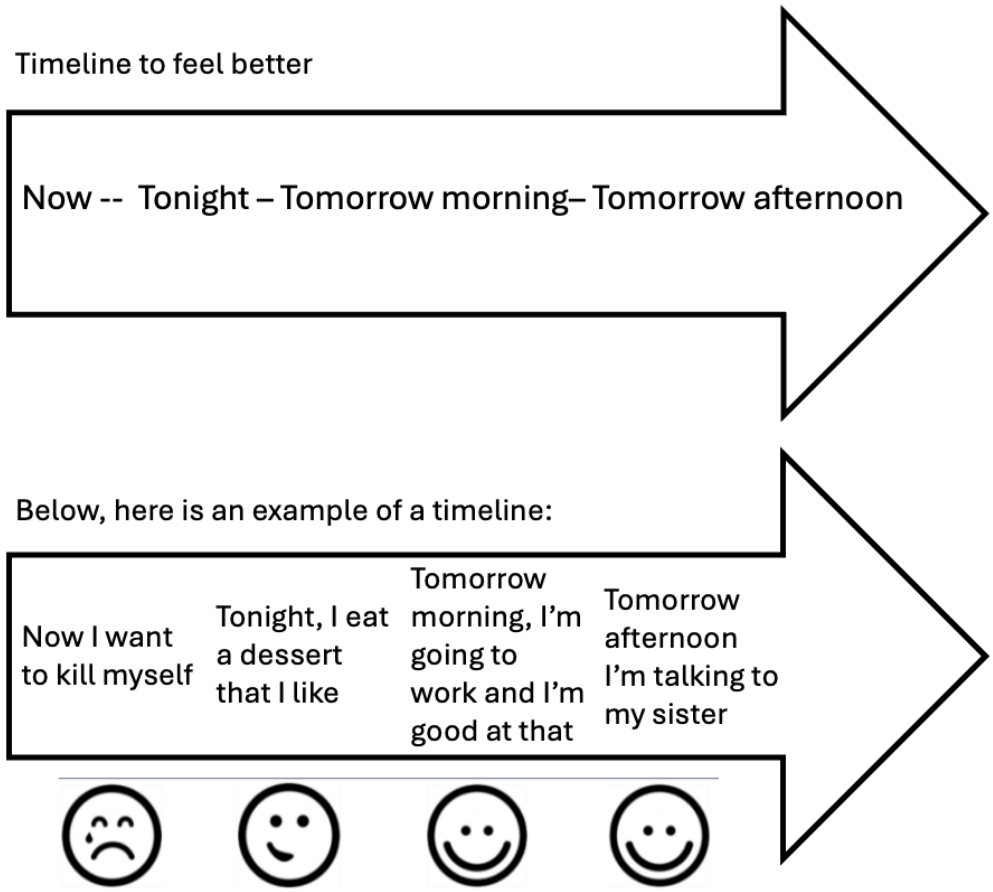
Time scale similar to that usually used by the person	What happens	How one feels – by using signs typically used by the person	What we're going to do to feel better
Questions and themes to touch on to construct the calendar:	▪ I have the impression that what makes you (perceptible emotion) is … ▪ And you, what do you think?	▪ How do you feel? Do you feel sad or angry? ▪ It's OK and normal to feel like… ▪ After a little time, emotions like … pass and after we can feel… ▪ How do you think that you'll feel in… (length of time adapted to the situation and the person)? ▪ After a little while we feel better. ▪ What's it like for you to feel better? ▪ How are you going to feel when you feel better?	▪ What are we going to do so that you feel better faster? ▪ What are the things that we already know how to do which make us feel better and that we can do again?
Now			
In a few minutes			
In an hour			
Tomorrow			

D.2 Timeline of Hope

The timeline is a simpler option than the calendar and better adapted to people having a lower understanding of their emotions. It fulfills the same objectives and is based on the same principles.

Objective
The timeline is composed of actions. It facilitates the planning of events and actions that will help the person to feel better. By visually tracking these events and actions on a timeline, the person can more easily find hope and notice a positive change in his life and his mood.

Intervention process
The method is similar to the calendar, except that the focus is put on activities that are going to take place, the actions to take in order to feel better, social contacts planned or to plan, or even, on positive or validating activities that the person will do in the hours or days that follow. Before constructing the timeline of hope, it's important to recognize, validate and relieve the current stress.



D3. The Garden of hope: concentrating on what is going well

Objective
The objective of this intervention is to bring out the positive elements of the person's life, despite his difficulties and the things that are not going right. This exercise promotes hope and the anticipation of positive things, but without minimizing difficulties.

Justification/explanation
Hopelessness is a key component in the development of MAS. On the other hand, hope is an important element upon which we can build a suicide prevention intervention. Reinforcing hope can be done as much in the short term as in the long term and is based on strengths and projection in the future.

Intervention process
Make a list of things that are going well with the person. Elements written down on this list must be attainable and reproducible by the person in the near future. For example, if we identify good relations with a member of the family, we must include the prospect of another meeting that will reinforce this positive feeling.

The first step of intervention consists in writing or drawing the things that are going well in the left-hand box (see figure 9). We can also glue photographs of loved people, animals or objects. All these things constitute the garden. In the second step, the Garden of Hope metaphor materializes: we *cultivate* and we *water* good things. Each time that an item on the list comes to pass, we note it in the right-hand box in order to illustrate the growth of the garden of hope. For example, we can glue stickers on the plant, color one of the plant’s leaves, glue on tactile things or use any other method that allows the person to understand that he has helped his garden to grow.

If the box on the right fills up completely, we begin another but keep the first one and continue to *cultivate* the garden of things that are going well. When the person feels down, or when he expresses suffering or hopelessness, we consult the garden and we talk about what is also going well. The idea is not to deny what's going badly, nor to move too quickly over to the garden. It is important to validate the distress or the frustration before being able to talk about what's also going well.
Expected outcomes are: 1) negative perceptions are reframed; 2) the person visualizes the positive to counterbalance the perception of the negative; 3) his mood is improved; 4) a baseline is established to develop other things that might go well.

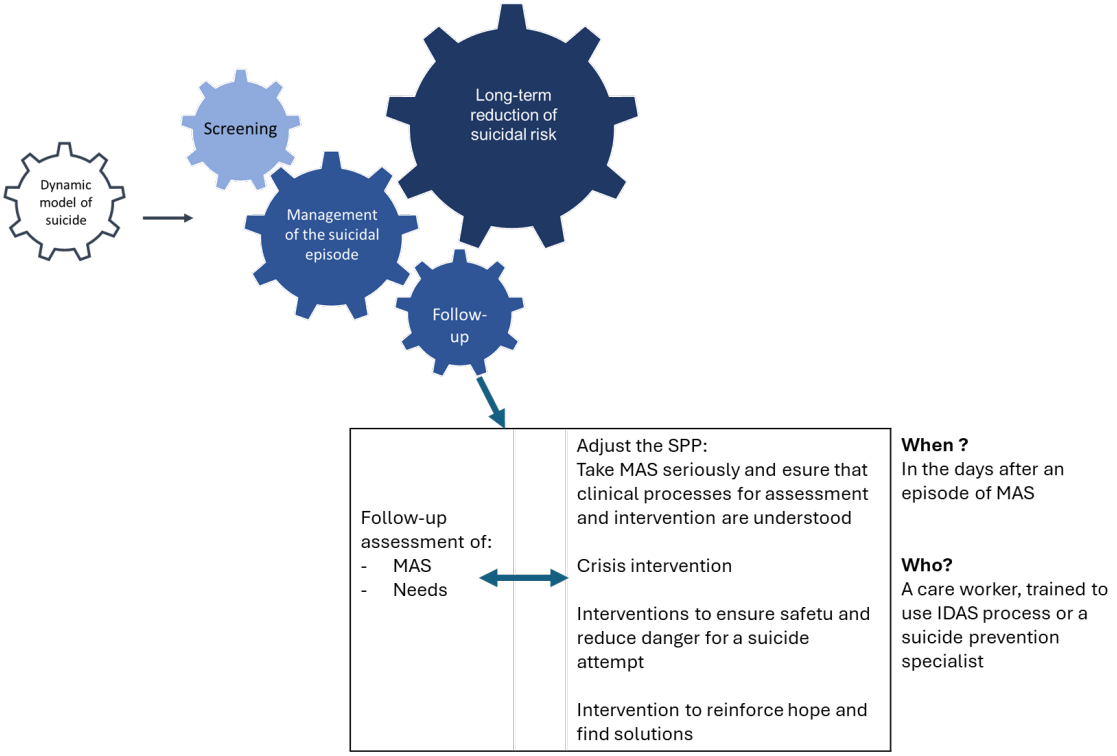
Figure 9 - Garden of hope

The Garden of Hope for : ____, made the ____

The list of things that are pleasant, that are going well, that you want to do again, that make you proud	Watering
	

Section 4 – Making a post suicidal episode follow-up – SPP-Follow-up

This step is often neglected and too often, people with autism or those presenting an ID prefer not to talk about a MAS episode once it is over. For their part, care workers and caregivers often feel reticent about bringing up the question again, for fear that it provokes a recurrence of suicidal ideations.



However, timely follow-ups are necessary to re-assess the situation, progress and needs. There are several reasons for this:

- An episode of MAS can last longer than it seems on the surface after the initial expression of suicidal ideations.
- There is a natural fluctuation in suicidality and danger. It is important to verify that the MAS episode has dissipated completely and that it is not actually a passing fluctuation.
- A follow-up allows us to enrich our understanding of the episode's consequences and its unfurling over time.
- It allows for adjusting the action plan according to the person's evolution and for verifying the usefulness of the intervention plan
- Doing a follow-up is part of the process of "taking seriously" the MAS, showing the person that we are keeping track of what happened and that it's important.

The follow-up is based on results from the initial assessment. It can be done within informal discussions or formal interventions with the person, according to the situations and needs.

This follow-up is important after an observable suicidal episode. The fact that the MAS seem to have disappeared is not a reliable indicator that the person is not thinking of suicide any longer (see figure 10). In addition, as in other situations of distress and disorganization, ideations can fluctuate through time, in relation to one's capacities to resolve problems or to use resources.

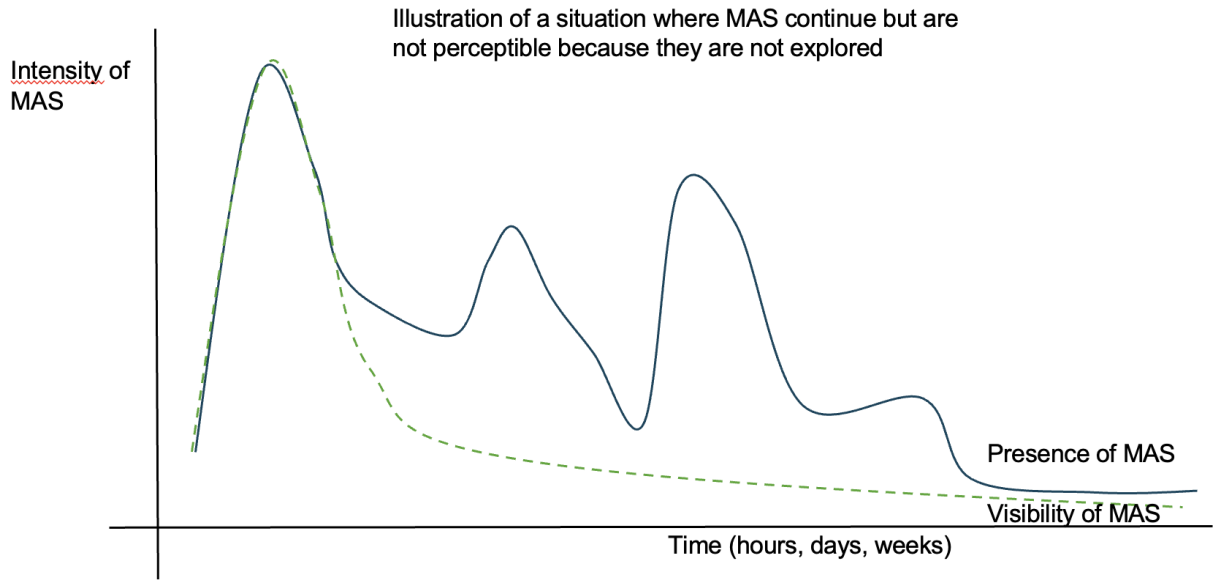
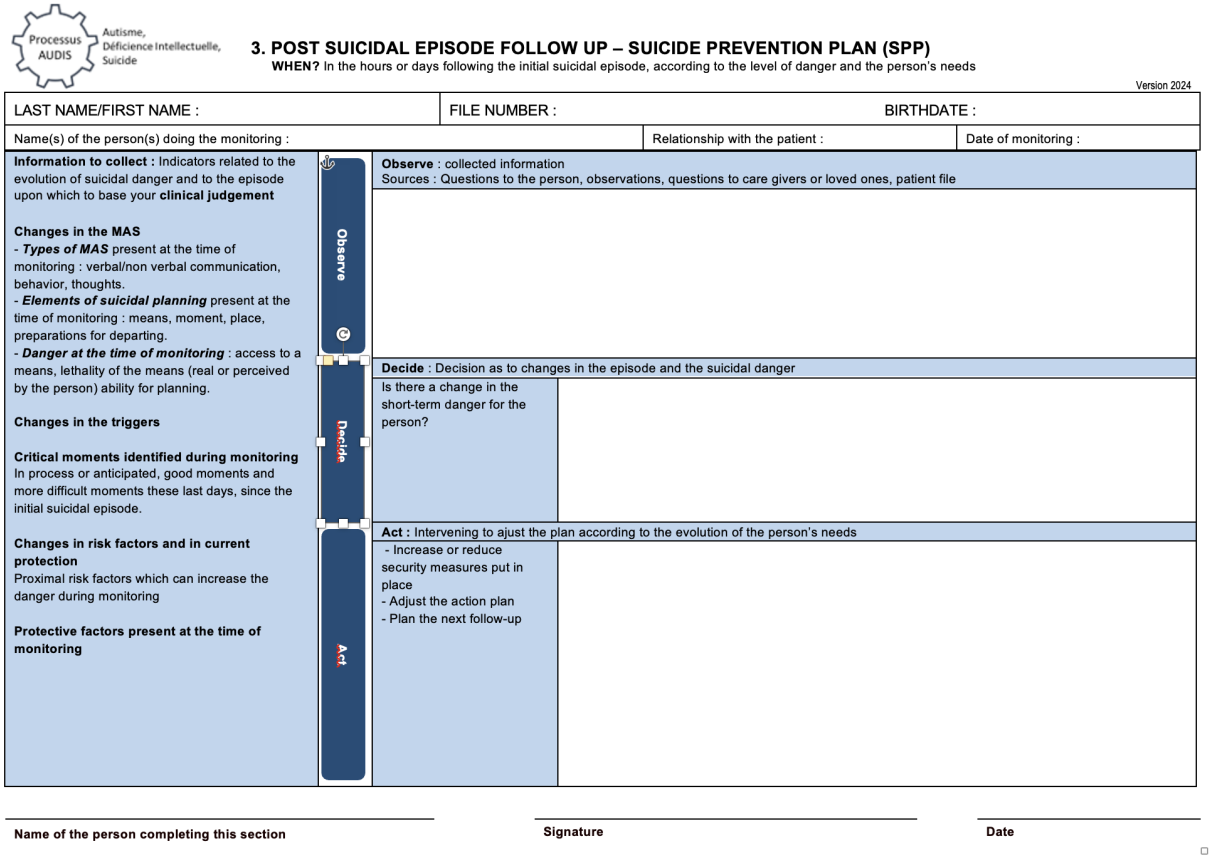


Figure 10 - Evolution of MAS over time

General structure of the follow-up process

The follow-up process is based on the structure presented in figure 11.



