Section 3 - Managing the Suicidal Episode - Suicide Prevention Plan-Episode (SPP-E)

Once the screening process is completed and it is recognized that the person is experiencing distress with MAAS, a full analysis of the current situation, including an assessment of the danger of attempting suicide, and intervention to manage the suicidal episode can be made. This management of the suicidal episode can be completed by the same person who did the screening if properly trained and equipped, or by a different professional. However, it must be done very quickly after the screening in order to ensure the safety of the person and his or her family and friends, and because the intensity of the distress and of the suicidality can vary very quickly.

General structure of the suicidal episode management process

The process for managing the suicidal episode is based on the structure below:

Processus AUDIS — Autisme, Déficience Intellectuelle, Suicide

Managing the suicidal episode- Suicide prevention plan -Episode (PPS-E)

When? Once a person raises concern regarding a suicidal risk

2. Estimate the danger level

Name, last name :	PPS-E date :
Name of the person managing the suicidal episode:	Relationship with person :

Information to collect: Indicators on which to base your **clinical judgment** about the suicidal episode and risk of an attempt.
Proximal factors that may increase danger or be protective in the current situation

Episode risk factors:

- History of MAAS (which ones? When?), suicidal behaviours or death, by suicide or otherwise, in the environment (less than 1 year), level of impulsivity/aggressiveness, mental health disorders and associated issues (**behavioural disorders**, ADHD, etc..), type and level of ID and ASD, negative interpersonal relationships or isolation, risk-taking behaviours or injury proneness, current state of disorganization, current state of intoxication, hopelessness, exasperation, discouragement (short, mid-term), planning ability (generally and in relation to suicide behaviour)

Episode protective factors:

- Varied options for expression (needs, emotions, frustrations, asking for help), and problem solving, presence of support during predictable or stressful events, reasons for living, ambivalence in relation to suicide, social support

Critical moments/ trigger events related to the current MAAS episode:

- Recurring situation of powerlessness, accumulation of apparently minor events, major predictable events, major unpredictable emotional events

Environmental demands

- Mismatch between the person's current capacities and the environmental demands

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

Observer — Décider — Agir

Observe: Collected information
Source: Questions to person, observations, questions to professionals or close persons, person's file

Decide: Decisions resulting from the danger assessment process

- Is there a foreseeable danger of an attempt if the person is left alone?
- Is there a foreseeable danger of an attempt within the next few days?
- Does the person have serious suicidal ideations?
- Could the situation change quickly for the person?

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

Ensure security
Reduce risk of an attempt
Close monitoring
Increase hope
Find solutions to current problems
Take (MAAS) seriously, do not trivialise or minimise

Concluding the process of managing the suicidal episode:
Ensuring that the person understands and feels comfortable with the conclusions reached by the intervention process
Check with the person on how they feel about their suicidal ideations, on the changes made and with the action plan
-The person's ease with the action plan (including the solutions), their willingness and engagement with the action plan, their ability to put the plan into action, help them to put the plan into action (how to help, who will do what? When?), critical moments to monitor in the next hours, days, weeks, status of suicidal ideations and suicide plan
Verify the potential effects of having addressed the subject of MAAS
-Check how the person feels after having talked about their MAAS, explore what was helpful and what made them uncomfortable, support and **intervene with** the person if they are having difficulties with the discussion on suicide, reinforce protective factors, emphasize effective coping strategies, validate help seeking, emphasize strengths and qualities, remind of reasons for living, indicate that you are happy that the person no longer thinks (or less so) of suicide in this moment, that this is positive for them.

Objectives of managing the suicidal episode

As described in Table 5, the objectives are twofold and complementary: to assess and to intervene.

Table 5 - Objectives of suicidal episode management

Assessing the danger of suicide (danger assessment)	Intervening during the suicidal episode
▪ Qualifying the danger of a suicidal act ▪ Identifying the presence/nature/intensity of suicidal ideations ▪ Identifying risk and protective factors ▪ Identifying triggers ▪ Documenting individual and family history of suicidal behaviour ▪ Describing the level of despair ▪ Understanding the person's impulsivity ▪ Understanding what is happening to the person with preconceived ideas ▪ **Directing the intervention (allocating the right servi the right time with the right intensity)**	▪ Ensuring security ▪ Preventing the act ▪ Strengthening hope ▪ Decreasing the risk of future suicidal act ▪ Strengthening protective factors ▪ Reducing risk factors

Observe: Sources of information and indicators for assessing danger during a suicidal episode (danger assessment)

The relative weight of the various factors observed varies according to the level of ID or ASD, the individual's life history, his or her cognitive, social and emotional abilities, and his or her living environment. This relative weight is established by the counsellor making the assessment based on his or her clinical judgement and knowledge of the person's usual functioning. The suicidal episode management process is intended to support the exploration of factors associated with the development of suicidal ideation and danger in order to make an intervention of adequate intensity to ensure the person's safety.

In addition, it is important to take into account that the decision made about the danger is valid in the shorter or longer term, depending on the situation. A danger assessment made at a given time is no longer valid when conditions change for the person, for example, or after an intervention has been put in place.

Beyond the short-term danger of attempting suicide, this stage also allows for an assessment of the form and intensity of suicidal ideation. It is important to understand what may cause suicidal thoughts and to implement appropriate interventions. Suicide

prevention is not limited to preventing the transition to the suicidal act. Reducing suicidal thought and distress must be part of the goals of intervention.

We suggest some clues to observe in order to carry out the danger assessment and the analysis of the suicidal episode.

Information to be collected	Description and instructions
Risk Factors	
▪ History of MAAS (which ones? When?) ▪ Suicidal behaviour or death, by suicide or not, in the entourage (less than 1 year) ▪ Level of impulsivity/aggressiveness ▪ Mental disorders and associated disorders (SBD, ADHD, etc.) ▪ Type and levels of ID and ASD ▪ Negative interpersonal relationships or isolation. ▪ Risk-taking or injuries behaviours. ▪ Current state of disorganization. ▪ Current state of intoxication ▪ Hopelessness, exasperation, discouragement (short, medium term) ▪ Ability to plan (in general and the suicidal gesture)	These risk factors are used to supplement the information gathered during the identification process. They are essential for estimating dangerousness and supplement the information on elements of suicide planning, which are important but insufficient for clinical decision-making, especially since planning is often very vague for people with IDs or ASDs. They make it possible to target the areas of vulnerability to be considered for establishing an action plan, ensuring safety, and for short-, medium-, and long-term follow up
Protective Factors	
▪ Varied options for expression (needs, emotions, frustrations, asking for help), and problem solving. ▪ Presence of support during foreseeable events or events that lead to increased stress. ▪ Reasons for living ▪ Ambivalence about suicide ▪ Social support	Protective factors are levers of intervention. The absence of protective factors increases risk. The absence of certain risk factors can be considered protective, but there must also be positive protective factors, such as the presence of reasons for living clearly identified by the person, the bond of trust, the presence of a responsible person who is aware of suicidal ideation. Protective factors are built into the plan of short-term action.
Triggers and critical moments	
Chronicisation of a situation of powerlessness: increased reactivity to a situation in which the person has an emotional stake, autonomy or self-esteem.	This type of critical moment was identified in the study as being more often present during suicidal episodes in individuals with ID or ASD. They may or may not be present in a particular case. A critical moment observed once in a suicidal episode may not be present during a subsequent episode. Critical moments can be identified and anticipated for prevention purposes. There are other types of critical moments than those mentioned here.
Accumulation of events (even seemingly minor ones): failures in socialization, hindrance to freedom, mourning or loss of objects.	
Foreseeable major events: Changes, annual recurring events.	
Unexpected major emotional events (bereavement, conflict, rejection episode)	

