Understand and prevent suicide in persons with an I/DD: lessons learned from a collaborative research program

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ABOUT THE TEAM
• Cécile Bardon, Diane Morin and the team

• CRISE (Centre for Research and Intervention on Suicide, Ethical Issues and End of Life Practices)

• Chaire DI-TC

• Institut de recherche DITSA

• Université du Québec à Montréal
• Province of Québec
• Montréal
• French-speaking Canadians
• Research programme
  – Financed by Canada and Québec public funding agencies
  – since 2013 and ongoing
  – 5 research projects

• Collaborative research
  – With rehabilitation services and suicide prevention partners in Québec

• Community psychology approach
Some data on suicidal behaviour in persons with an ID or an ASD

SCOPE AND CHARACTERISTICS OF SUICIDE BEHAVIOURS
### Data on suicidal behaviour in persons with an ID or an ASD

#### ASD

<table>
<thead>
<tr>
<th>Category</th>
<th>Data</th>
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<tbody>
<tr>
<td>Suicide</td>
<td>0.17% population (+gen pop, especially women: 3x higher than gen. pop.)</td>
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<tr>
<td>Suicide attempts</td>
<td>15% (Balfe et al., 2010)</td>
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<tr>
<td>Suicide attempts</td>
<td>1-35% (Hedley et al., 2018)</td>
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<tr>
<td>Suicidal ideations</td>
<td>40% (Balfe et al., 2010)</td>
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<td></td>
<td>11-66% (Hedley et al., 2018)</td>
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#### High functioning ASD

<table>
<thead>
<tr>
<th>Category</th>
<th>Data</th>
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<tbody>
<tr>
<td>Suicide</td>
<td></td>
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<tr>
<td>Suicide attempts</td>
<td>35% (Paquette-Smith et al., 2014, Cassidy et al., 2014)</td>
</tr>
<tr>
<td>Suicidal ideations</td>
<td>66% (Cassidy et al., 2014)</td>
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#### ID

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Suicide</td>
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<tr>
<td>Suicide attempts</td>
<td>11% (Lunsky, 2004)</td>
</tr>
<tr>
<td>Suicidal ideations</td>
<td>23% (Lunsky, 2004)</td>
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</tbody>
</table>
Suicidal behaviour in persons with an ID or an ASD

• Thoughts (non observable if not communicated)
  – Thinking about one’s own death when sad
  – Thinking about hiding a knife in one’s bedroom
  – Having suicidal flashes, when seeing oneself dead
  – Thinking about relatives’ reactions if one was dead or disappeared

  – Verbal communications
    • Direct verbal communications: “I want to die”, “I want to kill myself”
    • Indirect verbal communications: “I want to join my grandmother at the cemetery”, “I would like to be dead”, “You would be better off without me”, “I want to go far away and not come back”, “I want to go away with the birds”, “I want to do like… (a person who died by suicide)”
    • Texts or social media communications
• Non-verbal communications
  – Drawings representing a violent act, a suicidal act, tombs, pain, objects to commit suicide, etc.
  – Miming cutting or strangling oneself

• Self-aggressive behaviour without injury
  – Trying to push an object through the skin (branch, spoon, etc.)
  – Swallow non-toxic substances or pills without knowing the level of actual danger
  – Trying to strangle oneself with hands or holding breath
• Self-aggressive behaviour with injury or death
  – Swallow potentially toxic substances or pills
  – Injure oneself by cutting
  – Strangle or hang oneself with towel, belt or rope
  – Jumping from a window or a high place
  – Jumping in front of a vehicle
  – Jumping in the water
PROCESSUS AUDIS
A dynamic process to support clinical decision regarding suicide risk assessment and intervention for persons with an ASD or an ID

**Processus AUDIS-Model**

**Processus AUDIS-Assessment**

1. Identify an individual at risk
2. Short term risk assessment (danger)
3. Long term risk assessment
4. Understand suicide option

