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

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

- Suicide
  - 0.17% population (+gen pop, especially women: 3x higher than gen. pop.)
- Suicide attempts
  - 15% (Balfe et al., 2010)
  - 1-35% (Hedley et al., 2018)
- Suicidal ideations
  - 40% (Balfe et al., 2010)
  - 11-66% (Hedley et al., 2018)

High functionning ASD

- Suicide
- Suicide attempts
  - 35% (Paquette-Smith et al., 2014, Cassidy et al., 2014)
- Suicidal ideations
  - 66% (Cassidy et al., 2014)

ID

- Suicide
- Suicide attempts
  - 11% (Lunsky, 2004)
- Suicidal ideations
  - 23% (Lunsky, 2004)

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

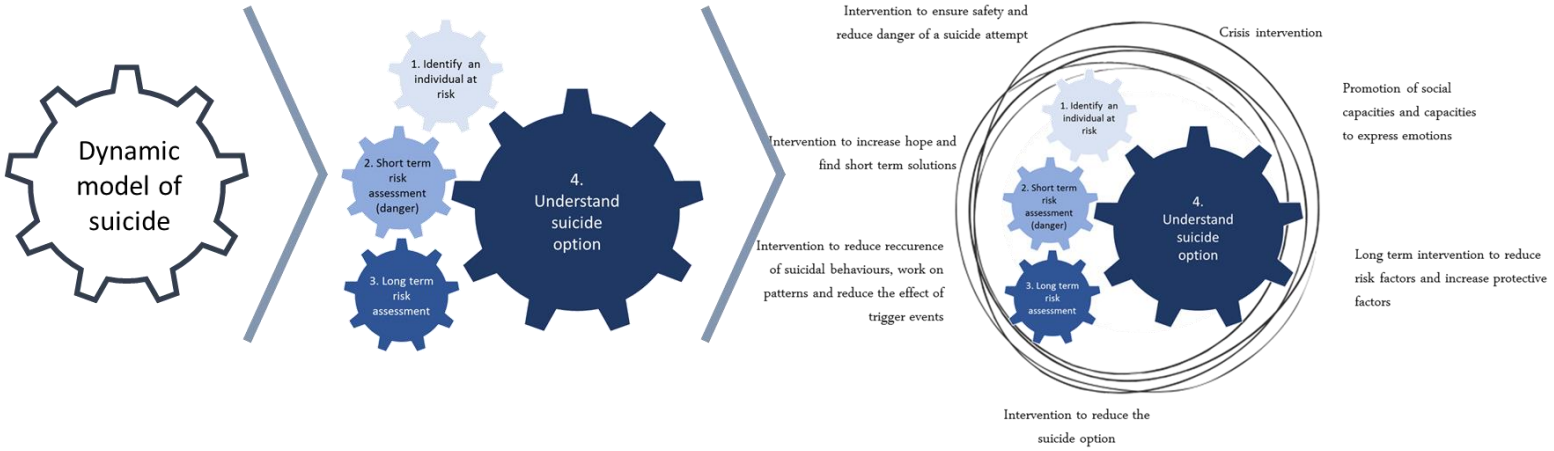
- Self-aggressive behaviour without injury
  - Trying to push an object through the skin (branch, spoon, etc.)
  - Swallow non-toxic substances or pills without knowing the level of actual danger
  - Trying to strangle oneself with hands or holding breath

- 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* *Processus AUDIS-Intervention*