Processus AUDIS — Autisme, Déficience Intellectuelle, Suicide

3. POST SUICIDAL EPISODE FOLLOW UP – SUICIDE PREVENTION PLAN (SPP)

WHEN? In the hours or days following the initial suicidal episode, according to the level of danger and the person's needs

Version 2024

LAST NAME/FIRST NAME :	FILE NUMBER :	BIRTHDATE :
Name(s) of the person(s) doing the monitoring :	Relationship with the patient :	Date of monitoring :

Information to collect : Indicators related to the evolution of suicidal danger and to the episode upon which to base your **clinical judgement**

Changes in the MAS
- ***Types of MAS*** present at the time of monitoring : verbal/non verbal communication, behavior, thoughts.
- ***Elements of suicidal planning*** present at the time of monitoring : means, moment, place, preparations for departing.
- ***Danger at the time of monitoring*** : access to a means, lethality of the means (real or perceived by the person) ability for planning.

Changes in the triggers

Critical moments identified during monitoring
In process or anticipated, good moments and more difficult moments these last days, since the initial suicidal episode.

Changes in risk factors and in current protection
Proximal risk factors which can increase the danger during monitoring

Protective factors present at the time of monitoring

Observe

Observe : collected information
Sources : Questions to the person, observations, questions to care givers or loved ones, patient file

Decide

Decide : Decision as to changes in the episode and the suicidal danger

Is there a change in the short-term danger for the person?

Act

Act : Intervening to ajust the plan according to the evolution of the person's needs

- Increase or reduce security measures put in place
- Adjust the action plan
- Plan the next follow-up

Name of the person completing this section | **Signature** | **Date**

Figure 11 - SPP - Follow-up

Follow-up objectives in the context of managing the suicidal episode

The objectives of post-suicidal episode follow-up are:

- Check that the MAS episode has resolved and that it is not a temporary fluctuation (fluctuation natural to suicidality and danger)
- Enrich the understanding of consequences of the MAS episode and its course over time
- Adjust the action plan according to the person's progress
- Check the effectiveness of interventions carried out in the management of the suicidal episode
- Show the person that we take his experience into account and that it is important (part of the process of "taking MAS seriously")

Observe: Sources of information and follow-up indicators

A few days after the MAS episode, a follow-up is useful to re-assess the situation to verify:

- Changes in the MAS: **Types of MAS present during follow-up** (verbal/nonverbal communications, behaviors, thoughts), elements of suicidal planning present at the time of follow-up (means, place, preparations), danger at the time of follow-up, access to the means, lethality of the means (real or perceived by the person), ability to plan
- Changes in the triggers: **Critical moments identified during follow-up**, in progress or anticipated, good moments and more difficult moments in the last few days and since the initial episode of MAS
- Changes in current risk and protective factors, proximal risk factors that can increase the danger during follow-up. **Protection factors present during follow-up.**

Decide: Decisions resulting from analysis

The central questions for follow-up are the following:

- Are there changes in the short-term danger for a person? yes/no
- Is an adaptation of SPP-E necessary? yes/no

Act: Intervention to put in place to adapt the suicide episode management plan

If an adaptation of the SPP-E is necessary, it must be based on changes observed while gathering follow-up data. The adaptations aim to increase or reduce follow-up, adjust interventions and the intensity of measures put in place. When necessary, subsequent follow-ups are also planned.

Close monitoring after a suicidal episode

Objectives

The principal objective of this intervention is to verify the persistence or the reduction of MAS after an initial suicidal episode. It can be part of the follow-up.

Justifications/Explanations

A person with suicidal behaviors can present an elevated level of danger for a suicide attempt. Closely monitoring the person allows us to verify the evolution of MAS over a few hours/days in order to adjust the intensity of protective measures. We only do this close monitoring with those who present an elevated level of danger and who have security measures in place.

Intervention process

The caregiver can use the Close monitoring sheet (table 12) to follow the evolution of MAS and assess current danger at different points in time for a few hours, days or weeks following the initial MAS episode. This sheet is used to determine the persistence or the reduction of MAS after the SPP-E has been implemented.

The danger can vary rapidly with time; the level and intensity of the intervention to ensure safety must be adjusted to the level of danger. These regular assessments stop when the multidisciplinary team concludes that the person no longer presents an elevated danger of attempting suicide. Family members or caregivers can be trained to notice certain specific signs from the person in order to monitor variations in danger during the close follow-up after an episode of MAS with elevated danger.

Close Follow-Up Table

Monitoring on:_____ During the period: _____

Rhythm of observations: _____

Elements for estimating the danger of a suicide act during monitoring	Period 1	Period 2	…
Types of MAS present and change			
Elements relating to suicidal planning and changes: means, moment and place			
Danger : access to a means, lethality of the means, capacity for planning			
Proximal risk factors that can increase the danger			
Temperament (type) Ex.: sad, agitated, anxious, happy, holds back…			
Stability of temperament Improvement ↗, stable→, decline ↘ Variations of temperament noted here are global. It is impossible to know if they are directly linked to MAS or not. The goal here is to know to what degree the person finds their usual temperament level, whatever that level is.			
Good moments and more difficult moments during the period of observation			
Critical moments identified			
Factors of protection			
Adjustments in the security plan			

Figure 12 - Close monitoring sheet

Training close persons to recognize MAS

Training close persons to recognize MAS among people with autism or ID can be useful. Indeed, suicidal behaviors and manifestations associated with suicide are produced within one's usual environment, whose members often feel ill-equipped to face them.

The training can be done starting from the screening phase. It allows those close to the person to feel useful by observing, identifying and intervening in case of signs of suicide risk.

Close persons making an observation can take the first steps to assure the person's safety, apply the safety plan or contact care workers, according to the needs of the moment. They can also transmit information about suicidal episodes to care workers who can then base their clinical judgment on better information.

Section 5 – Intervening to reduce suicide risk – Suicide Prevention Plan–Risk: SPP-R IDAS Process

This last step in the clinical process for suicide prevention is crucial and must not be neglected. It is built over the long term through an analysis of the functioning, risk and protective factors and mechanisms present in a person's life (see figure 13).

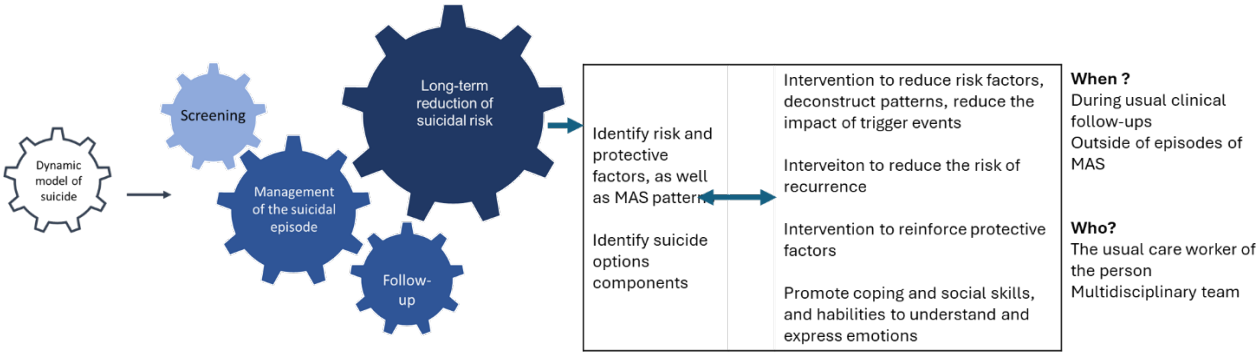


Figure 13 - Overall suicide risk reduction phase

General structure of the process for reducing suicide risk

This phase is based on the structure described in figure 14.

Processus AUDIS — Autisme, Déficience Intellectuelle, Suicide

4. INTERVENING TO REDUCE SUICIDE RISK – SUICIDE PREVENTION PLAN (SPP)

WHEN? Outside of all periods of disorganization or of suicidal episodes

Version 2024

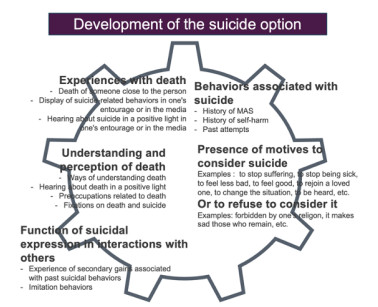
LAST NAME/FIRST NAME:	FILE NUMBER:	BIRTHDATE:
Names of the people making the intervention	Connection to the patient :	Period covered byt the SPP :

Information to collect: Indicators to base your clinical judgement relating to the following elements :

- (Individual- and Environment-related) risk and protective factors associated with suicidal risk
- Risk and protective factors are even present in the absence of MAS. The understanding of these factors develops with suicidal episodes and MAS. **This part of the evaluation does not need to be filled out with each episode, but can be made more detailed.**

The suicidal option

The suicidal option is built through time and from experiences with suicide and death. It can develop even if the individual has not had observable MAS.



/

Observation

Observer : collected information
Sources : Questions to the person, observations, questions to care-givers or family members, patient file

Emphasis

Decision

Decision : Decision as to the interventions to put in place with respect to:

Risk factors
- Does the person present risk factors it is important to act upon to diminish distress and re risk of another MAS?

Suicidal option
- Does the person present elements associated with the suicidal option?

Patterns of MAS
- Does the person present patterns of MAS which could be the target for an intervention?

Processus AUDIS — Autisme, Déficience Intellectuelle, Suicide

4. INTERVENING TO REDUCE SUICIDE RISK – SUICIDE PREVENTION PLAN (SPP) (con't)

WHEN? Outside of all periods of disorganization or of suicidal episodes

Version 2024

LAST NAME/FIRST NAME:	FILE NUMBER:	BIRTHDATE :

Patterns of MAS: Understanding the patterns and functions, risk of repetition and chronicization in the case of multiple episodes of MAS

- Critical moments and noted consequences at the time of different MAS episodes
- Presence of preceding MAS, understanding the function of MAS by examining one of multiple episodes (functional evaluation)
- Triggers
- Types of MAS
- Associated elements of distress/despair
- Consequences

Hypotheses on the links between factors of risk and protection, triggers, MAS and their consequences (In particular, responding to the question: Why do MAS as opposed to another behavior play this role for the person?)

Action

Action : intervening to reduce the risk

Risk Factors
- Increase protective factors
- Diminish risk factors
- Increase social skills and abilities for the expression of needs and emotions
- Adapt surrounding structures
- Treat health problems (physical and mental)
- Work on self-esteem

Suicidal option
- Reduce fixations
- Psychological education on death and suicide
- Work on positive perceptions or received ideas about death and suicide
- Understand and reduce secondary benefits (in interactions with others) of MAS
- Reduce the use of MAS in interactions
- Reframe suicide and suffering as it relates to finding help and solutions
- Understand the impact of MAS upon the environment (consequences)

Patterns of MAS
- Reducing the risk of a repeat attempt
- Undoing the patterns and functions of MAS
- Reducing the impact of triggers

Name of the person completing this section | **Signature** | **Date**

Figure 14 - SPP-R - reduce suicide risk

Objectives for the reduction of suicidal risk

The evaluation and intervention objectives of the SPP-R phase are:

Evaluation Objectives	Intervention objectives
• Complete the information collected • Identify the most distal risk factors, the factors of vulnerability and the factors for protection working over the long-term in the construction of suicidal risk • Understanding the person's suicidal process • Making decisions about suicidal risk	• Determining interventions aimed at reducing risk factors, reinforcing protection factors and modifying the suicidal process • Identifying and putting in place avenues of intervention aimed at improving the person's well-being and reducing the person's distress

We aim to identify more distal risk factors and to complete information collected during the management of suicidal episodes in order to understand the suicidal process of the person, make a decision about the long-term suicidal risk (including the danger of a recurring suicidal episode) and determine the interventions to reduces risk factors and increase protective factors.