**Processus AUDIS-Intervention**

1. Identify an individual at risk
2. Short term risk assessment (danger)
3. Long term risk assessment
4. Understand suicide option
5. Long term risk assessment

- Intervention to ensure safety and reduce danger of a suicide attempt
- Intervention to increase hope and find short term solutions
- Intervention to reduce recurrence of suicidal behaviours, work on patterns and reduce the effect of trigger events
- Intervention to reduce the suicide option
- Crisis intervention

Promotion of social capacities and capacities to express emotions

Long term intervention to reduce risk factors and increase protective factors
Modeling suicide risk

PROCESSUS AUDIS MODEL
Observable indicators of suicide risk

- **Cognitive**: confusion, difficulties concentrating, indecisiveness.
- **Emotional**: mood swings, sadness, anger, irritability, increased worries, fears and insecurities about upcoming situations, anxiety, increased aggressivity, dissatisfaction, disappointment, feelings of incompetence.
- **Behavioural**: changes in behaviours (for better or worse), agitation, agitation or withdrawal, increase in usual disruptive behaviours, increase in substance use or in compulsive behaviours, social isolation, increase in help-seeking behaviours, absenteeism.
- **Somatic**: new or increased physical complaints (digestive, back pain, headaches,...)
- **Psychiatric**: increase in symptoms.
- **Autonomic**: increased problems with sleep, appetite, energy,...
- **Loss of capacities – adaptation difficulties (current)**: stagnation or regression
- **Signs of hopelessness**: negative communications regarding the future, resignation, self-depreciation, treatment interruption, treatment refusal, refusing help.
Long- and short-term protective factors: individual, family, environmental, etc.

- Forseeable major life event
- Unforseeable major life event

Single trigger event – limited in time

- Accumulation of minor events
- A situation of powerlessness becomes chronic
- Mismatch between demands from the environment and the person’s current capabilities

Cumulative trigger events

- Powerlessness
- Perception of imposed dependancy
- Hopelessness

Sudden loss in the person’s equilibrium

Risk of a suicidal episode

Suicide option

Indicators of distress and suicidal behaviour

- Observable changes in:
  - Cognitions
  - Behaviours
  - Emotions
  - Autonomic nervous system functions
  - Competencies or adaptive skills

Or

- Suicidal behaviours
  - Communications
  - Behaviour
  - Suicide plan (method, location, time, access to method)
  - Signs of preparation

(Usual functioning and individual characteristics of the person)
Suicide option

Experiences with death
- Death of someone close or in the environment
  - Exposure to suicidal behaviors in the environment or media
- Hearing about suicide in positive terms in the environment or media

Suicide behavior history
- History of indicators associated with SB
- History of suicidal behavior
- History of self-harm

Understanding and perception of death
- Degree of understanding of death
- Hearing about death in positive terms
  - Concerns about death
- Fascination with death or suicide

Reasons to consider suicide
Examples: stop suffering, stop being sick, feel less bad, feel good, go and meet a loved one, change a situation, be heard, etc.

Or not to consider suicide
Examples: forbidden by religion, it would make a family member sad, etc.

Functions of suicidality in interaction with others
- Having secondary benefits associated with previous suicidal behaviors
- Imitation
Suicide risk assessment

PROCESSUS AUDIS - ASSESSMENT
What is suicide risk assessment useful for?

- Qualify danger of a suicidal act
- Identify presence, nature and intensity of suicidal ideations
- Identify risk and protective factors (including mental health problems)
- Identify trigger events
- Document the person’s and their family’s history of suicidal behaviour
- Describe hopelessness
- Understand intent and impulsivity
- Understand what is happening without prejudice

Guide and support intervention
- Allocate the right services at the right time with the right intensity
Issues in suicide risk assessment

- Danger and lethality of considered suicide method
- Self-mutilation and its interaction with suicide
- Importance of clinical judgment when direct verbal communications are difficult
- Tools will never replace clinical judgment, they aim to support it
Suicide risk assessment should be understood in a long-term and systemic perspective