Information to be collected	Description and instructions
Inadequacy between the person's current abilities and the demands of the environment.	Note here the changes in the person's functioning in relation to the demands of the environments he or she frequents: either 1) he or she is no longer able to do things that he or she could do before, or 2) he or she is bored or experiences lower self-esteem because the requirements are too low.
Episode impact	
Impact of the suicidal episode or MAAS on the person's activities, cognitions, environment, loved ones and relationships.	Note here what has changed in the person's life routine or relationships as a result of MAAS, either positively or negatively. From a functional behavioural assessment perspective, the "consequence" component of the ABC sequence is explored here.

Decide: Decision following danger assessment

The analysis of the episode and the assessment of the danger of suicide is based on all the information gathered in steps 1 and 2. It is based on the clinical judgment of the practitioners, taking into account the person's abilities, their level of cooperation to ensure their safety and the abilities of their environment to protect them.

The clinical decision may be based on the following questions:

- Is there a danger that the person will attempt suicide if left alone?
- Is there a danger of suicide attempt in the next few days?
- Does the person have serious suicidal thoughts?
- Can the situation change quickly for the person?

Act: Intervention to be implemented following the assessment to manage the suicidal episode.

Answers to the assessment questions above make it possible to evaluate the person's needs and to decide on an intervention plan whose intensity is adapted to the person's needs and characteristics. The general objectives of intervention at this stage are described in Figure 6.

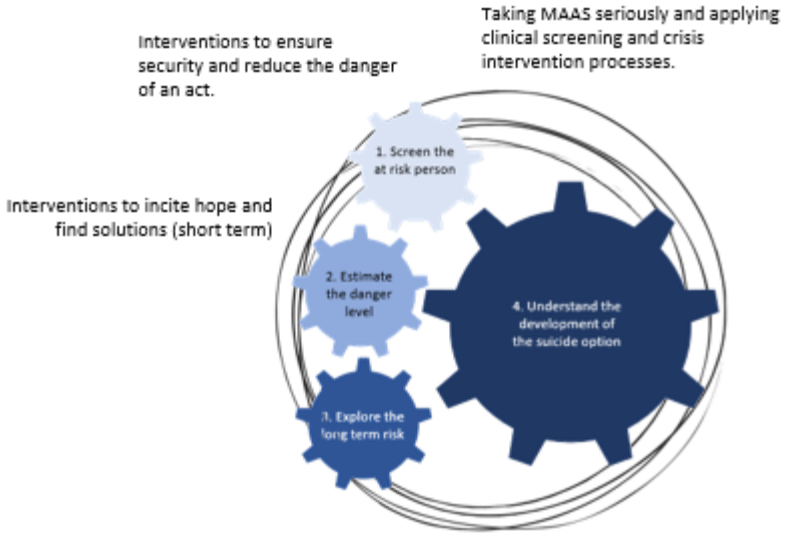


Figure 6 - Intervention objectives for managing the suicidal episode

Concrete tools for intervention are described in section Intervention Tools for Managing the Suicidal Episode.

Adequately conclude the process of managing the suicidal episode

The checklist described below can help adequately conclude the process of managing the episode (assessment and intervention).

- Make sure that the person understands and feels comfortable with the conclusions of the assessment and the action plan put in place. **Check with the person how he or she feels about his or her suicidal thoughts**, the changes that have taken place, the action plan, etc.

- Check: the person's comfort with the action plan (which includes solutions), the person's willingness and mobilization in relation to the action plan (collaboration), the person's ability to implement the action plan, the help to be given to the person to implement the action plan (how to help, who will do what? When?).

- Check: the critical moments to be monitored in the following hours, days, weeks, the status of suicidal ideation and the suicidal plan at the end of the assessment process. The danger of committing suicide should be re-evaluated at the end of the danger assessment process. The danger may have changed

during the encounter and it is important to keep track of this change so that future interventions can be informed.

- Finally, the following should be checked with the person:
  - Verify the potential effects of having addressed issues related to MAAS
  - Check how the person feels about talking about their MAAS.
  - Explore what helped and what may have made the person uncomfortable.
  - Reframe if the person is having difficulty with the suicide discussion.
  - Reinforce protective factors, highlight good coping strategies, validate the request for help, highlight strengths and qualities, remind the person of reasons for living.
  - Indicate that you are happy that the person is no longer (or less) thinking about suicide right now, that it is a good thing for him or her.

Intervention tools for managing the suicidal episode

The following intervention tools can be used as is or adapted according to the person's needs and abilities. They are presented in the order shown in Figure 7. Interventions in black are in the workbook and interventions in grey are generally available in the clinical settings. These intervention tools are suggestions. You can develop new ones according to your needs. However, it is important that each intervention clearly addresses a specific objective that is derived from the episode analysis and danger assessment.