This phase makes possible the continuous collection of information on the vulnerability factors to suicide that can be modified or whose effects can be mitigated for the person, as well as the avenues for intervention to reduce risk factors and increase protective factors. Decisions must then be made as a team and included in the person's long-term intervention plan, as well as in the action plans for subsequent suicidal episodes. The elements collected can be used during a therapeutic follow-up or in the development of the person's activities.

Information for this phase is collected from different sources (the person's file, discussions with different involved caregivers, close persons, interviews, observations, during planned meetings, during routine activities, etc.). It is not necessary to bring up the question of suicide to explore most of the examined risk factors. A large part of the analysis is done under the model of functional behavioral assessment (FBA). It can also be done by using tools from the Process IDAS or directly in the functional behavior assessment grids, depending on the organization's practices. It can also integrate into multimodal analysis plans (MAP).

Suicide risk evaluation and intervention address three major sections:

- **Risk and protective factors** underpin the development of long-term suicidal risk. Their identification supports psychosocial and psychiatric intervention (intervention plans, activities for the development of social skills.)
- **The development of the suicidal option,** which allows for the analysis of makes it possible to analyze the cognitive and social components of suicide risk. This section is transversal, it is observable at all the clinical process phases. It aims to understand how the idea of suicide emerged in the cognitions and behaviors of the person in order to implement psychoeducation, reframing, or other types of intervention to modify them.

- The **patterns of MAS** if the person seems vulnerable to experiencing several episodes, this analysis can be integrated into the functional analysis approach and the multimodal analysis plans (MAPs).

While exploring the suicide option, we are seeking to know how the person understands suicide, and why the idea that suicide can be a solution to the situation he experiences has come into being. We explore the cognitive and social components of suicide and its acceptability, in addition to the role of suicidal behaviors in the interaction of the person with his relations.

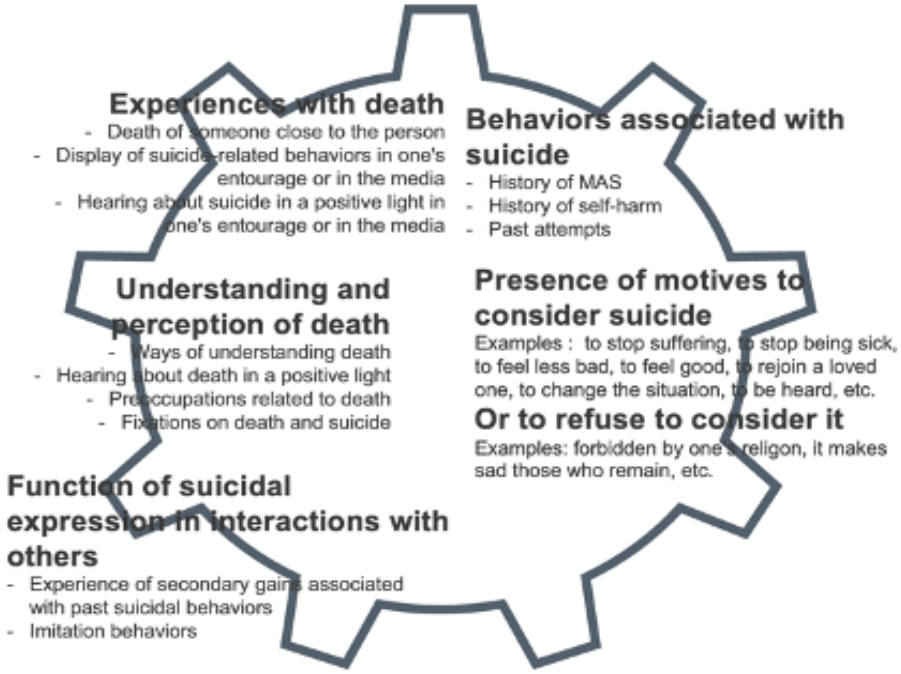
The suicide option can help us to understand the sources of suicidal ideations, identify the elements which can feed these ideations and, inversely, the elements that can diminish the impact of these ideations. It can support an individual approach, but it can also provide methods of intervention and activities to prevent suicide for small groups. For example when a person has suicidal behaviors in front of others; when suicide is presented in the media or on social media; or when a death occurs in the community. When information is collected from an autistic person or one presenting an ID, it is important to pay attention to the way they approach these subjects; this can reveal the person’s understanding of death and suicide and help the caregivers establish a preferred mode of communication about the subject with him.

Observe: Sources of information and risk assessment indicators

The elements presented in table 10 can be observed to assess suicidal risk and determine long-term courses of action to put in place. They are not comprehensive and others can be observed in individual situations. They are based on the model of suicide risk presented in figure 2.

Tableau 10 - Risk and protective factors and mechanisms to assess in SPP-R

Information to collect	Description and Instruction
Risk Factors *The risk and protective factors are present even in the absence of MAS, however,the understanding of these factors can become deeper with subsequent MAS episodes. This part of the evaluation does not have to be filled out with each episode, but can be added to with each episode and SPP-E.*	
Predisposing factors	Cognitive rigidity, low capacity for adaptation, generally anxious affect, unstable mood, problems with attachment, history of substance use, mental health issues, type and level of intellectual disability or autism, associated issues (ADHD, severe behavioral disorder, etc.)
	Personal experience or significant or traumatic events including negligence, abandonment, abuse, aggression, intimidation, family dysfunction, difficulties in school progress
Contributing factors	Feeling of being limited / dependent, perception of the self as being abnormal, misunderstanding of one's diagnosis, low self-esteem, substance use, impulsivity.
Precipitating factors and triggering elements	Worsening of mental issues, current substance use, etc
	Any element that acts to overflow the vase (trigger) which comes from outside: bad news, loss, etc.
Protective factors	
	Ability to calm down quickly, ability to identify solutions, ability for adaptation, feeling of control over one's life, the presence of reasons to live, capacity to express one's emotions and needs
	Harmony between the demands of the environment and the person's abilities, appropriate social integration, presence of people who assure safety, presence of sources of satisfaction, a knowledge and acceptance of the diagnosis by one's entourage, bonds of trust

Information to collect	Description and Instruction
Exploration of the suicide option	
	
Understanding the patterns and functions, risk of repetition and chronicization	
Critical moments and consequences of MAS episodes experienced by the person	Difficult periods experienced between the follow-up meetings and possibly foreseeable critical moments that demand the implementation of a safety net. Identification of critical moments can be done by observing the person's reactions in their environment and by consulting close persons and caregivers who spend time with them. **If there is only one episode, it is not necessary to rewrite the information here. This section aims at understanding patterns over several episodes.**
Presence of preceding MAS and synthesis of different episodes experienced by the person	Analysis based on the functional behavioral assessment, describing the pattern of MAS, if a pattern emerges from the observation of several MAS episodes. Identified recurring triggers (more than the trigger itself, it is useful to identify the category): Type of MAS and structure of MAS escalation (warning signs, words used, behaviors, means to attempt suicide, rituals, etc.) Immediate consequences (including the behaviors of close persons, other persons, caregivers, the interventions of emergency services, medical consultations, formal risk

	assessments, changes in the person's routine, etc.): **Here again, if there was only one episode, it is not necessary to rewrite the information here. This section aims at understanding patterns over several episodes.**
Understanding the function of MAS by examining one of several MAS episodes (Multimodal Analysis Plan)	The goal here is to develop hypotheses as to the links between the triggers, the risk and protective factors, the MAS and the consequences (including potential hypotheses on the development of secondary benefits, if applicable). This phase is similar to what is done during a multimodal analysis plan (MAP). Each hypothesis must be based on arguments identified during the preceding stages.

Decide: Decisions resulting from analysis

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

- Are there risk factors important to act upon in order to diminish distress and the risk of a recurrence of MAS? Yes/No
- Does the person present elements of the suicide option? Yes/No
- Does the person present patterns of MAS which can be the object of an intervention? Yes/No

Act: Intervention to put in place to reduce the risk of suicide

The long-term interventions put in place do not directly target MAS, but their associated factors. The deployment of these interventions does not require speaking about the suicidal episode again with the person.
The following section provides examples of intervention tools that can be used to support this phase.

Intervention tools to reduce suicidal risk

1. Interventions to reduce the short-term recurrence of MAS, deconstruct the patterns of MAS and the effect of trigger elements

Autistic persons and those presenting an ID are sometimes at risk for the recurrence of MAS when they again feel distressed. The MAS can also become a tool for communication and a mode of interaction in a complex dynamic with close persons and caregivers. It is nevertheless important to keep in mind that the utilization of MAS as a mode of interaction is far from systematic. Above all, the MAS must always be considered as an expression of distress.

Changing the patterns of behavior developed over long periods is difficult. In the presence of such patterns, the existing tools of intervention (intervention plan, functional evaluation, multimodal analysis plan) and a good understanding of the reasons that brought on the distress and the construction of the suicide option (how the idea of suicide became acceptable for the person) can help to change them.

A. Story: Daniel often thinks of suicide– he often says that he wants to kill himself

We talk about recurrence when a person experiences several episodes of MAS. It is sometimes possible to identify a pattern for the occurrence of MAS; for example, if they always appear in similar situations. However, these recurrent patterns are not systematic, and a person can also have MAS in different contexts.

It is important to really understand the function of MAS for the person and to take them seriously, even if they seem to be a mode of communication or of “manipulation.” It is never trivial to manipulate by putting one's own life at stake. The MAS that do not produce the desired result can evolve and become dangerous for the person. For example, not being able to escape a frustrating situation by expressing suicidal ideas can encourage the person to make an attempt. In this context it is essential to explore the person’s distress to identify the sources and put interventions in place that aim to reduce it.

The recurrence of MAS is an important concern for clientele with Autism and ID. Reliable data does not yet exist to assess the prevalence of this recurrence, but it is often described by caregivers and our study indicates it is a major issue. We documented it in the model of suicide risk (figure 2).

Daniel's story presented below describes a situation of recurrence of MAS. It was devised to take account of several specific issues brought up by caregivers who work with these clientele. These issues are related to impulsivity, the refusal to talk about a crisis once it's over and the use of MAS to communicate a frustration or a need.

Boxes 1 to 3 show Daniel’s current situation of crisis. The intervention’s goal is to help the person identify and describe the trigger of the crisis (and which is not the first occurrence of MAS). Box 3 underscores how Daniel uses MAS to obtain something. It can be useful to mention to the person that he sometimes says he wants to die when he wants to avoid a situation or get something. It is important to name the function of the MAS in this context, without condemning the behavior. The objective of the intervention is to allow the person to recognize the function of MAS, in order to be able to develop other strategies with him which help him explain his needs.

Boxes 4 and 5 describe Daniel's resistance to discussing the situation and the strategies of distraction which can be utilized to help him cool down. The intervention aims to bring up this

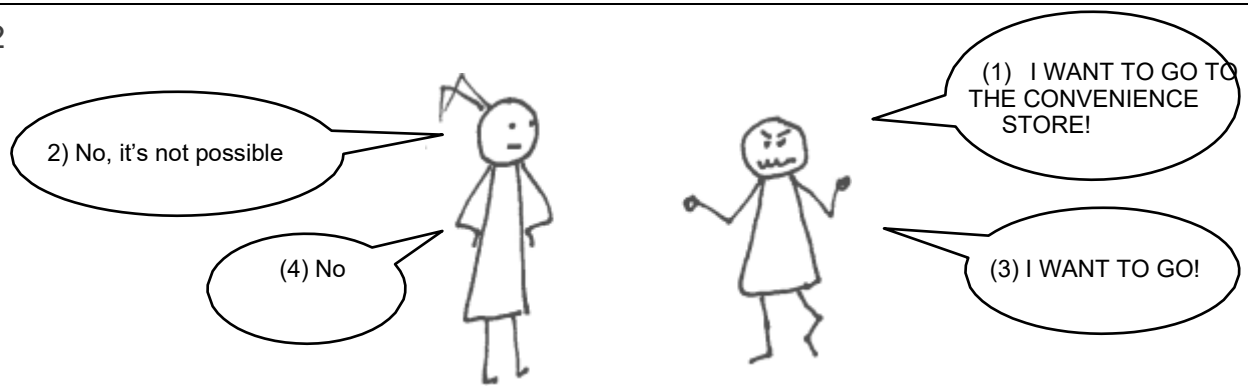
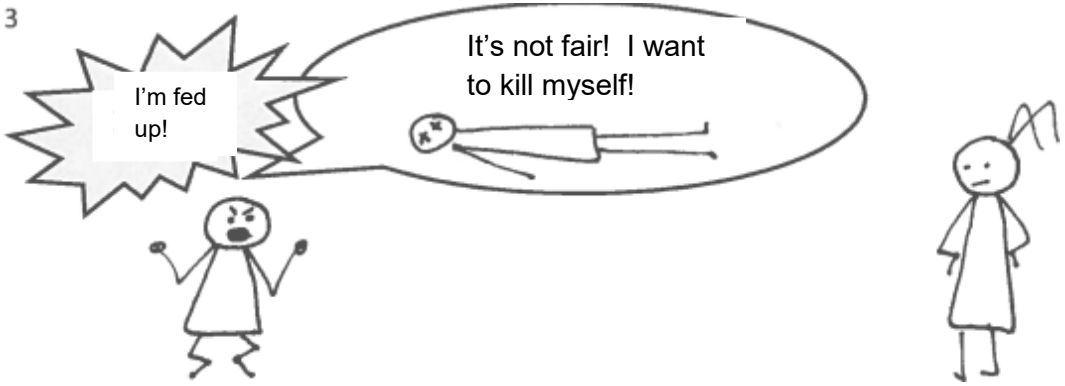
resistance with the person who also experiences it (for ex.: “You are also like Daniel sometimes, and you don't feel like talking sometimes or you say that you want to die.”) It's important to avoid judgment or insisting that the person talk about it at that moment.