Processus AUDIS - Assessment

1. Identifying an individual at risk

2. Short-term risk assessment

3. Long-term risk assessment

4. Understanding suicide option

During a suicidal crisis

When the person is not in danger, during usual follow-up activities
Methods to gather relevant information for suicide risk assessment

• Use of diverse communications strategies and sources of information
  – Direct open questions
  – Indirect questions
  – Visual support (drawings, pictograms,...)
  – Observations
  – Activities

• Attitude
  – Caring, warm, reassuring, patient, welcoming
  – Adapt to the person’s emotional level – take their understanding of emotions into consideration – adapt to intensity of crisis

• Validate communication and help seeking

• Reassure the person
Facilitators to exploring suicidal behaviours

- Adjust to cognitive and social capacities
- Ask unequivocal and clear questions
- Adapt language to the person’s capacities
- Start from what the person does and understands (their own words)
- Use a neutral tone in the discussion and questions
- Be sensitive to non-verbal indicators (yours and theirs)
- Reassure the person that they will not be punished, that you are trying to understand in order to help
- Remain open in order to understand without diverting the thinking process with too many questions (tolerate silences, be patient)
- Listen to the person’s story from their point of view, encourage them to express their distress
- Use familiar communication strategies
Try to avoid:

- Putting words in the person’s mouth
- Suggesting (ex.: did you think about suicide to stop suffering?)
- Disapproving (ex.: I hope you do not think about suicide)
- Implying (ex.: did you hide this knife to kill yourself?)
- Interrupting the person’s thoughts by asking too many questions
- Interpreting what the person says
- Stigma and guilt (ex.: did you think about the pain people would feel if you died?)
- Too many questions on intent: it may not be the most effective indicator of risk in persons with an ID or ASD
- Give privileges or sanctions because of suicidality
Refusal to collaborate

- Sometimes, when the person calmed down, they may refuse to discuss what happened and will not collaborate to risk assessment
- Multiply / vary information sources
- Observation, talking to relatives, friends and colleagues can complete information
- Establish an environment supporting trust and tolerance to discuss the suicidal crisis

Follow-up

- Wait until the person is calm and safe to come back to the issue of the suicidal crisis
- Address your perspective and express your needs to support the person
Suicide prevention actions and interventions

PROCESSUS AUDIS - INTERVENTION
What is intervention useful for?

– Ensure safety
– Prevent a suicide attempt
– Build hope
– Reduce risk of future suicide attempts
– Strengthen protective factors
– Reduce risk factors
To consider in the context of suicide prevention interventions

• Adapt intervention intensity to the actual level of danger and risk

• Do not ignore suicidal behaviours

• Do not overreact

• Do not reinforce suicidal behaviour by inadequate intervention (misplaced increase in attention, positive side effects, overreaction)

• Adapt intervention to language, cognitive, affective capacities

• Use also non-verbal interventions
General structure of Processus AUDIS-Intervention

1. Identify an individual at risk
2. Short term risk assessment (danger)
3. Long term risk assessment
4. Understand suicide option

Intervention to ensure safety and reduce danger of a suicide attempt

Crisis intervention

Intervention to increase hope and find short term solutions

Promotion of social capacities and capacities to express emotions

Intervention to reduce recurrence of suicidal behaviours, work on patterns and reduce the effect of trigger events

Long term intervention to reduce risk factors and increase protective factors

Intervention to reduce the suicide option
General recommendations for intervention and applying *Processus AUDIS-Intervention*

- Intervention objectives must be aligned with assessment results
- Suicide prevention activities should be imbedded within usual care routines
- Various activities should be combined within a strategy
- General care and support practices for persons with IDD can include suicide prevention strategies
CONCLUSION
• Talking about suicide in the right way will not make a person suicidal

• Instruments and tools are here to support clinical judgment and processes, not replace them

• Never work alone with a suicidal person
Thank you

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