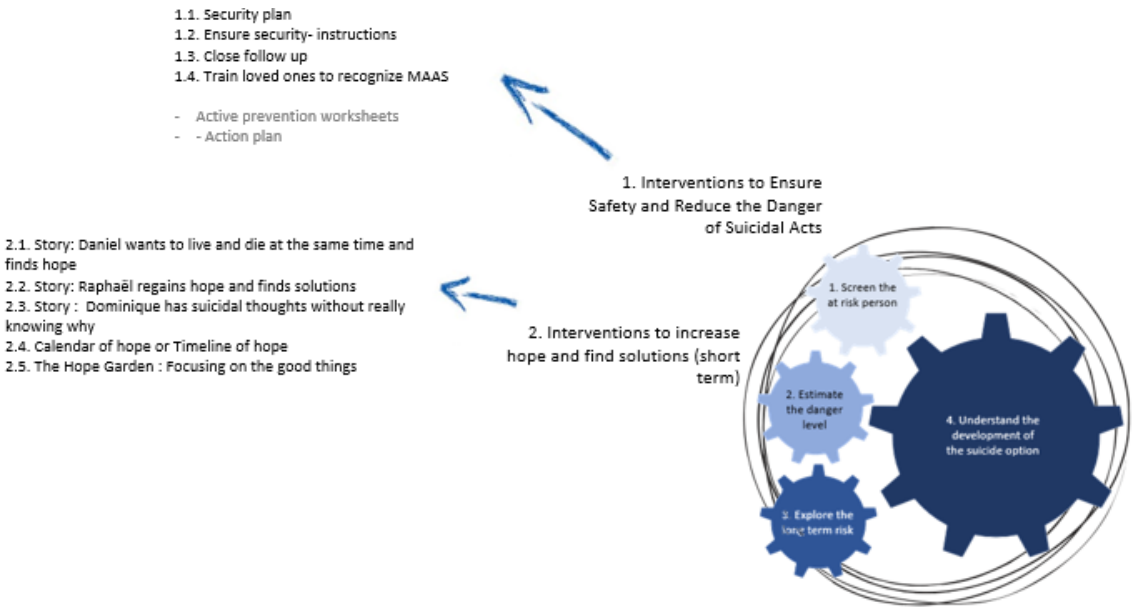


Figure 7 - Suicide Management Intervention

1. Interventions to Ensure Safety and Reduce the Danger of Suicidal Acts

This first series of interventions is used during a suicidal episode or when the person worries his or her loved ones or caregivers, following a screening and danger assessment.

1.1 Safety plan for a person with suicide-related manifestations (MAAS)

Objectives

- To ensure the safety of the person with MAAS to avoid a suicidal act during a suicidal episode;
- Empowering the person to take action and seek appropriate help during episodes of distress in order to reduce the onset of suicidal thoughts or the risk of attempting suicide.

Justifications/rationale

When a person is suicidal (ideas or behaviours), he or she may have difficulty using strategies to reduce tension or ease the crisis. A safety plan allows the person to use strategies that he or she knows will work for him or her to deal with the situation, without immediately resorting to high-intensity intervention. The safety plan can help the person regain control of the crisis process by giving them the opportunity to apply solutions pre-identified with them and within their reach.

A person with ID or ASD may, however, have more difficulty than another person in assessing his or her emotional state. He or she may not know *when* or *how* to use his or her safety plan alone.

The safety plan includes solutions developed in collaboration with the individual. This plan proposes actions that are graduated according to the intensity of support needed to defuse the crisis process. At one end of the continuum are actions that the person can do alone. If these actions are insufficient, we find at the other end of the continuum strategies such as calling on specialized services. The inclusion of this solution graduation strategy is particularly relevant for people who tend to call 9-1-1 immediately when they are in crisis. In a safety plan, the person is encouraged not to use a higher intensity strategy until they have tried the previous level. The goal is to help the person develop a sense of empowerment and confidence in themselves and their personal coping and problem-solving mechanisms, while reducing unnecessary use of emergency services.

The plan is implemented in collaboration with the stakeholders and services usually involved with the person. This plan requires good communication between the different actors involved in order to maintain its optimal use over time. For example, in Lea's plan, she must call her sister before communicating with her counsellor. If Lea has

not called her sister, the counsellor can encourage her to do so, accompany her while she calls, and then intervene if her sister is not available at that time.

In its most classic form, the security plan is aimed at a relatively autonomous clientele, who may be able to recognize the intensity of a crisis or disorganization. The person can also be guided by the counsellor through the various stages of his or her safety plan. In the case of less autonomous people, each step of the safety plan can be deployed with the support of a counsellor or a relative.

The safety plan falls into the same category of tools as the active prevention sheets. These tools reflect a progression in the intensity of interventions and include a set of actions that the person can do alone in order to regain an acceptable level of well-being. The safety plan is specifically aimed at preventing MAAS, by applying interventions of increasing intensity to reduce the risk of MAAS.

Intervention Process

The security plan is developed with the individual and includes the identification of several components which are:

- The triggers of suicidal episodes and the type of MAAS that the person shows, along with the person's associated emotions and warning signs (e.g., level of agitation, disorganization or confusion).
- The actions the person can take on their own to reduce the effect of the trigger as well as the benefits of using the identified strategies to enhance the person's motivation.
- Actions involving others and the use of outside help (counsellors, family and friends) and key phrases enabling them to understand that the person has suicidal thoughts and needs their help as part of the safety plan.
- The people who will have a role to play in the safety plan. These people should be familiar with the plan and the key phrases that mean the plan is being implemented. They must be equipped to respond to the person and help the person explore the situation for distraction, defusing the crisis or calming down. Everyone's role must be well defined.

Each action identified must be feasible for the individual and clearly planned and described. It can be drawn in a social scenario, written or illustrated with gestures or objects.

It is also possible to include a reminder of what not to do, if the person is able to refer to it. For example, actions that the person has already done that are known to increase the risk of MAAS and reduce the person's ability to feel better can be recorded.

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

It may be important to conduct regular situational exercises with the person to allow them to become familiar with their safety plan and to practice the identified means in order to alleviate suffering.

Illustration of intervention tools

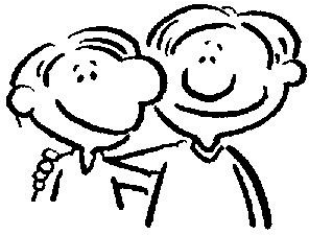
Here is Raphaël's plan (Table 6), an example of a safety plan that a person with an ID or ASD can use alone or with the support of an counsellor.

Table 6 - Raphaël's safety plan

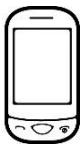
Things that make me think about suicide or make me sad (emotional or behavioural warning indicator that can be linked to a MAAS episode): I'm fighting with someone at school and it makes me unhappy.		
	The actions I can do to stop thinking about suicide and why it is useful for me to do them.	The actions I have to avoid because they still make me think more of suicide.
		
By myself, all alone	• I take three deep breaths and then I do my relaxation exercise. • I draw how I feel. It helps me to feel stronger, to decide for myself. I can be proud of myself.	• Thinking about the fight alone in my room.
Ask my friend for help	I feel miserable. I have been trying to do my relaxation exercises on my own. I still feel unhappy. • I ask my friend for help by saying, “I'm unhappy, can I talk to you to distract myself?” • It makes my friend understand that I need help and he knows how to help me. I feel able to tell my friend what is wrong.	• Being angry because my friend cannot distract me. • Drinking alcohol • Staying alone
Asking for help from my sister who is not next to me. I call her on the phone	I feel miserable. I tried to talk to my friend. It did not work (he was not available because he was busy, or we played but I still feel unhappy). I still feel unhappy. • I ask my sister for help by calling her on the phone and saying: "I'm unhappy, can I talk to you to discuss what's going on?”	• Yelling at my sister • Yelling at the other people around me.