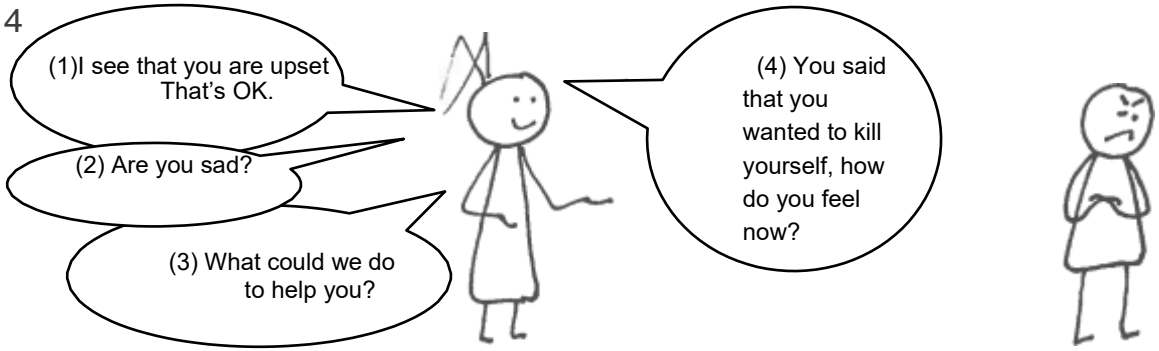
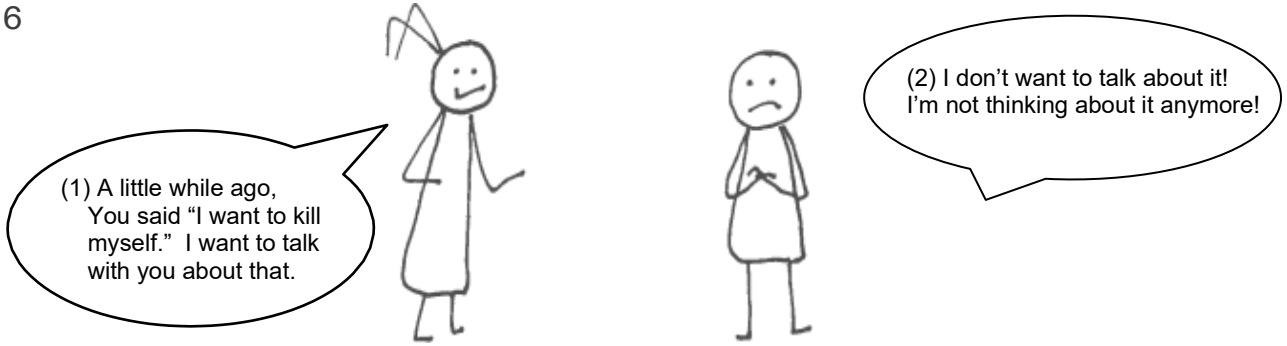
Boxes 6 and 7 describe the intervention of the care worker addressing Daniel's resistance and the necessity to talk about the suicidal episode. The intervention goal is to show that the MAS are taken seriously and that they command the care worker's attention, without necessarily leading to secondary benefits. The MAS are presented as the object of an intervention to allow the person to feel better right away, but also in the future.

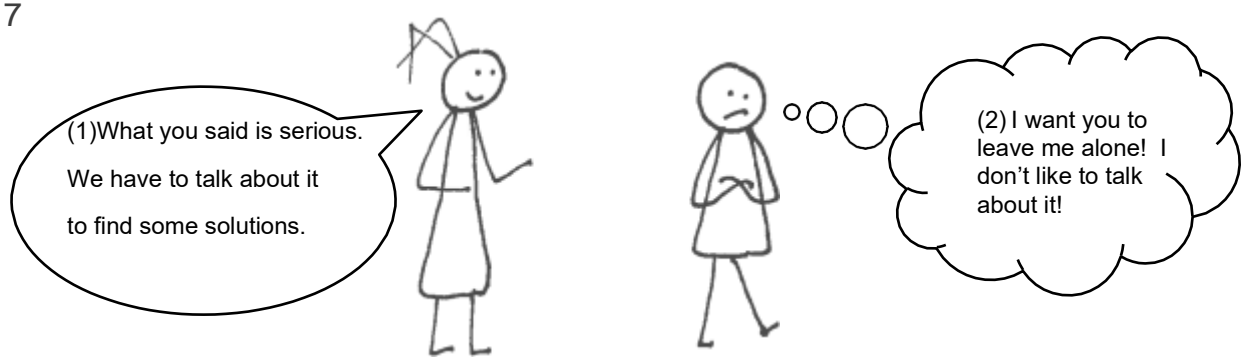
Boxes 8 to 10 describe the pattern of Daniel's MAS. The intervention here aims at describing the pattern of the person’s MAS, if he has one.

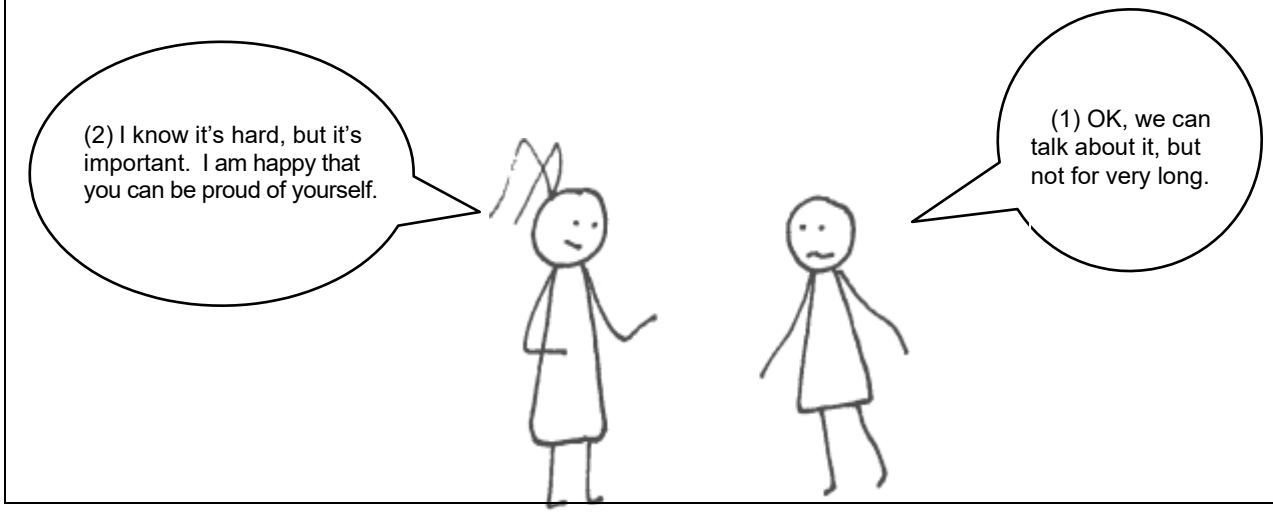
Boxes 11 and 12 insist on the validation and normalization of Daniel’s lived experience so that he is more receptive to intervention. The objective is to show the person that he can have a benefit by accepting to work on alternative ways of expressing his needs when it's not going well. Once this stage is achieved, the intervention aims at putting in place other ways for the person to express what he wants, without talking about MAS. The caregiver can reward the use of these new behaviors and can apply suicide prevention interventions when MAS reappear.

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

1 	Daniel is frustrated. He argued with his brother and he got in trouble.
2 	Daniel wants to go to the convenience store. But his caregiver refuses. He is in trouble.
3 	Daniel cries. He says that he wants to kill himself. The caregiver does not lift his punishment.

4 	The caregiver understands that Daniel is not doing well. She asks questions, but he doesn't respond. She tries to help him find solutions but he is too upset.
5 	The caregiver suggests to Daniel that he watch TV. Daniel calms down. He likes TV. His smile returns.
6 	Before dinner, the caregiver 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 past.

7 	The caregiver explains that it's important. Daniel has said something serious, and it is necessary to do something to find a solution. Daniel refuses to talk about it. It bothers him.
8 	The caregiver explains that she has noticed that, sometimes, when things don't go as Daniel wants, he gets angry and frustrated, he yells and says that he is going to kill himself.
10  Punishment – upset – upset and want to kill himself – calmed – ashamed	The caregiver draws a scenario for Daniel that explains what happens when he says that he's going to kill himself. Daniel thinks that the caregiver draws badly, but Daniel sees what happens.

11 	The caregiver explains that she wants Daniel to be OK. She wants to find solutions with him so that he thinks of something besides killing himself when he is frustrated.
12 	Daniel isn't very happy, but he accepts talking to the caregiver about the times he says he wants to kill himself. He doesn't like wanting to kill himself. He wants to find other solutions

C. Taking MAS seriously

Objective
Taking each episode of MAS seriously aims to reduce the risk of trivialization, while also avoiding an overreaction when a person communicates suicidal ideations, makes plans, mimes a suicidal gesture, or makes a non-dangerous suicide attempt.

Explanation/Justification
Taking an MAS episode seriously is different from:

- Reacting intensely or over-reacting
- Stopping all current activity to treat suicidal ideations or behaviors

It is important to take every MAS episode seriously. It is never trivial for a person to express putting his life and death into the equation. Distress whatever it's intensity or it's form, is present when a person has MAS even if he seems to repeat words without really understanding their meaning, or seems to have developed a habit of using suicidal communications. Taking the MAS seriously shows that we heard and that we are really going to do something.

If the person's MAS are not sufficiently taken seriously, he can react in different ways:

- He can think that his distress is not important and withdraw into himself;
- he can intensify his message and increase the danger to be heard;
- He can make a suicide attempt without really understanding the meaning of his action, if this action is not understood and correctly explained by another person.

Intervention process
Taking the MAS episode seriously implies the following elements: 1) validating what you heard, perceived and understood concerning the distress that was expressed; 2) reassuring the person that you are going to look at this distress together and find some ways to reduce it; 3) assessing current suicide risk and danger.

It is important to meet the person in a calm place at a time when he is attentive. For example, here's how the caregiver could introduce the subject: "I want us to discuss together what we can do for you to feel better, and so that the ideas and behaviors (describe the MAS episode) don't come back soon. It's important for me that you feel okay and I want to work with you for that. We don't have to talk about the episode again in detail, just what caused it."

Here are the traps to avoid and the things not to do:

- Minimize the MAS
- Bring about a function or behavioral goal for the person without having made an analysis of the situation to identify what the person understands of his situation and his behavior;
- Analyze the MAS according to the same model as behavioral problems, to make them disappear like a disruptive behavior.

2. Interventions to reduce the suicide option

These interventions aim to understand and to reduce the suicide option, which constitutes a key element of the development of suicidal risk (see figure 2). It is important to explore the person's perceptions, cognition, beliefs and experiences with death and suicide to diminish the suicide risk. These interventions can be done with a person who has had MAS or with a person who was witness to MAS in another. In this latter case, these interventions are desirable when the person witnessing MAS seems affected or is asking himself questions about suicide and death. the interventions must be made outside of the MAS episodes and when the person is calm[4].

A. Working on the beliefs of persons with autism or ID and caregivers

Many beliefs regarding suicide can be conveyed by persons with autism or ID, families, or caregivers. These beliefs affect the understanding of MAS, the type of intervention chosen and the behaviors of the suicidal person. Certain beliefs are well-founded, but others are false and must be demystified in favor of a more suitable intervention.

Table 11 presents the most common beliefs that can be observed, regarding suicide. It is recommended to not limit oneself to these and to discuss specific beliefs according to people's needs. Some of these beliefs more often are related to caregivers and have been observed in the words and actions of caregivers.

Tableau 11 - Popular beliefs concerning suicide

Suicidal people are resolved to die and cannot change their minds.	**False**
You must have courage to commit suicide. The desire to die is essentially a desire to stop one's suffering and this takes neither courage nor cowardice nor weakness. These people do not see any possible solution to their suffering and suicide takes up all of their thoughts.	**False**
People who talk about suicide or who threaten to commit suicide do not commit suicide. They talk about it to attract attention or to manipulate their entourage. Many people talk about their suicidal thoughts in one way or another, sometimes clearly and sometimes less so. Certain people have suicidal thoughts during long periods and talk about them. They look for and get help. Among the people having suicidal ideations, some attempt suicide and can die. We must never consider suicidal ideations as simply an attention getting device and we must always assess suicide risk, to understand why the person is communicating in this way. It's not trivial to give the impression of manipulating one's entourage by putting one's life at stake.	**False**
People who use suicide to manipulate or get something are not in danger.	**False**

[4] Postvention practices should be used in that instance.