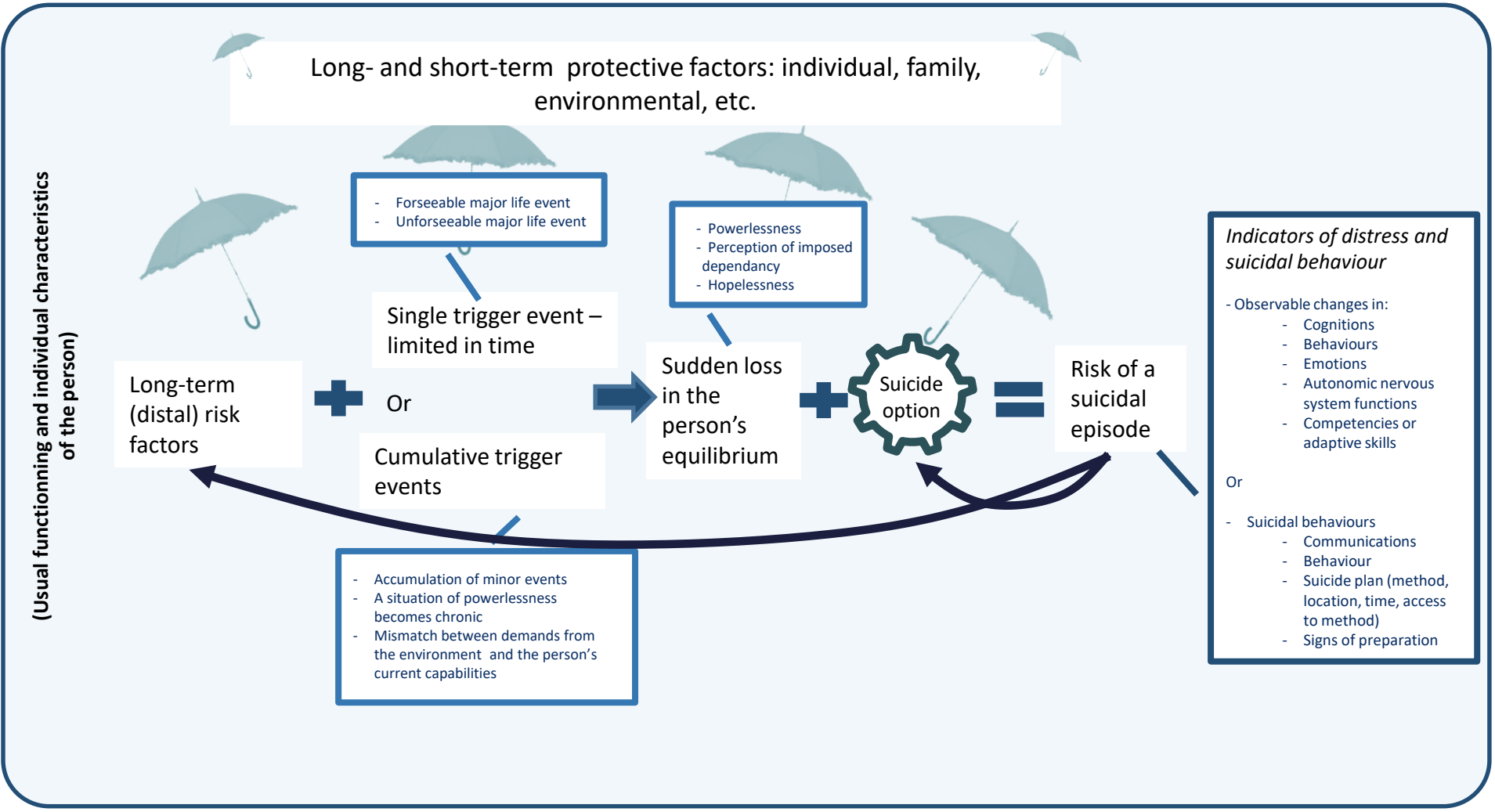


Modeling suicide risk

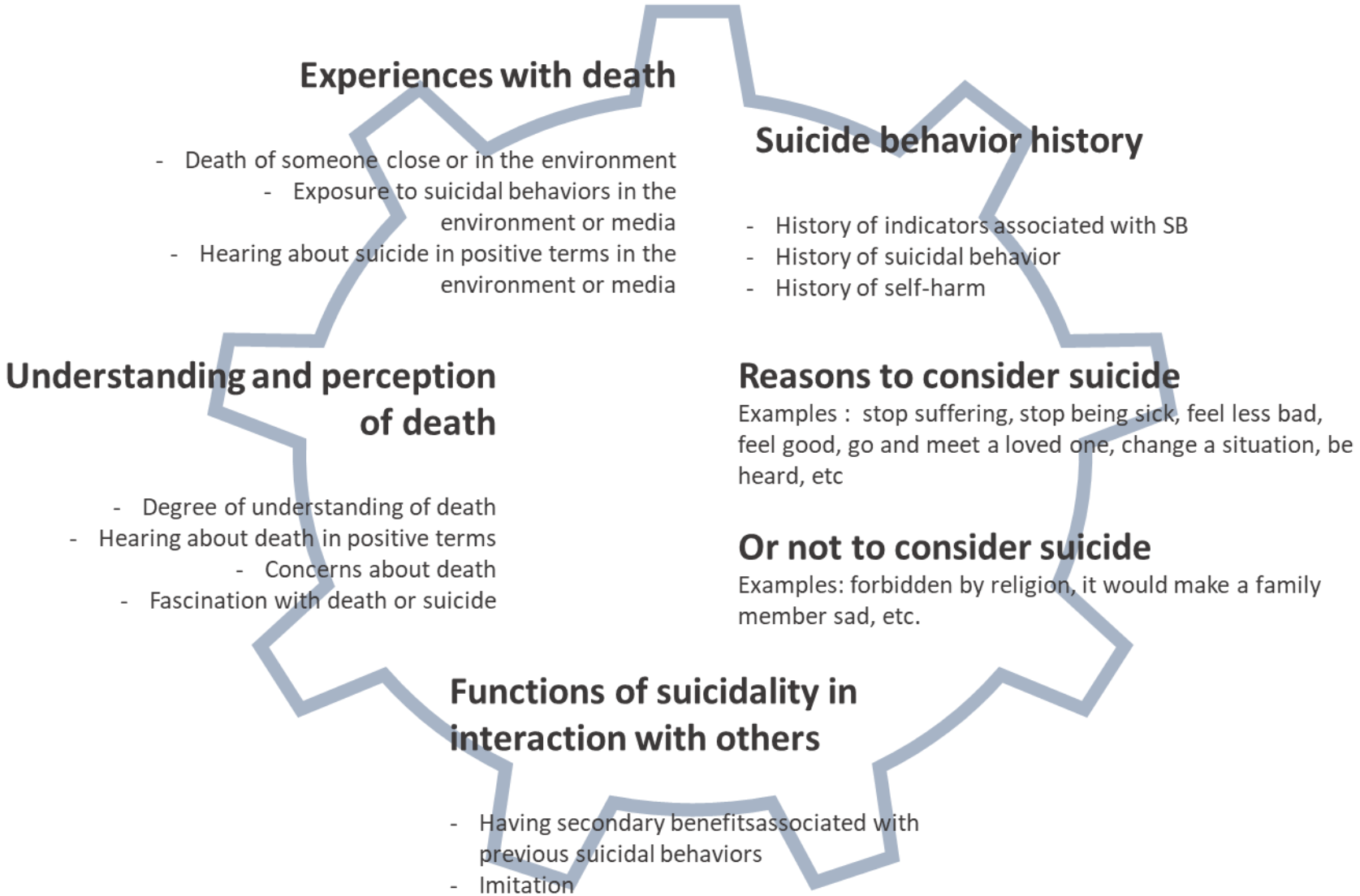
PROCESSUS AUDIS MODEL

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.
(Usual functionning and individual characteristics of the person)
- Forseeable major life event
- Unforseeable major life event
Single trigger event – limited in time
Long-term (distal) risk factors
Or
Cumulative trigger events
- Accumulation of minor events
- A situation of powerlessness becomes chronic
- Mismatch between demands from the environment and the person's current capabilities
- Powerlessness
- Perception of imposed dependancy
- Hopelessness
Sudden loss in the person's equilibrium
Suicide option
Risk of a suicidal episode
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

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 benefitsassociated 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