Asking for help from the counsellor	I feel miserable. I tried to ask my sister for help. It did not work, she did not answer the phone. I still feel unhappy. • I ask the counsellor for help by saying: "I'm unhappy, can I talk to you about what's going on?"	
Asking for help from the crisis centre	I feel miserable. I spoke with my counsellor, but I still feel unhappy. My suicidal thoughts are still there. • I ask for help from the crisis centre by calling (phone number)	
Asking for help from emergency services	I think very hard about killing myself and I tried to do everything in my plan. Nothing works. • I call security with my counsellor or with the crisis centre.	• Calling emergency services alone

Some actions in the safety plan may be more detailed. For example, the act of asking my friend for help in Raphaël's plan may include a simple procedure written on a card, as shown below:

Peter 	Peter's number: 514-333-2211	Sentence to say to Peter: "I'm unhappy, can I talk to you to distract myself?"

A card of the same type can be used for asking for help from the emergency services:

  The crisis centre I can call	Crisis centre number: 514-333-2211	I call with my counsellor Julie

If possible, it may be worthwhile to arrange a visit to the local crisis centre with the person to show them around and explain what the workers are doing there. The person can be familiarized with the intervention procedures and the questions that are asked by counsellors when a person calls on their services. This will give the person a better understanding of what he or she can expect if he or she seeks help from the crisis centre. This visit can also be an opportunity to explore the various ways of contacting the crisis centre (telephone, text message, chat, e-mail, visit), some of which may be more suitable for the person.

Table 7 describes another example of a safety plan. This is Dominique's plan, which has more significant functional limitations. The safety plan is very simple, schematic and visual.

Table 7 - Dominique's Safety Plan

I want to leave, I feel sad, I hit myself...	
I'm stopping what I'm doing.	
I give the counsellor my distress token.	

A safety plan can also be developed to prevent a suicidal episode. It can then take a form more similar to a de-escalation sheet in which alarm signals and levels of disorganization are identified, along with the means to be put in place to defuse the agitation or distress.

1.2 Ensuring the safety of a person in danger

Objectives

- Ensuring the immediate physical safety of the person and others.
- Preventing an imminent suicidal act if verbal interventions are not sufficient to reduce the danger (prevent) or managing a person to reduce the effects of a suicide attempt (treat).

Justifications/rationale

This type of intervention should only be done when the life of the person appears to be in danger within a short period of time. Its intensity depends on the level of danger and therefore on the assessment.

An intervention to ensure safety must be followed by interventions to bring hope, to reduce the risk of recurrence and secondary benefits, and to reduce the suicide option.

There may be a gradation of intensity in interventions to ensure safety. It is important to adapt the intensity of the intervention to the safety needs of the person and not to overreact because of a high level of stress from the practitioners or loved ones. Overreacting could discourage the person to talk about their suicidal ideations and planning and seek help in the future.

The intervention can be based on a good knowledge of the person, his or her usual level of impulsivity, current impulsivity, and the environment's ability to physically control the person.

Removing the means the person has thought of to kill himself or herself is a good strategy for preventing a suicide attempt, since suicidal people often conceptualize a means in their plan. The loss of access to this means provides an opportunity to intervene to reduce distress and risk.

Intervention Process

Removing dangerous objects

The removal of dangerous objects can serve two purposes:

- Preventing a life-threatening gesture in the case where suicidal thoughts are accompanied by sufficiently elaborate planning according to the danger assessment (ex.: the person has hidden a knife in his room and wants to cut himself with it).
- Reduce the risk of a suicidal act when the person presents a high level of danger of acting out, regardless of the actual lethality of the act planned, defuse the tension and open up the space for an intervention focused on reducing the risk of committing suicide, strengthening hope and problem solving (e.g., a person thinks that vitamin pills can be used to commit suicide. It then becomes important to remove them from the immediate environment.)

The mere presence of suicidal ideation without a thorough danger assessment (IDAS-Screening during a suicidal episode) and risk (IDAS-evaluation of suicide risk) is not sufficient to remove objects considered dangerous from the person's environment. The removal of dangerous objects from the person's environment must be done carefully and ideally, in collaboration with the person. It is important to understand what the person considers to be dangerous before removing objects, and not to limit oneself to what practitioners or relatives consider as such.

The removal of objects considered dangerous can be experienced as punishment by the person with little control over his or her life and may reduce the likelihood that he or she will talk about his or her suicidal ideas and plans in the future. If the reaction of family members or caregivers seems "excessive" (disproportionate to the perceived danger to the person), the removal of dangerous objects may be counterproductive and should not be a systematic intervention.

Withdrawal of the means (regardless of the level of lethality) contemplated or used by the person must be immediate and accompanied by an explanation that the person is important, that we are worried about them, that we do not want them to get hurt, that we want to be able to take the time we need to talk, to find solutions to problems and ways that would make the person feel better. A practitioner might say, “My job is to do everything I can to keep you safe and removing dangerous objects is part of that.” Or: "I will gladly return (the object in question) to you as soon as you feel better. I just want to make sure you are safe now.”

The removal of dangerous or potentially dangerous objects that are not related to an ongoing or planned suicide attempt should not be carried out without a prior danger assessment and exploration of the means envisaged by the person. If the objects have not been identified during the assessment, removing them poses the risk of giving the idea of a more dangerous means of suicide. For example, if a person says that he or she is thinking about killing himself or herself and caregivers remove his or her shoelaces, robe belt and trouser belt, he or she may identify strangulation as a good way to kill himself or herself.

Returning objects that have been removed from the person because of concern about the danger of committing suicide should not be done before a follow-up assessment of the danger. Returning objects should be presented and experienced as a clinical success. The person has managed to get through the difficult time and this should be primarily an opportunity to recall what has been put in place to help the person to no longer feel suicidal, to remind them of the available resources they can use and to review the actions they need to take to seek help.

When a person refuses to give an object that is considered dangerous by practitioners **and** presents a high level of immediate or imminent danger based on the danger assessment, the situation can quickly become complex. It is important here to be familiar with the person, the way he or she disorganizes, his or her triggers, warning signs and calming elements. Calling the paramedics may be the most appropriate option. On the other hand, an approach using the basic principles of Dialectical Behavioural Therapy can help defuse the dangerous situation:

- **Validation**: this consists in welcoming the person without judgment; it is necessary to reflect and recognize the fact that the person's behaviour, feelings and thoughts are perfectly logical and normal under the circumstances.

- **Orientation**: this consists in describing what we understand about the person's situation, what we would like to do and why we think it could help, in clear terms that respect his or her autonomy.
- **Commitment**: this consists in engaging with the person in an action aimed at improving the situation and forming part of the plan developed from the orientation phase.