If there is a component of manipulation in someone's suicidal behaviors, it's important to be aware of it and help this person to develop other ways of communicating his needs. A person who has learned to express suicidal ideations to get something can escalate the danger of his behavior if he doesn't get what he's looking for. Also, a person can have suicidal behaviors independently of any manipulative relationship. Talking about suicide often can desensitize the person to danger and trivialize suicidal behaviors, making it easier for him to attempt suicide during a period of distress. The use of suicidal behaviors in a manipulative dynamic happens within interactions and results from a learning process.	
Suicide can come up quickly in young people. it can be difficult to decode the signals sent by a suicidal person, giving the impression that there was no warning. Often, we understand the signals after the fact. Impulsivity seems to play a large role in MAS for young people, and coupled with a lesser understanding of death, it can increase the danger of a suicide attempt.	**Often True**
Suicide happens without warning. It is sometimes difficult to detect the warning signs in some people. Observing changes in behavior, attitudes, centers of interest, sleeping or eating habits can be clues of a worsening mood. Validating a person's anxiety and distress therefore becomes important.	**False**
Suicide is a problem that lasts throughout one's life. The majority of people have suicidal behaviors during difficult psychosocial situations and are no longer suicidal when the situation improves for them (for example, when their depression is controlled, when they get support in a difficult situation, etc.). Having had suicidal behaviors in the past increases the risk of having them again during a future difficult situation. It is one of the biggest risk factors. However, when people receive the support that they need, it can remain an isolated episode. Most people who have had suicidal ideations or who have made a suicidal attempt at one moment of their life never try it again. A person who has been suicidal in the past should not be categorized as suicidal for their whole life. On the other hand, it is important for care workers to know that this person has already had suicidal behaviors, in order to take into account the potential risk during difficult situations.	**False**
When someone commits suicide, the members of his family or his entourage are more at risk.	**True**
All suicidal people have a mental illness. It is estimated that around 80% of suicidal people have problems with mental health. However, most of the people having mental health problems are not suicidal. The presence of mental health problems is not a sufficiently direct cause to explain suicidal behaviors. Even in the presence of mental health difficulties, a suicidal episode can be provoked by a psychosocial crisis without any link to this problem.	**False**
The Improvement that follows a suicidal crisis means that there's no more danger. It is important to do a post-MAS follow-up and a longer-term intervention, because	**False**

the calm can be temporary. If the sources of distress that brought forth the suicidal episode are still present, the danger is likely to persist.	
Thinking about suicide can happen to anyone, rich, poor, in good health, sick…	**True**
When someone thinks about committing suicide she is bound to do it.	**False**
It's impossible to stop someone from committing suicide.	**False**
Talking directly about suicide with someone can encourage him to do it. In an intervention context, it is always relevant to talk openly about suicide with a person who worries us. This allows us to use clear words about a person's feelings, validate the presence of ideations and help the person to understand how he feels. Studies show that there is no danger of provoking suicidal behaviors by talking about them in a clinical context. However, caregivers often seem concern about the risk with autistic people and those presenting an ID. But the existing data do not show that there is a danger in talking about suicide in intervention with these persons. The phenomena of suicidal contagion or imitation must be distinguished from intervention. Certain people begin to think about suicide or make suicidal attempts after having spoken about it in their environment or having witnessed it. These phenomena of contagion / of imitation constitute a different process than the one that is produced in intervention.	**False**
When a person is suicidal it shows, he looks depressed. Many suicidal people don't show it; they are not visibly sad or depressed. In certain cases, these people are able to hide their sadness and their depression from close persons; in other cases, they're just not sad. They can be angry, restless, aggressive, or detached from their emotions. There is not a typical profile for the suicidal person. We must never minimize suicidal communication or analyze the risk based on the appearance of sadness or of depression in a person.	**False**
Suicidal people are weak.	**False**
Intellectual disabilities are a protective factor against suicide. Intellectual disabilities are often perceived as protective factors against suicide, because people presenting an ID are perceived as unable to plan a suicide attempt or to understand death. However different levels of ID interact differently with suicidality. Indeed, suicidal behaviors have rarely been observed in people presenting a severe ID. The difficulties of communication and of planning seem to protect them against suicide attempt or death. However, this does not protect them from distress and a desire to stop living can exist and come out in another way (stop eating for example). People presenting a moderate or light ID have suicidal behaviors similar to the general population. The inability to plan and execute a dangerous suicidal attempt does not minimize the distress they feel. Suicidality must be understood in its entirety and the presence of ideations must be treated seriously, because they reflect distress.	**True and False**
People who do not completely understand the concept of death cannot want to kill themselves.	**False**

A partial understanding of death can still be a risk factor. For example, a person who does not understand the permanence of death can want to die one day while thinking that he can come back to life the next.	
Unhappy, depressed or sad people commit suicide. When someone is unhappy he should commit suicide.	**False**

B. Vignettes: What I think about suicide

Objective
The following vignettes seek to support intervention around the themes related to beliefs about suicide. They seek to: 1) identify beliefs held by autistic people and those presenting an ID, to help reframe them; 2) help people to understand what happens when he or a close person thinks about suicide, in order to generate avenues for intervention to reduce the attraction of the suicide option and therefore the risk of suicide.

Explanation/Justification
When a person has MAS or when he is confronted with someone else's MAS, any false beliefs that he holds towards suicide can reduce the effectiveness of the intervention or bring about damaging cognitive fixations. Knowing these beliefs and intervening to correct them can help to reduce the tension associated with cognitions and limit the risk of contagion. In addition, a “constructive” explanation of suicide can help the person to understand without putting him at risk of developing or maintaining MAS.

Intervention process
The following vignettes represent different beliefs about suicide. They can be used to start a discussion with the person and ask him questions about his beliefs. The person's perception can be discussed according to the response illustrated by the story. We can ask the person if he knows people who are in the described situation, to then ask him if he himself has already felt the emotions described.

A person who thinks about killing herself cannot change her mind.

I agree I don't agree

And you, do you know someone who thought about killing herself like Gisèle, and then changed her mind? Tell me what happened.

Do you sometimes have thought like Gisèle?

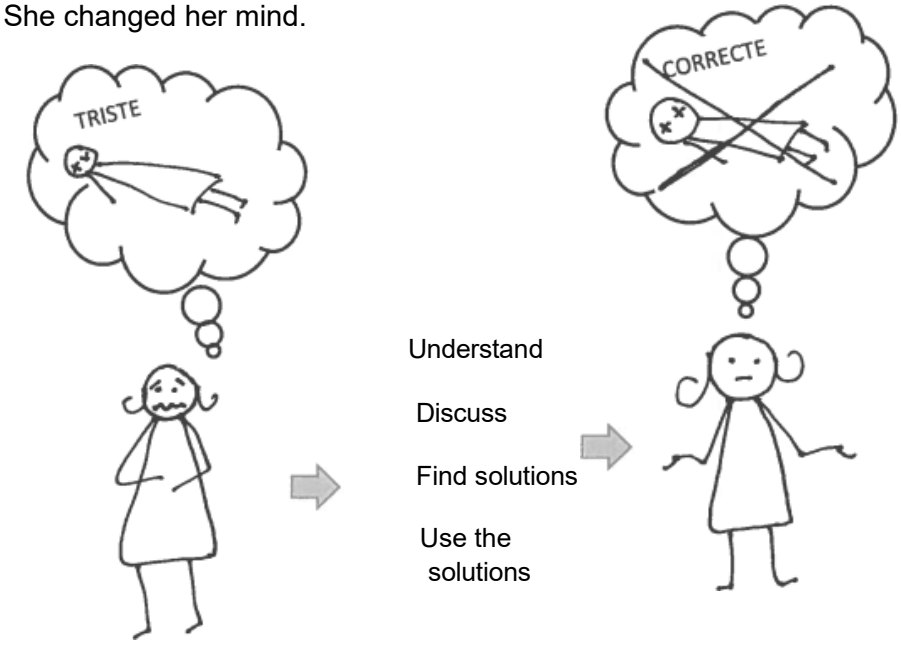
Tell me what happened.

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

Gisèle is sad because her boyfriend left her.

She thinks she'll never find another boyfriend and she is very sad. She is thinking about killing herself. She does not see any solutions.
Her sister sees that Gisèle is very sad. She talks to her. It helps Gisèle a little bit to talk about what is not going well.

After a while, Gisèle feels less sad. She knows that it's difficult to have a boyfriend. But she knows that there are also good things in her life, like the love of her sister and her parents. These things are positive and important for Gisèle.
Gisèle does not think of killing herself anymore and that's good news! She changed her mind.



If someone commits suicide or thinks about suicide, others will surely do it too.

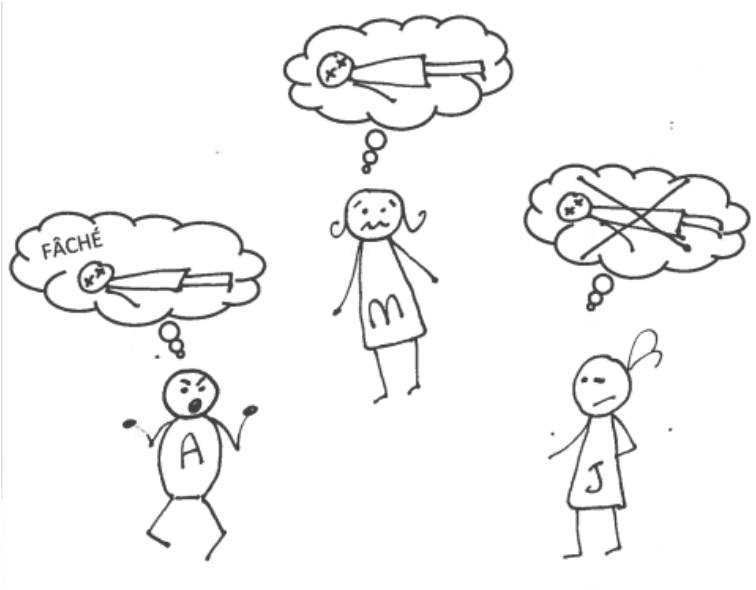
I agree I don't agree

And you, do you know someone who had thought of suicide after seeing another person do it?
Tell me what happened.

And you, have you ever thought of killing yourself after seeing another person talk about it? Tell me what happened.

When a person thinks of killing himself, tries to kill himself or kills himself, it can happen that others think about it, but not everyone. Those that think about it can talk about it and get help.

Marie heard Alex say that he wanted to die. Alex is very angry and unhappy. He yells; he cries. He says: "Since it's like this I want to kill myself." Marie is sad. She feels bad. She begins thinking that she also could kill herself like Alex said. She is afraid!
She tells the caregiver that she wants to kill herself. The caregiver helps Marie understand what's going on.
Marie feels better.
Josiane also hears Alex say that he wants to die. She does not understand what's going on. She is sad for Alex. Josiane doesn't think about killing herself. She knows that sometime, we can be sad but that afterwards things get better.
The caregiver helps Alex. Josiane sees that Alex is doing better. Everything works out.



We cannot stop someone from committing suicide.

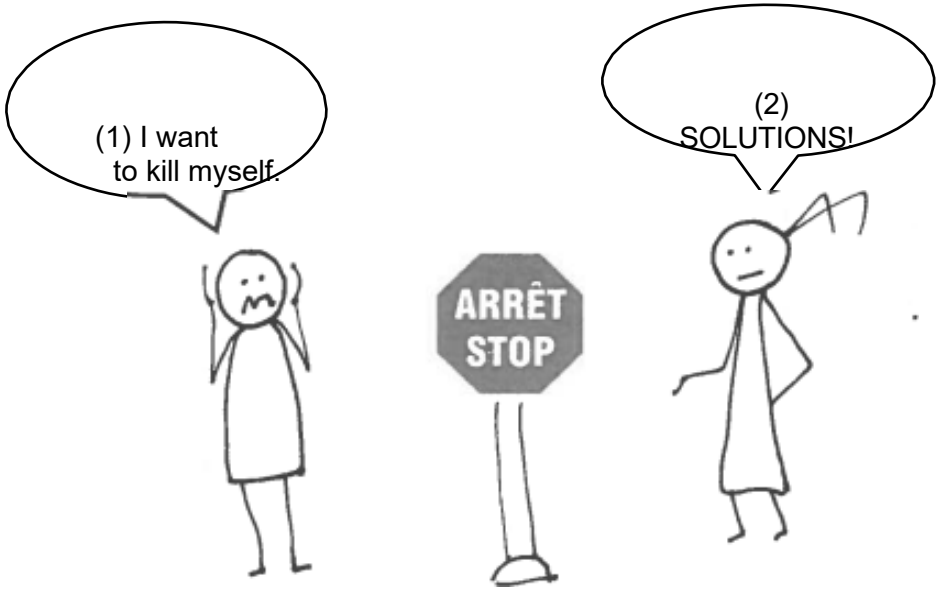
I agree I don't agree

And you, do you know someone who thought about suicide but was stopped from killing himself? Tell me what happened.

And you, have you ever thought of killing yourself, but then were stopped by someone? Tell me what happened.

When a person thinks of killing himself, we can stop him while helping him to feel better.

Raphael wants to commit suicide. He is sure, he wants to die. He is fed up with everything and he wants to stop suffering. He finds a way to commit suicide.
He is in danger. He says that he wants to kill himself. The caregiver sees that Raphael is thinking about killing himself.
The caregiver quickly goes to see Raphael and talks to him. Raphael agrees to give her the method that he found to kill himself. His caregiver helps Raphael to protect himself so that he doesn't hurt himself. Then, she works with him to help him feel better and to find solutions.



Unhappy, depressed or sad people commit suicide. When someone is sad, they commit suicide.

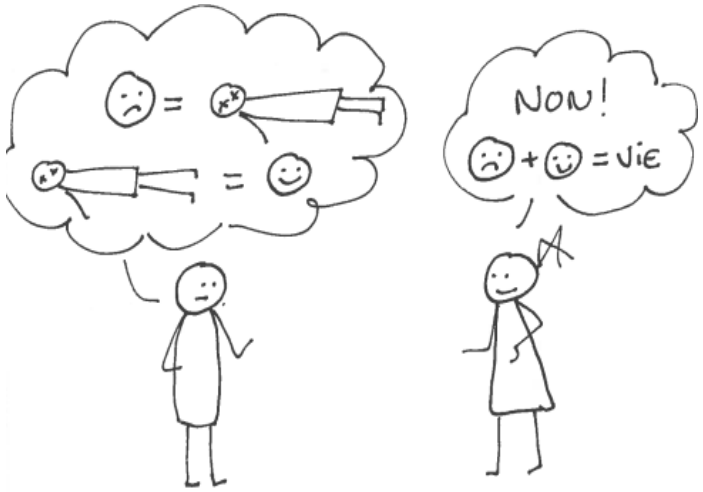
I agree I don't agree

And you, do you know someone who is sad (or unhappy) and who is alive?
Tell me what that person does to be less sad.

And you, have you ever felt unhappy?
What do you do in those situations? What do you do to be less sad?