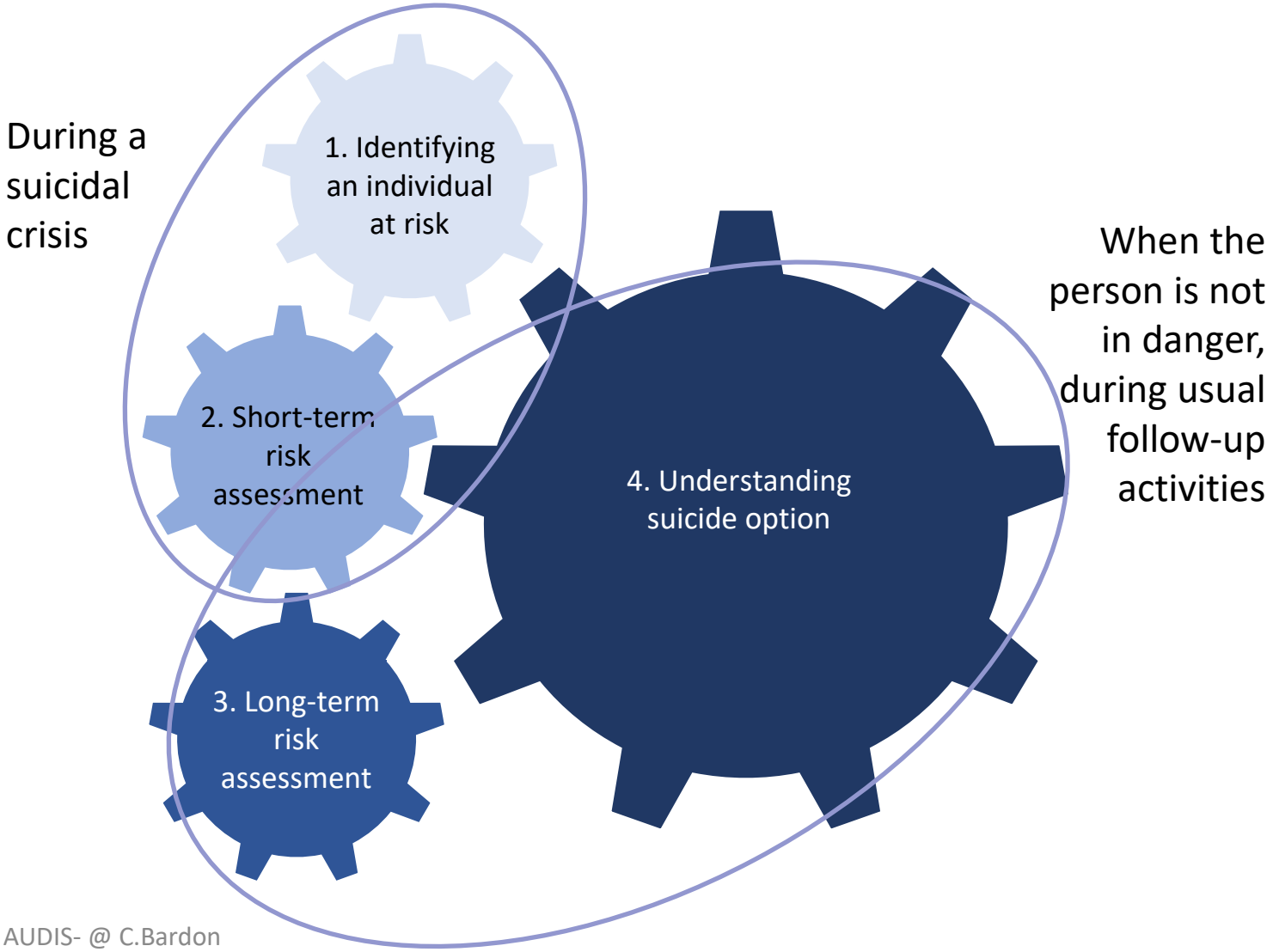
- Guide and support intervention
  - Allocate the right services at the right time with the right intensity

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



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

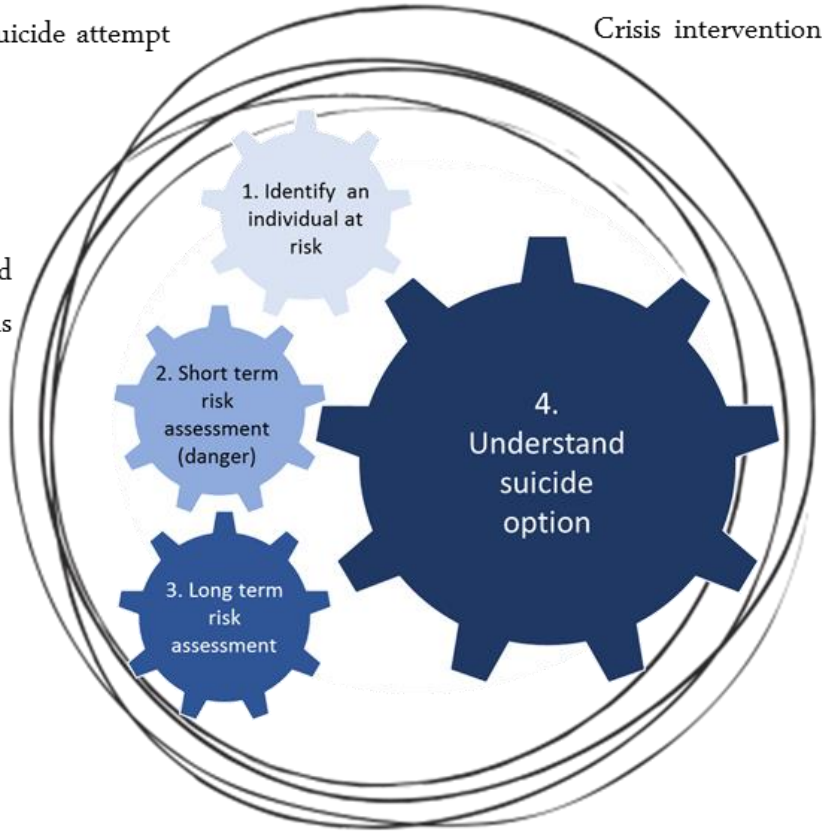
What is intervention useful for?

- 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 P*rocessus AUDIS-Intervention*



Intervention to ensure safety and reduce danger of a suicide attempt

Crisis intervention

Promotion of social capacities and capacities to express emotions

Intervention to increase hope and find short term solutions

Intervention to reduce reccurence 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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