Here is an example that uses these basic principles. Jo is locked in his room with a belt that the counsellor tried to take off earlier when he said he wanted to kill himself. He refuses to come out and talk, but the practitioner hears him walking back and forth and he is agitated. The practitioner may begin by taking a few deep breaths herself to take time to refocus, calm down for a moment, regain control over her voice and her own emotions. She can then talk to Jo to validate what he is experiencing by saying:

> "Jo, I can see you're angry and unhappy. You've tried a lot of different ways to solve the problem and it didn't work. It's okay to be angry. It's okay. I understand that."

She can then give a guidance to her words, saying, for example:

> "I understand you had a fight with your mother and you're sad. You want to stop fighting with her. We can talk about it together if you want, later. Also, you want us to leave you alone in your room, because you're angry and sad. I agree with you. I want to leave you alone, but I want you to be safe, because it's important that you are safe. So I suggest we open your door. I'm not going in, you're not going out, but we just leave the door open so I can make sure you are safe. I won't take your belt and you open the door."

The counsellor may subsequently seek Jo's commitment. It could be expressed as follows:

> "What do you think, shall we do this? I'm doing my part and you're doing yours?"

The important thing is always to validate the source of distress and the person's reaction by giving them an authentic message that they are considered a person in their own right. He or she only reacted as best he or she could, with the means available to him or her, in the situation in which he or she was at the time.

Physical intervention to block a gesture

Physical interventions to prevent a suicidal act are the same as those to prevent self-harm or violence towards others. They must be applied only when the person represents an imminent or immediate physical danger to himself or herself or to others. These interventions must be used in accordance with guidelines developed by the community and must be carried out in a manner that respects the dignity, rights and safety of each person.

They should not be trivialized either. An intervention to ensure safety in a suicidal context does not have the same objective as the same intervention aimed at eliminating undesirable behaviour. It cannot be experienced as a punishment. In fact, physical control must be explained as an intervention aimed at ensuring the safety of the person and it must be a step in the intervention aimed at reducing the danger of acting out, arousing hope and finding solutions to distress.

Transport to hospital

Transportation to hospital should always be a last resort in a suicide prevention intervention. Indeed, this type of intervention has potentially significant consequences for the individual, his or her entourage and the intervention structure:

- Stigma due to being taken away in an ambulance;
- Withdrawal from the usual living environment and confrontation with a potentially anxiety-provoking environment;
- Obtaining a secondary benefit.

The danger varies very quickly in a person. This means that by the time the person arrives at the emergency room and sees a doctor, the danger may have become minimal . It is therefore important that the intervention does not rely solely on transport to hospital and psychiatric intervention in the emergency department.

If the person calls 911 themselves, without consulting family or caregivers, a danger assessment must be made before letting them leave by ambulance (obviously, if they have not already made a life-threatening attempt). However, it may be difficult to reconcile the perspective of the practitioners who regularly work with the person and that of the emergency services responders. Indeed, while the former have knowledge of the person's functioning and usual mode of disorganization,, emergency responders judge the situation based on what they observe when they arrive on the scene. For instance, the person may make comments (including suicide planning) that could be considered worrisome for a practitioner who does not know the person, whereas these comments could be part of a known method of avoiding a constraint.

After a visit to the emergency department and once the sources of distress are known and understood, an intervention can be planned with the person in order to minimize the possible secondary benefits from hospitalization, while also demonstrating to the person that MAAS are taken seriously. If there are secondary benefits from hospitalization, it is also possible to work with hospital staff to identify and understand the nature of these benefits. Involving hospital staff members in this analysis also helps to make them aware of the dynamics surrounding emergency room visits and the risk of developing a pattern of functioning that is harmful to the person in the long term.

It is important to validate the distress experienced by the person by acknowledging and normalizing their emotions. Ex.: "I understand that you don't feel well. This is okay. We'll take care of it and we'll take care of you". However, in the case where a person uses MAAS to negotiate a benefit, it is also crucial to carefully analyze why this person uses MAAS rather than another behavior. This way, we can help the person use emergency and hospital services more appropriately and not for the secondary benefits they might gain.

The post-suicidal episode follow-up tools described in the IDAS-Screening Process or the tools applied during the return to calm in situations encountered in other contexts may be useful for planning the return to the usual living environment after a visit to the emergency department. This return should include discussions about what happened. The person should be encouraged to talk about his or her emotions, thoughts and behaviours. He or she may also have questions about what happened in the hospital. Specific barriers that may have prevented the person from implementing the safety plan that was developed with them should be explored, as well as solutions and ways to do this that could be used next time. If necessary, the person can be encouraged to discuss this again with the navigator.

1.3 Close monitoring after a suicidal episode: Assessing the danger of committing suicide in the hours and days following the initial suicidal episode.

Objectives

The main objective of this intervention is to verify the persistence or disappearance of MAAS after an initial suicidal episode. This close monitoring differs from post-episode follow-ups aimed at adjusting the action plan.

Justifications/rationale

A person who has engaged in suicidal behaviour may present a high level of danger of suicide. Close monitoring allows the evolution of MAAS to be checked over a few hours / days in order to adjust the intensity of protective measures. Close

monitoring is only done with individuals who present a high level of danger and with whom security measures have been put in place.

Intervention Process

The practitioner can use the Close Monitoring Grid below to track MAAS and assess the danger for a few hours, days or weeks after the initial suicidal episode.

The degree of danger can vary rapidly over time and the level and intensity of safety intervention must be adjusted to the level of danger. These regular assessments cease when the multidisciplinary team concludes that the person no longer presents a high degree of danger of a suicidal act. Relatives or community workers may be trained to identify warning signs specific to the person in order to monitor changes in danger following a high-risk suicidal episode.

Close Monitoring Grid

Follow-up with:_____During the period: _____Rhythm of observations:_____

Elements for assessing the degree of danger of a suicidal act during close monitoring	Period 1	Period 2	…	
Types of MAAS present and change observed				
Elements of suicidal planning present and changes observed: means, time, place				
Danger: Access to the mean, lethality of the mean, planning ability				
Proximal risk factors that may increase danger				
Mood (type) E.g.: sad, agitated, anxious, happy, withdrawn...				
Mood stability improvement ↗, Stable→, worsening ↘ The mood variations noted here are global. It is impossible to know if they are directly related to MAAS or not. The goal here is to know to what extent the person regains their usual mood, whatever this usual level is				
Good times and more difficult times during the observation period				
Critical moments identified				
Protective factors				
Adjustment of the safety plan				

1.4 Train family and friends to identify MAAS.

Training people in the entourage of people with ID or ASD to identify suicidal behaviours is an interesting strategy. Indeed, suicidal and suicide-related behaviours occur in people's usual living environments and these environments often feel very helpless to deal with them.

Identification training can be based on the tools used in the screening stage. It allows family members and friends to feel equipped to observe, identify and intervene in the event of suicide-related manifestations (MAAS).

Relatives or friends carrying out a screening can take the first steps to ensure the person's safety, apply a safety plan or contact the person's counsellors, depending on their needs. They can also effectively transmit information about suicidal episodes to caregivers, who can then base their clinical judgment on better information.