Most people do not commit suicide when they are sad or unhappy. They do things to feel better and keep living. Even if they are sometimes sad, most people are happy to be alive.

Daniel has a cousin who committed suicide, François. Daniel's mom explained that François was very unhappy and that's the reason he committed suicide. Daniel thinks that if he becomes unhappy like François, he will have to commit suicide too.
Daniel also knows other people who have died. People say that they are no longer unhappy now.
Daniel thinks that in order to not be unhappy, you have to be dead.
He is mixed up and afraid of this thought.
Daniel talks about this with his mom. She explains some ways to no longer be sad or unhappy. When someone is dead, they are no longer happy either. When someone is sad, they can become happy again later. When someone is dead, they can't say anything anymore.
.



Anyone can think about suicide.

I agree I don't agree

And you, do you know someone who has thought about suicide? Tell me what that person is like.

And you, have you ever thought about suicide?

Very different people can think about suicide. Sometimes, when a person says that they have already thought about suicide, it can surprise us.

Rich

With an Intellectual disability

A friend

A person who seems depressed

Poor

A person with autism

A person who doesn't seem sad

A person without an Intellectual disability

A person who laughs often

Someone famous

A person without autism

Someone's parent

Young

An actor

An older person

Saying that you have suicidal thoughts is bad.	Daniel is thinking about suicide. Daniel's family is upset by what he said. Coralie, Daniel's sister, is very angry with him. She says to him: "You're not allowed to kill yourself, that's bad! You're going to get punished!" Daniel's mother says: "Never do that again! It's not allowed!" The caregiver explains to everyone that it's not bad to think about suicide, that Daniel should not be punished. She explains that when someone thinks about suicide, it's because they are suffering, because they want to stop suffering and they need help. Thinking about suicide is not Daniel's bad behavior, it is a sign of distress. However, it does scare people who love him, and the people who love him do not want Daniel to suffer or think about killing himself.
 I agree I don't agree	
And you, do you know someone who believes that thinking about suicide is bad? Why do you think that person thinks this, in your opinion? And you, do you believe that thinking about suicide is bad ? And you, what do you think about those who have suicidal ideas?	
Thinking about suicide does not make someone a bad person. It means that they need help. We should not hesitate to ask for help.	

B. Story: Raphael and suicide

Explanations about the process of ideations and attempts can be necessary when a person has made a suicide attempt or when he has been rushed to the emergency room for a suicide attempt. These explanations can also be necessary when the person knows someone who has lived through these experiences. Exploring a person's ideations and suicidal behaviors can also lead to this type of intervention. Raphael's story helps us to begin a discussion about suicide attempts.

Boxes 1 to 4 address the most frequent risk factors (perception of social isolation, feeling of powerlessness, despair) and triggers. The intervention seeks to explore risk factors and triggers for the person. The caregiver can explain: “In the story, Raphael thinks that he will always be sad. And you, do you feel like Raphael?”

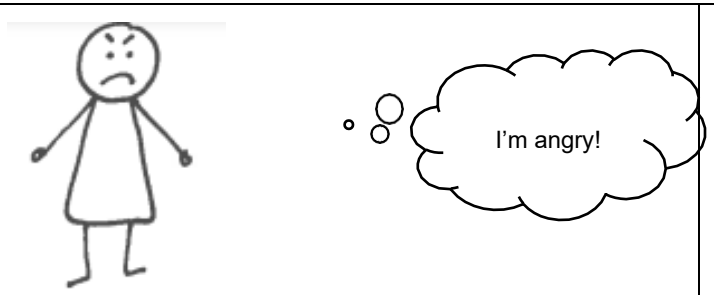
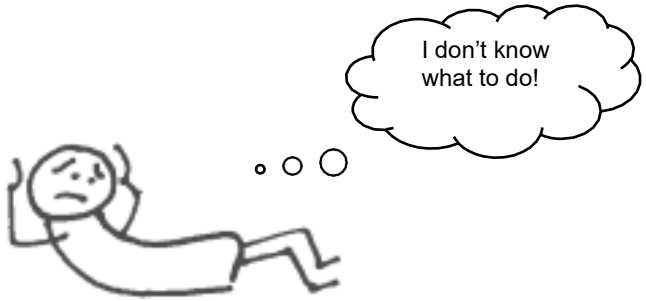
In box 3, Raphael expresses suicidal thoughts. The intervention seeks to explore the presence of ideations in the person, as well as his own reasons for thinking about suicide (suicide option). By way of example, the caregiver could say: “ Raphael thinks that if he killed himself, he would feel less bad. What do *you* think? And you, have you thought about killing yourself? What do you think happens when someone kills himself?”

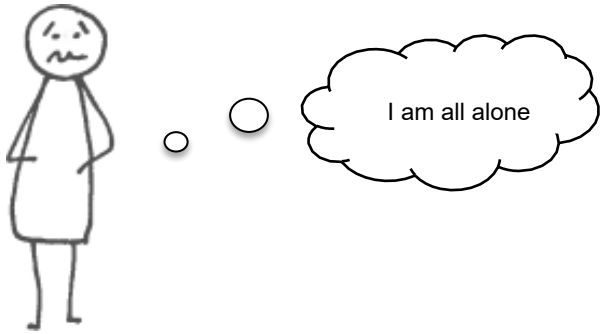
Boxes 5 to 7 present the sequence of events surrounding Raphael suicide attempt and its effects, on himself and on others. The goal here is to show the consequences of the attempt. Be careful: we must never describe the means used to commit suicide. The intervention aims at talking about consequences of the attempt (unresolved problem, pain, sadness still present) and the ride to the hospital, without guilting the person.

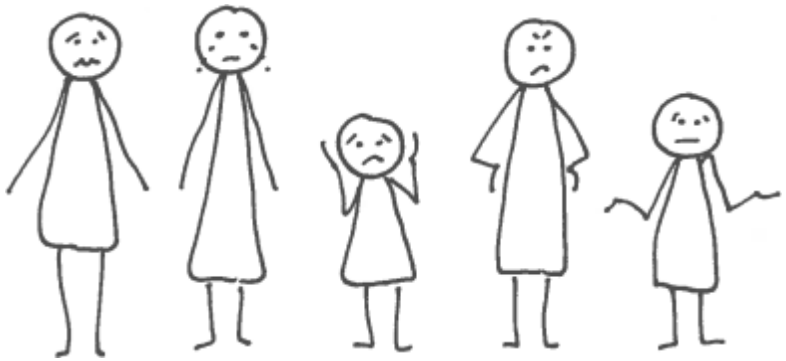
Box 7 describes the negative effect of the attempt on those close to Raphael. We're seeking here to bring the person’s attention back to his close persons, for whom he is important, Anyway that reinforces the reasons to live and his social support. The goal is not to blame, but more to help the person to project himself into relationships with others who are important to him.

Boxes 8 to 10 illustrate the meeting between the doctor and Raphael, during his visit to the emergency room. We understand that an intervention is put in place at the time of his return from the hospital. The story ends on a positive note of improvement and hope. The intervention seeks to discuss what happened at the hospital with the person. It also opens a discussion about the importance of implementing an intervention plan at the time of the return to regular life. It is necessary to explain that this intervention plan is here to help the person to feel better after a suicide attempt or suicidal ideations.

Raphael and Suicide

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

3 	Raphael would like to stop feeling bad. He thinks that if he killed himself, he would feel less bad.
4 	Raphael feels that no one understands him. He feels alone and he is afraid.
5 	Raphael tries to kill himself. He is wounded; he hurts. He is still unhappy.

6 	The ambulance comes and Raphael goes to the hospital.
7 	Dad and mum want him to come back home. His friends want him to come back in order to play cards. The caregivers want him to come back so he can continue learning lots of things.
8 	Raphael explains to the doctor what happened. It is difficult to explain.

9 	At home, Raphael works with his caregivers and his family. Raphael learns to explain how he feels things aren't going well. In this way, we can help him feel better.
10 	With help, Raphael finds solutions to his problems. He learns that things can get better without killing himself.

D. Story: Marie learns to say that she has suicidal thoughts by seeing others

This story addresses the theme of imitation or the contagion effect from MAS. This effect exists in the general population, and it is well documented: when a person commits suicide or has MAS, he can be imitated by other people in the community. Imitation can occur within small groups (for example, at school) or within small communities (for example, in villages). It can also occur when people hear of a suicide in the media or in other communities, or when they feel a link/associate themselves with the person who committed suicide (for example, in the case of a public figure, character in a film, or someone in another group home, etc.).

The studies carried out in the general population show that talking about suicide from a perspective of clinical intervention does not increase the risk of MAS. On the contrary, it allows us to clarify the lived experience and emotions of the person and thus, adjust the intervention to the real situation. For autistic persons or those presenting an ID, imitation has been described by caregivers and seems to touch as much on verbal communications, suicide planning and suicide attempts. The models of MAS can be available within the person's environment (close persons, friends, other residents, colleagues, etc.). As for the general population, there does not seem to be a contagion effect when we discussed suicide in the clinical or care context, as long as suicide is well explained.

The story of Marie can support the caregiver who suspects that a person is having MAS through the effect of imitation, that is to say when MAS are present in his environment. It seeks to calm down the contagion and to reinforce the adequate communication methods for needs and distress, without judging the MAS. The story and the intervention that accompanies it must be used after a complete risk assessment has been done with the person. Talking about imitation does not mean that the MAS are not serious; however, they may have a different function than the communication of distress. The imitation of MAS is not trivial and such MAS must be taken seriously. Beyond the risk assessment, the intervention aims here to understand the process of imitation and name it, in order to reinforce other coping and communication mechanisms.

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

Boxes 5 to 8 provide some explanations of the imitation and seek to normalize it. The intervention works with the person to identify other behaviors, ideas or emotions that they “pick up” from others or in the media.

Boxes 10 to 13 display Marie’s imitation of MAS. We seek to explain what could have happened for the person, to identify and to normalize the suicidal behavior.

Box 14 illustrates the process for identifying Marie’s triggers of distress. The intervention seeks to bring the person back to her present internal state in the here and now. We seek to identify

what could have triggered the MAS, outside of any imitation process, if applicable (taking the MAS seriously).

Boxes 15 and 16 allows us to identify and to rename the methods normally used by Marie (besides the MAS) to express her needs and emotions. The goal is to re-center the person on the ways she expresses herself normally to reinforce them, without judging or sanctioning the presence of the MAS.

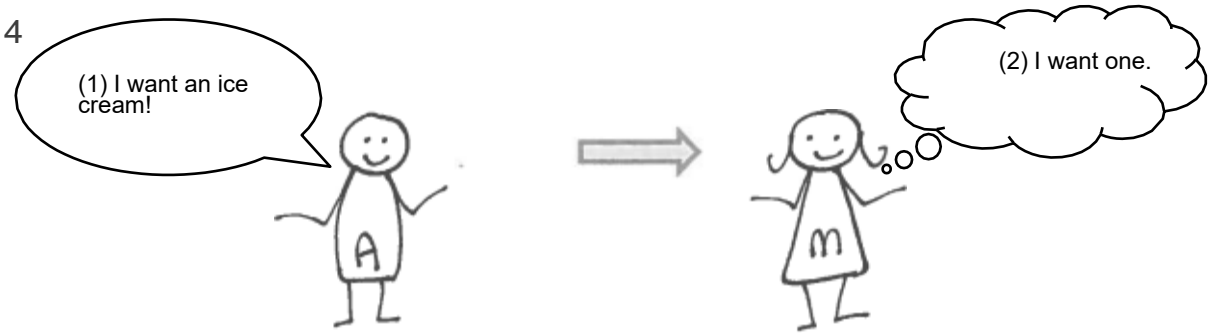
Box 17 shows how the caregiver reassured Marie about what happened to her friend who had MAS. The goal of the intervention is to explain that the person being imitated was okay and is doing better, if applicable. If the person being imitated has died, it is important to explain that they died because they didn't find adequate solutions. It is therefore important to contrast this situation with the situation of the person, reassuring them that they have solutions and that they are going to be fine. It is possible to explain that people sometimes use MAS to express a malaise or that things are not going well, and we can use other ways to express that. The goal here is to reassure the person, if possible, as to the well-being of the imitated person and to emphasize the person’s strengths.