2. Interventions to foster hope and find solutions

From a suicide prevention perspective, it is essential to foster hope and find solutions. Interventions that target these objectives are put in place once the danger of committing suicide is no longer as great and imminent for the person. If there is no short-term danger of acting out, or if the screening has not revealed the presence of MAAS in the individual, this type of intervention should be implemented immediately after the screening and danger assessment. Five interventions aimed at increasing hope are presented in this section.

General Instructions for Story-based Interventions

Purpose of using narratives and interventions based on a social scenario structure

The general objective of the stories is to provide support for explanations, psychoeducation or intervention. The stories explain different aspects of the suicidal process and intervention. They describe cognitive and affective processes often observed in individuals with ID or ASD, as well as assessment and intervention strategies that can be applied by practitioners.

Explanation/rationale for the use of this approach

The stories use appropriate vocabulary for people with ID or ASD who are verbal. They are particularly suitable for people with basic knowledge of emotions since they describe emotions. A certain amount of introspection is also necessary since these stories serve as a vehicle to explore the person's own emotions. In the danger assessment process and in the intervention, it is important to use clear, exact and unambiguous terms that everyone agrees on the meaning of. Talking about suicide in a clinical context does not increase a person's risk of suicide, especially if certain principles are followed.

The stories are based on social scenarios and are intended to support the practitioner in explaining, assessing, intervening and discussing with the client. The left-hand column presents the dialogue between a user and a practitioner, and the sequence of the exchanges is indicated by numbering. The right-hand column describes the narrative of the situation and its issues. A specific guide accompanies each story to define its objectives and process.

General intervention Process with stories

It is important to read the story with the client in a calm situation. This tool cannot be used in a crisis situation or when the person is agitated. It is also necessary to contextualize the use of the story (e.g., the person witnessed a suicidal act in his or her living environment) and the objective (e.g., "It is important to explain

what happened, I feel that you are wondering"), while indicating the time reserved for the activity (approximately 15 minutes, if the person expresses himself or herself a lot).

A story is a medium for exchange. It can be adapted to the situation, the needs of the person and the objectives of the intervention. It can be used in a variety of ways. The counsellor can choose to tell what is happening and describe the expressions and emotions of the characters, without necessarily reading the dialogue or the narration. The person can also read the story alone, do a written communication exercise related to the questions asked by the counsellor in the story, draw a picture of how he or she feels, or describe how close he or she feels to the character.

At each step, following the specific instructions for each story, it is important to take every opportunity to question the person about their experience, for example, by asking how similar or different they are from the character, or by asking them about what others have said or done, related to their experience or that of others. Finally, it is important to construct the intervention, whether in written form, orally, or with the help of drawings and symbols. It should be noted that the stories all use the same symbols and images to address concepts related to suicide.

If a person does not have the ability to identify, understand and recognize emotions, adaptations can be made with more schematic scenarios and simpler emotions, depending on the need for intervention.

Answer directing questions about suicide, what it means to commit suicide and how to commit suicide. It is normal for people to be curious and not answering questions can hinder the understanding of the process and potentially increase the danger.

It is also important for people to know the right terms for expressing their suicidal thoughts in order to be understood and helped appropriately.

For each story, the specific clinical accompaniment process is described in the intervention booklet.

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

It may be necessary to discuss the topic of ambivalence, especially with people with rigid cognitions. These people may tend to believe that once you want to die, there can be no change. Ambivalence is a theme that can be used to discuss the reasons for living with people who have suicidal thoughts in order to reinforce the part that wants to live.

Ambivalence is always present in the phases preceding the act and is the main intervention tool used. The story also provides an explanation of ambivalence, in simple and concrete terms, in order to support the counsellors who would have to make the suicidal person understand this concept.

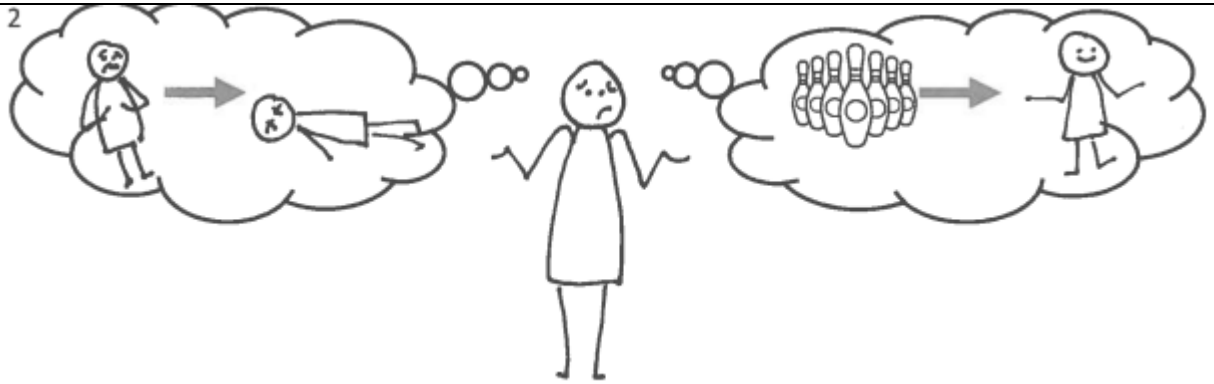
Boxes 1 and 2 describe the situation that led Daniel to have suicidal thoughts and ambivalence. The aim of the intervention here is to identify the triggering factors for MAAS and the proximal reasons for living (thus identifying the ambivalence).

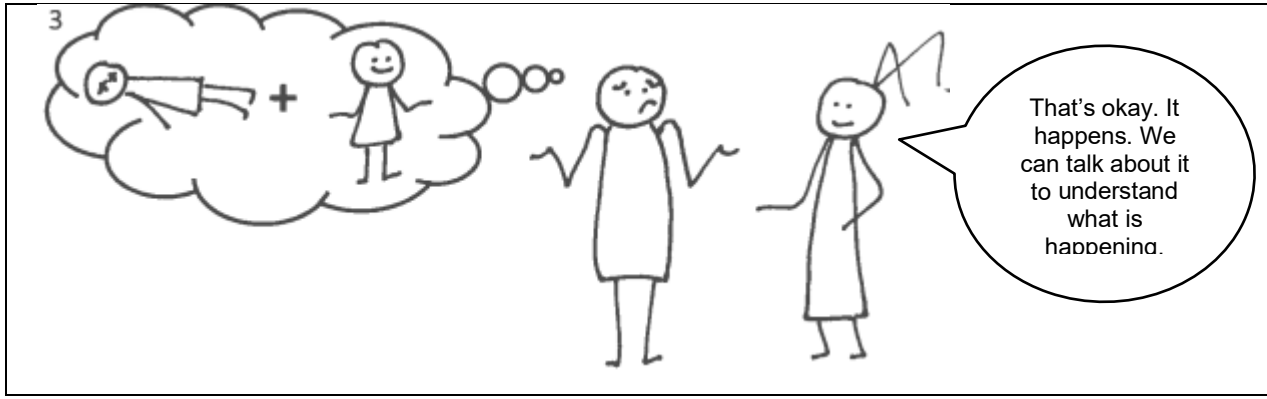
Box 3 illustrates the process of validating communication and the relevance of asking questions when we feel confused or disturbed by events or our thoughts.