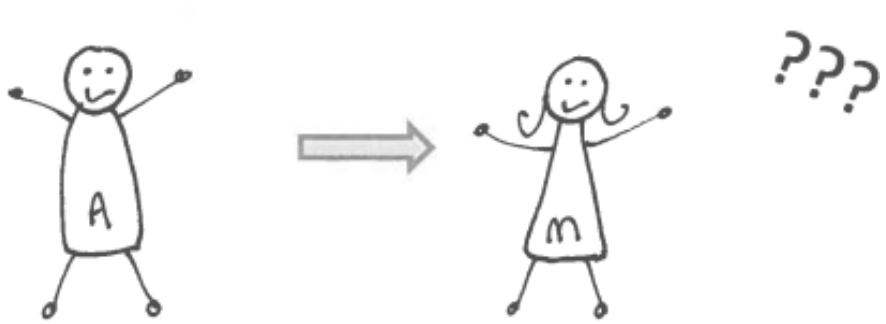
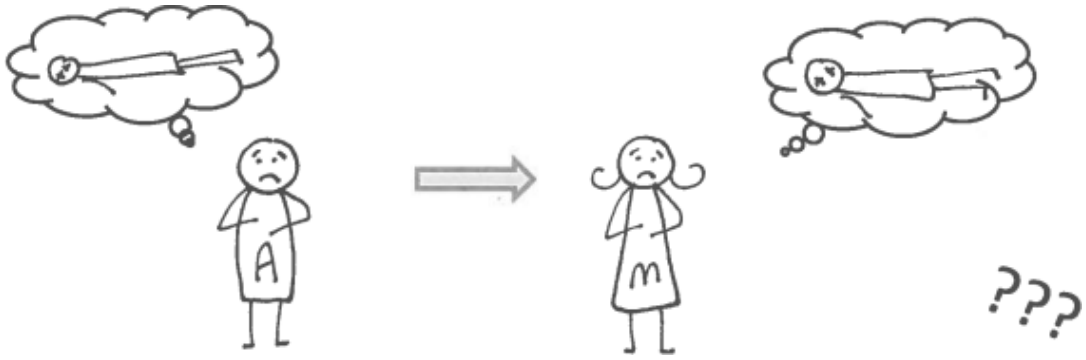
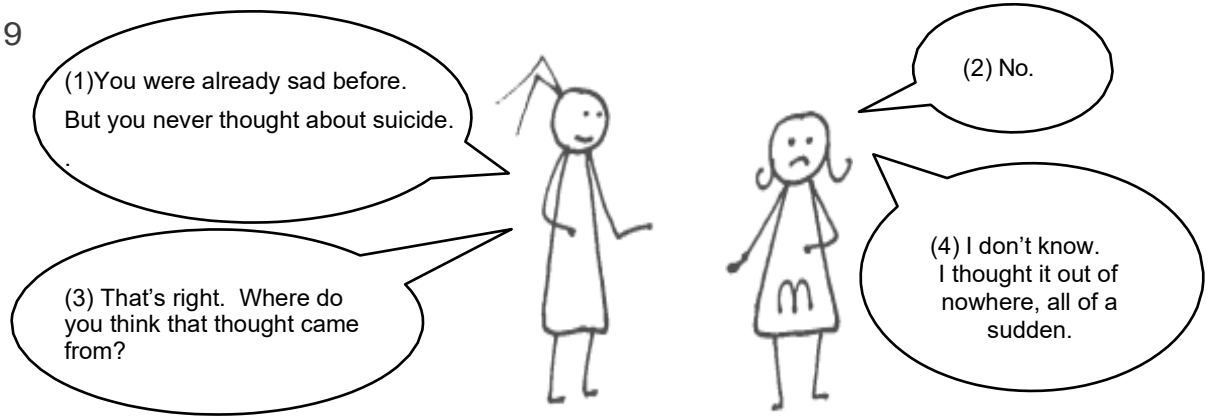
Box 18 illustrates the search for solutions for the person's situation, to reduce distress. This stage is part of the solutions-focused approach used in suicide prevention. It is therefore important to validate and to highlight the strengths of the person. By drawing on strengths, the person will be able to use solutions that work to help them feel better. It can be counterproductive to talk again about MAS in a negative way.

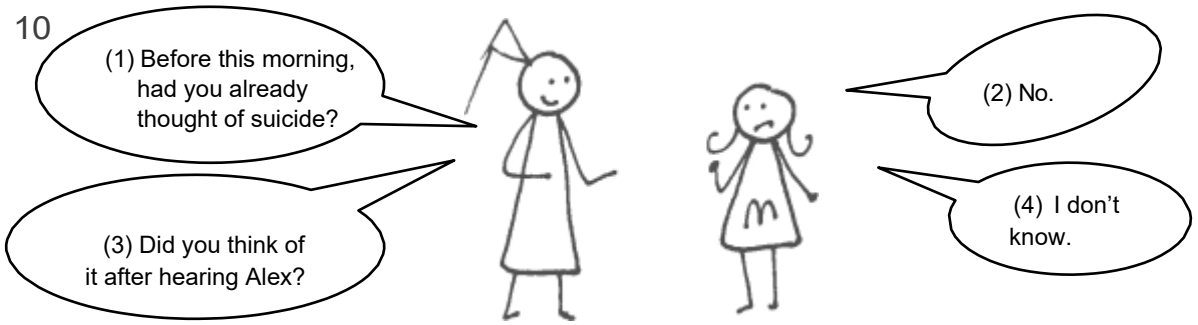
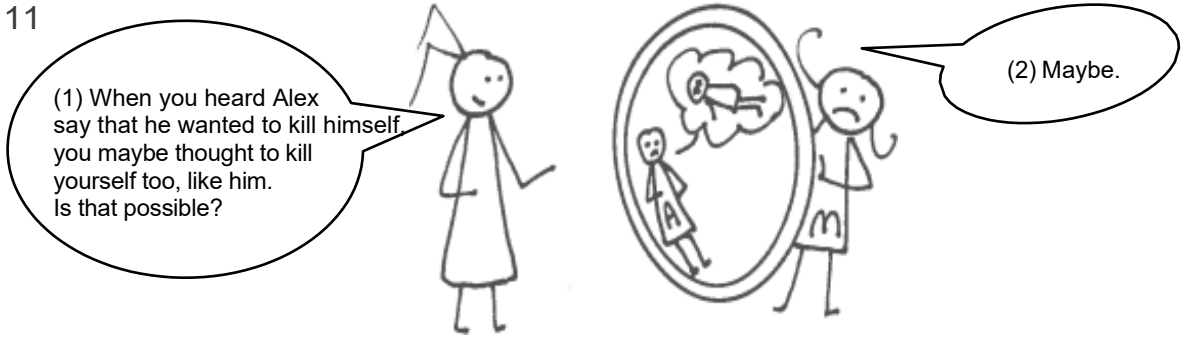
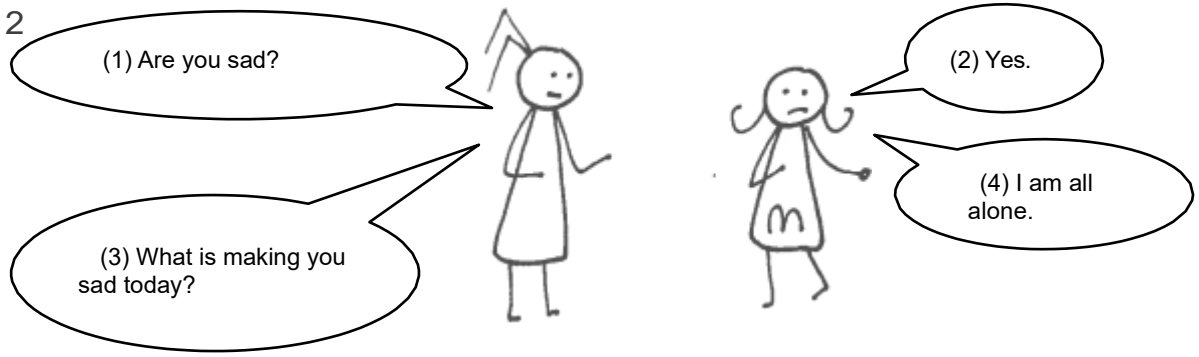
Box 19 shows how we can attempt to consciously break the vicious cycle of imitation of MAS. For example, the person can try to eliminate thoughts that do not belong to him by erasing or by crossing out a drawing that represents the idea of suicide. We can also choose to use words.

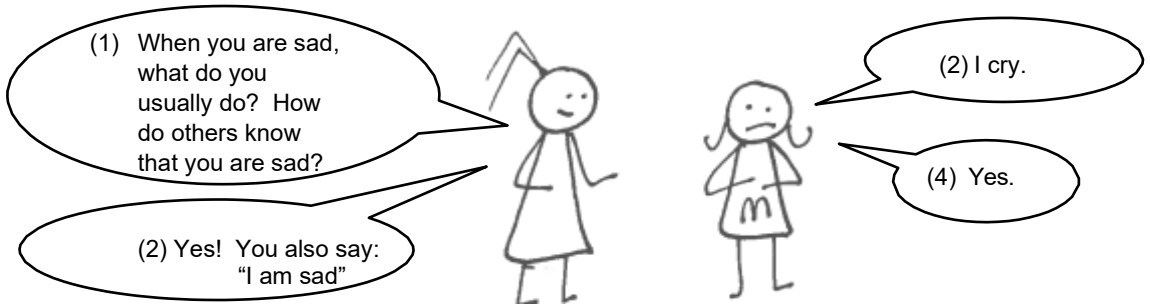
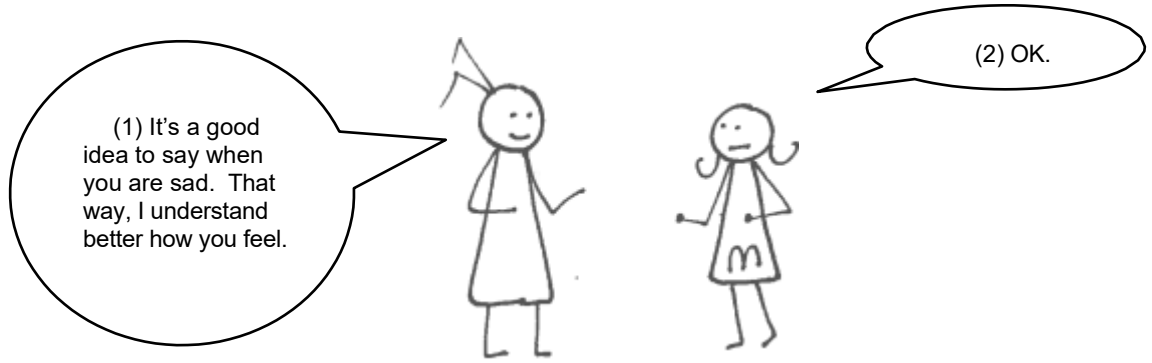
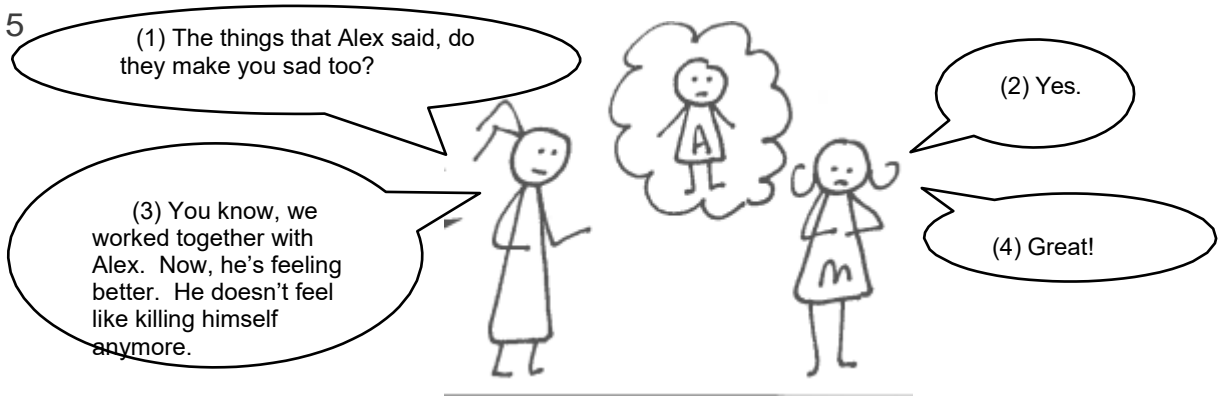
Marie learns to say that she has suicidal thoughts by seeing others

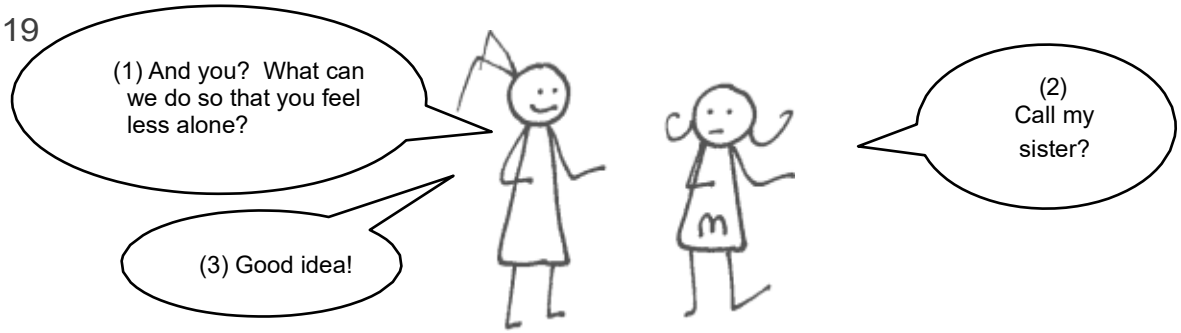
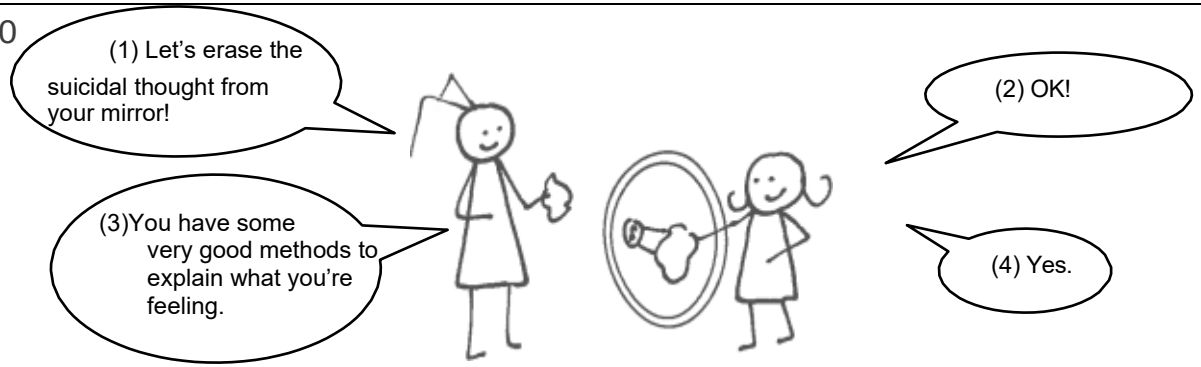
1 	Marie has a friend: Alex. Alex said he wanted to kill himself and Marie heard him.
2 	Marie is sad. She feels down. She begins to think that she could also kill herself.
3 	The caregiver talks with Marie to understand what's going on. She notices that Marie has thoughts of suicide since Alex had them.