Boxes 4 to 9 provide explanations of the different forms ambivalence can take. The intervention aims to identify with the person the ways in which he or she feels confused about his or her MAAS. It also aims to recognize the desires to live and die, their alternation or their simultaneous presence. The intervention helps normalize ambivalence.

Boxes 10 and 11 illustrate how the reasons for living can be explored and how they can be used to increase hope. Reasons for living are used to counterbalance suicidal ideation. The intervention allows the person to discuss his or her own reasons for living, the strategy being to help the person remember them in the event of MAAS. The goal is not to deny suicidal ideation or distress, but to remind the person that life is worth living, by reminding them of their own reasons for living. The intervention must also address the sources of distress in order to reduce the risk of recurrence.

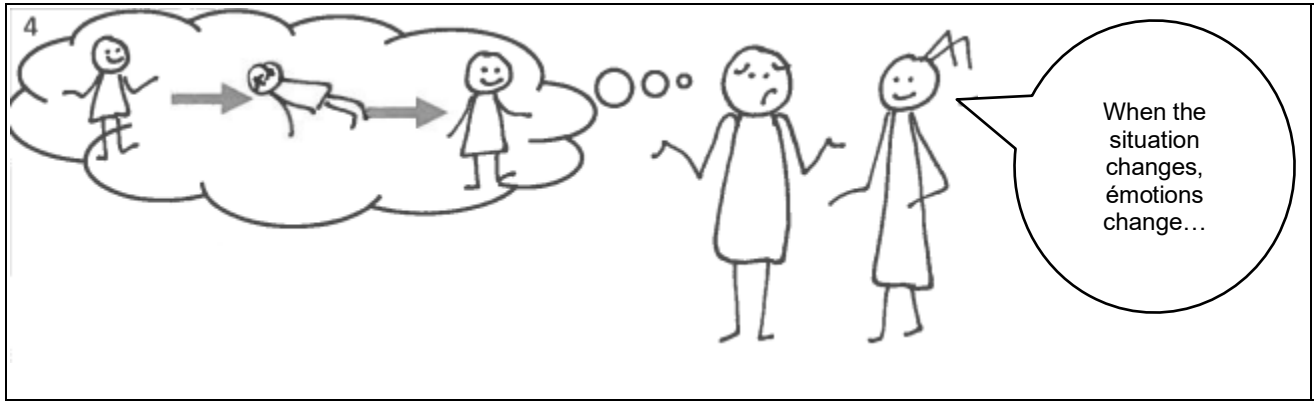
Daniel wants to live and wants to kill himself at the same time and finds hope again.

1 	Daniel had a girlfriend. She doesn't want to talk to him anymore. Daniel is sad.
2 	Daniel feels confused. He thinks about killing himself because he is sad that his girlfriend doesn't talk to him anymore. He also thinks that he wants to go bowling tomorrow. He likes bowling with his friends.



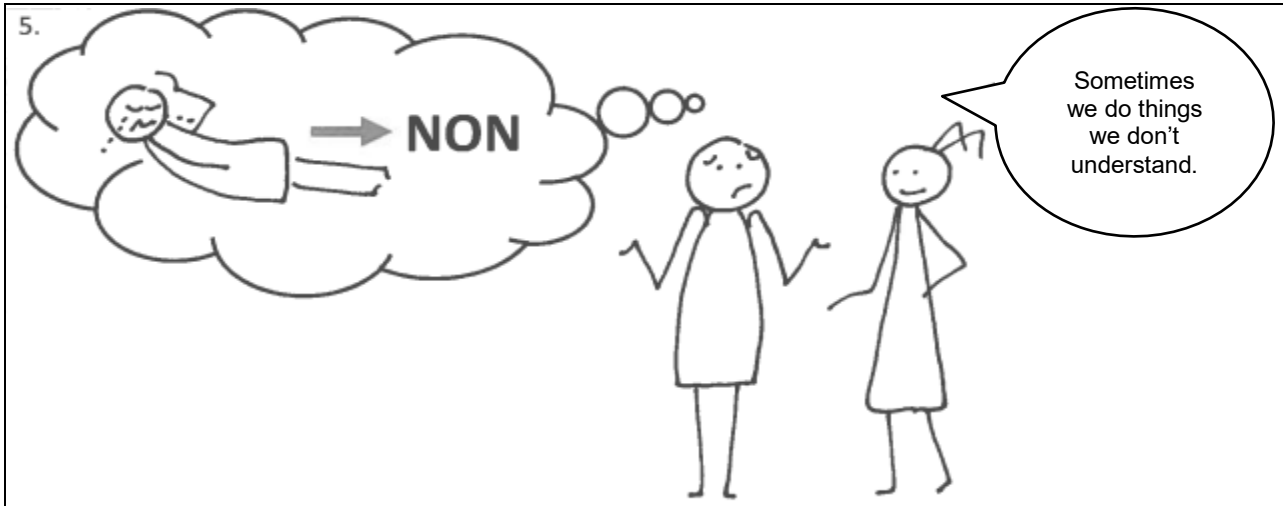
Sometimes, Daniel wants to live and die at the same time. His counselor explains that it's normal to feel like this.

Feeling like this can happen to anyone.