4 	The caregiver explains that this happens. When we see or hear someone say something, it's not uncommon to start to think like them.
5 	For example: when we see someone who feels sad, it's not uncommon to feel sad too, like the person. We feel like a mirror.
6 	For example: when we see someone with a certain behavior, it happens that we repeat the same behavior, like that person. We behave like a mirror.

7 	Sometimes, we don't know why we act like others. It happens to everyone. And often, it's not a problem, it's OK!
8 	Sometimes, the things that we do like others are serious. We risk putting ourselves in danger.
9 	In these cases, it's important to think about what happened. The caregiver asks Marie where the suicidal thought came from. Marie doesn't know. She feels mixed up.

10 	Marie had never thought of suicide before Alex said something.
11 	The caregiver asks Marie if her thought of suicide is like a mirror of Alex's thought. It's hard to know. That's OK! These things are difficult for everyone.
12 	The caregiver talks with Marie to understand if she is unhappy, angry or worried because of something particular in her life.

13 	The caregiver and Marie discuss some methods that Marie can use to express how she feels.
14 	They remember that it's important to use these methods.
15 	The caregiver also explains what happened for Alex.

19 	The caregiver and Marie work together so that Marie feels better and finds some solutions.
20 	The caregiver and Marie work together so that Marie doesn't retain Alex's suicidal thoughts for herself.

E. Working with fixations on death and on suicide

There is no typical intervention for working with fixations on death and suicide. Indeed, fixed ideas can play a very different role depending on the people and the context. Confrontation on this subject is not recommended because it can trigger greater cognitive rigidity. To our knowledge, there is not a valid guide of best practices to support interventions aimed at reducing the impact of cognitive fixations on suicide for autistic people and those presenting an ID. Consequently, this section is based on a few recommendations from the experience of clinicians that can help support an intervention plan to reduce fixations on suicide and death.

The presence of fixed ideas about death and suicide can increase the suicidal risk by reinforcing the attraction for the suicide option. For this reason, fixations on death and suicide should not be brought up during a MAS episode. The intervention for these fixed ideas would be better done during middle- to long-term follow-ups and in SPP-R. Talking about the MAS episode is not necessary to address this issue.

Certain people can have fixed ideas about suicide and death without having had episodes of MAS. However, these cognitions, as well as the interpretations and the beliefs that are associated with them, can render these people vulnerable if they are confronted by trigger events. It can therefore be useful to intervene on these fixations, even in the absence of MAS.

In every case, the first step of intervention consists of rigorously analyzing the form, structure, pattern of expression and functions of fixed ideas on death and suicide within a person. The evaluation can help to answer questions like:

- What expressions are associated with these fixed ideas? (behaviors, words, attitudes, etc.)
- What is the frequency of these fixed ideas? Can we identify external triggers when these ideas come up?
- Is this a particular or restrained interest that has been present for a long time? Is it an interest that has appeared recently? can we associate the appearance of these ideas with an identifiable exterior event (film, death of a close person or animal, suicidal talk in the entourage, etc.)
- Do the fixed ideas play a particular role for the person (reduce anxiety, relaxation, interaction, etc.)? What could be the function of these fixed ideas for the person?
- What is the impact of these fixed ideas on the person's entourage (close persons, caregivers, peers, etc.)? What is the effect on the person and on the expression of his fixed ideas (maintenance, augmentation or inhibition of her ideas, anxiety, provocation, etc.)?

The second step consists in analyzing the cognitive, emotional, behavioral, medical and social contexts in which these fixed ideas occur. The person can be confronted by all sorts of situations such as a depressive mood or an episode of depression, an increase in anxiety,

difficult life events, a period to adjust to medication. He might also have seen a movie, been witness to MAS or have been confronted with death of a loved one or animal.

Before doing an intervention on fixed ideas around death and suicide, it is useful to assess suicide risk to detect, if applicable, the current presence of MAS. Indeed the person could express an intense interest for suicide in general, in addition to having suicidal ideations that are not expressed directly.

The third step, the intervention must above all focus on the sources of fixations when they are identifiable (treatment of depression, anxiety, behavioral activation, social activation, work on self-esteem, reinforcement of goals and of the person's ability to act, etc.).

Interventions on fixations can have simple objectives:

- Clearly identifying the contents of rigid thoughts or of potentially damaging fixations with the person in order to favorize the development of his ability to nuance his judgment;
- Accompany the person in the identification of potential negative effects of his thoughts on his mood, to encourage him to replace them with more positive thoughts;
- Identify the person's questions associated with death and suicide. It can be necessary to explain death, to discuss alternatives to suicide when living through a difficult situation, and to reframe misunderstandings.

A. Work on cognitions associated with suicide– reasons for thinking to kill oneself and reasons for not thinking to kill oneself (reframing)

Objective

The intervention proposed here allows the person to identify situations when he thinks that someone could become suicidal and those which do not lead to suicidal thoughts. This exercise allows the person to understand the cognitive context in which MAS can become acceptable for him.

This activity may be done: 1) when a person worries his entourage without having obvious MAS; 2) when someone in the person's entourage has had MAS; or 3) when a person asks many questions about suicide. This activity is not done when a person is currently experiencing distress and MAS, since the exploration of reasons for living and dying is already part of the process for suicidal risk assessment.

Explanation/Justification

In identifying these situations, it is possible to reveal: 1) the values and beliefs of the person concerning suicide; 2) the reasoning processes of the person regarding death, suicide and reasons for attempting suicide; and 3) the situations where a person can become at risk for developing MAS. All these elements can become targets for intervention, cognitive reframing and exploration of the affect.

Intervention process

It is first important to sit down in a calm place with the person. Then, it is important to explain that we are going to talk about suicide because it's something that has been bothering the person in a general way, and that we want to help him answer his questions.

With the support of the care worker, the person explores the reasons to consider suicide and these reasons are written down in the first column of the table (see Table 12). We also identify means to make these reasons disappear. These means can be applied by the person himself or with his entourage.

With the support of the care worker, the person next explores reasons to refuse contemplating suicide. These reasons are written in the second column of the table (see Table 12). We also identify methods to reinforce such reasons. These methods can be applied by the person himself or with his entourage.

We can then reflect together of the reasons to contemplate and to refuse suicide, showing that there are elements in both sides, the goal being to show the person that when we think about killing ourself, we must concentrate on the elements for refusal.

The exercise brings together elements to reinforce hope, by introducing external situations to the person and by exploring more in detail cognitions associated with suicide that can reinforce the attraction for the suicide option. This exploration can be done during a quiet time, outside of moments of distress.

Tableau 12 - Reasons to kill oneself and reasons not to kill oneself

What reasons can a person have to think about killing themselves?	What reasons can a person have to refuse to think about 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 kill oneself disappear in the mind of the person? What are alternative methods to get to the same goals? 	How can we make these reasons not to kill oneself get larger (reinforce them) in the mind (the thoughts) of the person? 

B. Understanding and reducing the secondary benefits of MAS

Current studies provide very little information supporting the understanding the development of secondary benefits associated with suicidal behaviors. Likewise, we still understand little about factors that support recurring MAS, including those associated with surroundings and intervention settings. It is however important to take this phenomenon into consideration in the intervention.

Secondary benefits are gains or advantages that the person obtains through his behavior. These benefits occur in the context of an interaction between the person and his environment and can depend on the demands which are made on this person by his entourage, by his relations with others and by organizational settings.

Our study of care workers working with suicidal autistic persons and those with an ID identified several types of interactions, through which secondary benefits from MAS can occur and take root. Here are some examples:

- An episode of MAS brought about the cancelation of a demand or unwanted activity. Subsequently, it is possible that the person learns to use MAS to escape a similar unwanted situation.
- Certain people can learn to use the terms and expressions of assessment tools to be considered at risk in order to receive particular attention on the part of the caregivers.
- Caregivers often think that Autistic people or those with an ID who have MAS don't really think about suicide and that their behavior has another function. They therefore identify a specific function for the MAS and their interventions reflect this erroneous attribution. In this context, Autistic people and those with ID can align their behavior with caregivers' expectations and their analysis framework. In this way, they can begin to use MAS in the ways caregivers think they are using them.

Sometimes, caregivers think the person is straightaway using MAS as a tool for negotiation. However, the process is more complex and iterative; the expression of distress and of MAS could bring about particular attention and the person has learned to utilize this behavior to obtain the desired response. It is therefore the response of the caregiver which has brought about the learning and the use of MAS as a tool of negotiation, in context where many behaviors are developed by learning, as they relate to the reaction of caregivers.

Other processes associated with intervention can act as risk factors in the development and recurrence of MAS. Here are some of them:

- **A gap between the person's current abilities and the demands of the environment.** This situation can bring about a breakdown in functioning and MAS. Caregivers should therefore be attentive to variations between the person's abilities and the demands of the environment, to try to keep a harmony between the two.
- **The multiplication of caregivers working with a person.** This situation can bring about fatigue, when the person is constantly asked to work towards objectives, modify

behaviors, or to improve aptitudes. These multiple demands by different caregivers can bring about frustration, a breakdown of functioning and MAS.

- **Caregivers' attributions of the client's difficulties to internal factors.** This attribution can influence intervention targets and limit them to internal factors, neglecting intervention on the person's environment. This situation may support recurrence of MAS.
- **Changes.** Autistic people or those presenting an ID are susceptible to live through many changes (routines, caregivers, life setting) which are potential risk factors for recurring MAS.
- **Conflicts with caregivers and the escalation of aggressive or challenging behaviors in the presence of caregivers.**
- **Ignoring a behavior in order to not reinforce it.** This can also bring about an escalation of danger from MAS in the person who does not get the wished-for result.

These processes at play within the context of service and support structures must be known and taken into consideration when an intervention plan is made in order to reduce the recurrence and the appearance of secondary effects from MAS in patients.

Useful long-term clinical interventions to help prevent suicide

Many interventions help to reduce long-term suicide risk, such as those aiming to reinforce emotional regulation and expression, to develop social literacy and abilities, to reduce of anxiety, to treat symptoms of depression, to reinforce understanding and expression of needs, acceptance of one situation and the development of positive and attainable life goals and projects. The majority of these clinical interventions founded on best practices are available for caregivers. Most of them are already used with vulnerable persons. At the same time, it is important to put clinical interventions in place to mitigate the effects of negative or traumatic events lived through during childhood, which are strongly associated to suicidal risk.

Interventions must be adapted and put into place for a person according to the results of a suicide risk assessment (SPP-R). These interventions must also rely on an in-depth knowledge of the person's history and functioning, by the multidisciplinary team that accompanies the person on a regular basis.

To complete our brief overview of promising interventions, it is possible to adapt intervention tools developed for the general population to autistic persons or those presenting an ID.

A. Acceptance and commitment therapy (ACT)

Acceptance and commitment therapy (ACT) belongs to the third wave of Cognitive- Behavioral Therapies. It was developed on solid theoretical foundations focusing on cognition and language. It is based on six axes which address functional and behavioral aspects and the difficulties associated with characteristics of language. These axes are presented and defined briefly in Table 13.

Tableau 13 - Principal axes of acceptance and commitment therapy (ACT)

Axes	Definition
Acceptance	The active process aiming to limit flight behaviors or the avoidance of events or situations that are psychologically painful.
Défusion	Understanding and managing thoughts which do not reflect reality
The self as context	Perceiving oneself as the context in which thoughts and emotions appear and not only as the author or the object of these thoughts or emotions
Contact with the present	Focusing the attention on “the here and now” to limit the impact of the verbal, putting oneself back in contact with the immediate consequences of one's behaviors.
The manifestation of values	Identifying what really counts, the orientations that one hopes to give to one's life.
Action	Acting to develop behaviors linked to one’s chosen values, concentrating on behaviors that work.

ACT was evaluated with people presenting an ID in the treatment of mental difficulties with very promising results, despite the fact that this approach rests on the use of language and of metaphors. It seems particularly appropriate to complete behavioral analysis when the person presents thoughts and emotions that are problematic and intrusive.

Studies looking at the application of ACT with autistic people are rarer, but here again, the perspectives are promising particularly for people functioning at a high level. ACT is an approach that is used more and more with people having suicidal behaviors. It has significantly improved conditions underlying their suicidality.

It is therefore promising to use the principles of ACT with suicidal autistic people or those presenting and ID.

B. Dialectical Behavioral Therapy

Dialectical behavioral therapy (DBT) was developed specifically for people presenting major difficulties in emotional regulation and a potential for recurring MAS. It's efficacity has been well demonstrated to reduce self-harm behaviors and recurrent suicidal behaviors among diverse adult and adolescent clientele, particularly among those people presenting borderline personality disorder.

One of the advantages of this approach is that it is manualized and freely available in a version for adults and for adolescents. The interventions are structured around individual and group activities and are accompanied by clearly described activity sheets.

The DBT approach is beginning to be used with clientele presenting an ID and mental health problems. It seems promising to reduce challenging behaviors, emotional dysregulations and problems with anxiety.

However, DBT should be adapted to be more useful with people presenting an ID. There does not seem to currently exist a significant corpus of research concerning the application of DBT for autistic persons.

Even when it is not used in its entirety, DBT includes useful elements for intervention with suicidal autistic persons, or those presenting an ID. It's the case, for example, to obtain the collaboration of a person who, initially, resists any form of intervention.

C. General Improvement in quality of life

Improvement in the quality of life is an indispensable goal in suicide prevention, notably with autistic persons or those presenting an ID. This reinforces reasons for living, having control over oneself and over one's life, the feeling of belonging, self-esteem and well-being.
Moments of fulfillment are necessary in one's day to day life and no suicide prevention intervention can be effective in a general context where the person perceives that he has a low quality of life. Long-term intervention should focus on the improvement of well-being and of people’s quality of life. The effects of these interventions will also allow the reduction of long-term suicide risk.