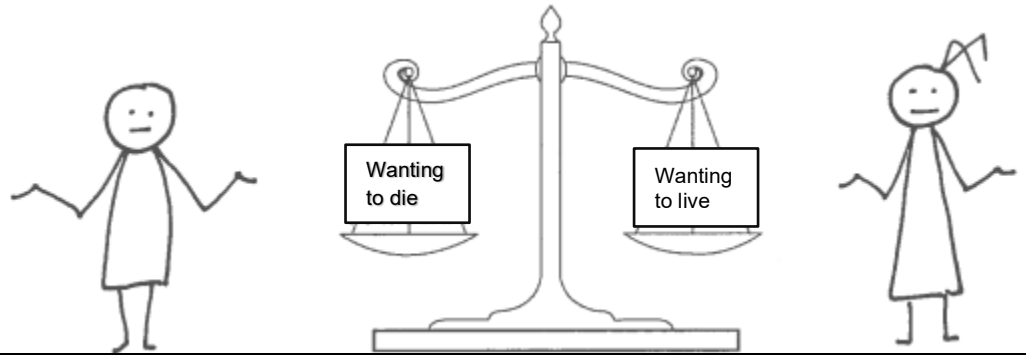
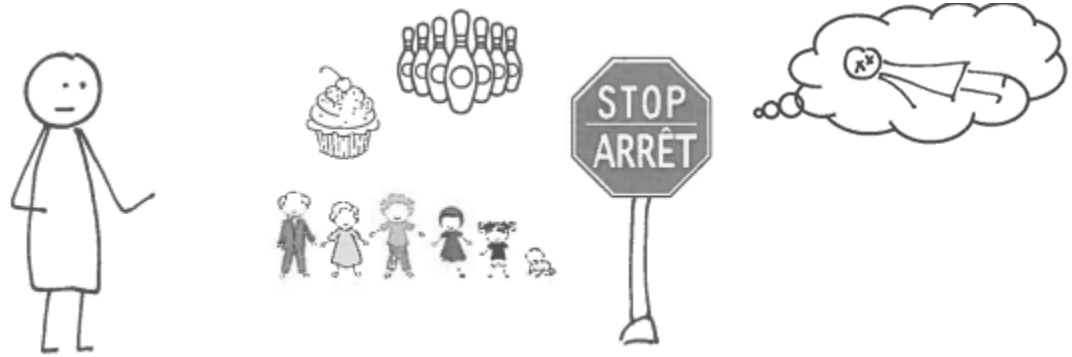
Sometimes Daniel wants to live and later, he wants to die, and after that he wants to live again.

His counselor explains that this can sometimes happen, it's okay.

	One time, Daniel tried to kill himself. But right after, he said that he didn't want to die. He didn't know why he tried to kill himself. His counselor explained that this happens sometimes. Sometimes we do things without thinking because we feel bad. When we feel better, we don't want to do those things anymore.

6 	His counselor reminds Daniel that there are days where we want to live and where everything goes well.
7 	There can be days where things go wrong. We don't think about the people we love or what makes us happy anymore. On those days, sometimes people can feel like Daniel did and want to die.

8		Daniel feels a storm of emotions that are scrambled in his head, that change the way he sees situations. He feels very confused.

9 	It's okay to feel confused when we want to die. It's okay to feel confused when we want to live and die at the same time.
10 	When Daniel feels like this, he can try thinking of reasons for living. Daniel's counsellor helps Daniel remember his reasons for living. This helps Daniel feel better.
11 	Daniel knows it's possible to want to live and die at the same time. The urge to want to die may come back, but Daniel can fight it with his will to live.

2.2 Story: Raphaël regains hope and finds solutions

In an ID-ASD context, solution-oriented interventions are used to discuss problematic situations that the person is living in the current moment. It is also used to defuse crises. It allows to reinforce hope and strengthen the person's empowerment regarding the situation and the envisioned solutions in order to improve the situation.

Of course, this intervention cannot guarantee the resolution of all problems. The objectives should be realistic in relation to the situation and the person's skills in the context of the current crisis.

Boxes 1 to 3 present the situation (risk factors, trigger events, despair, emotions, suicidal statements). The intervention aims to help the person describe their own situation and verbalize their ideations in their own terms. In the context of a discussion between the person and the practitioner, the practitioner might say: "Raphaël says "I'm going to kill myself!", and before, you said "xxx". What other words do you use to talk about your suicidal thoughts? Did you mean the same thing as Raphaël?" Another example that could be used by the practitioner is the following: "Raphaël is sad and frustrated. How do you feel when you want to kill yourself? Before, when you said it, how did you feel?" The practitioner can also suggest drawing their own emotions next to the ones described by Raphaël's character.

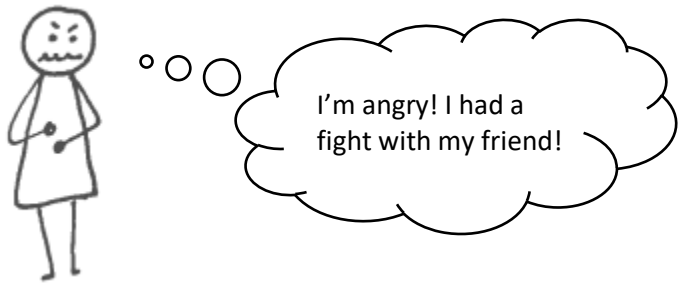
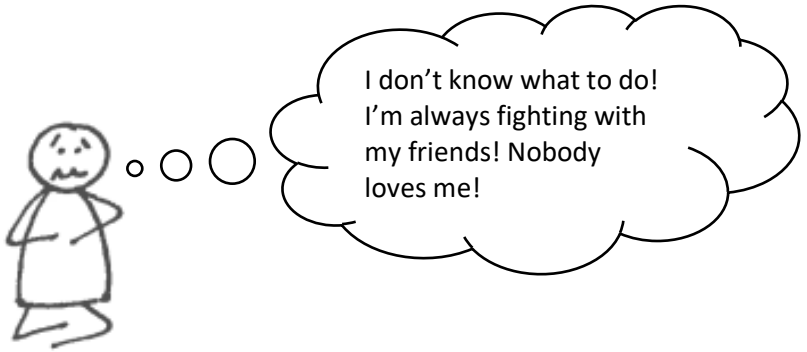
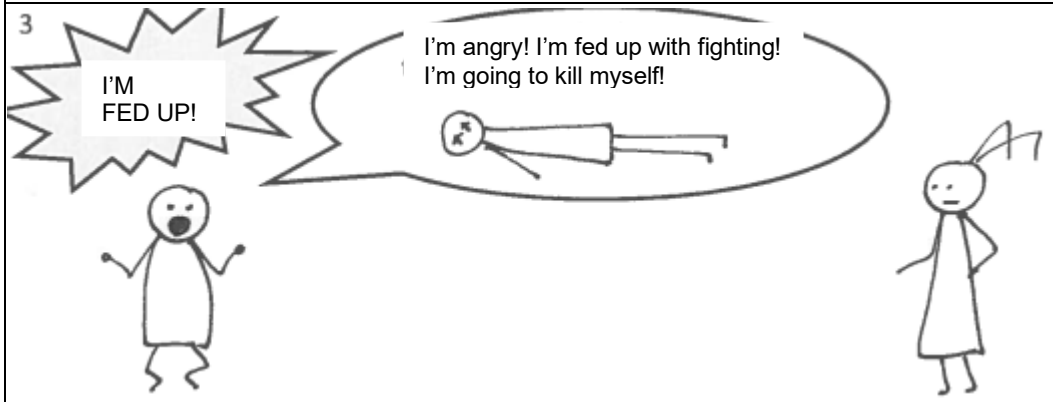
Boxes 4 to 6 explore the current problematic situation. The objective is to identify and name the suicidal episode's trigger events with the person and to validate their emotions. For example, the professional could say "Raphaël is not doing well because he had a fight with his friend. Is it the same for you? What things make it so that you don't feel good?"

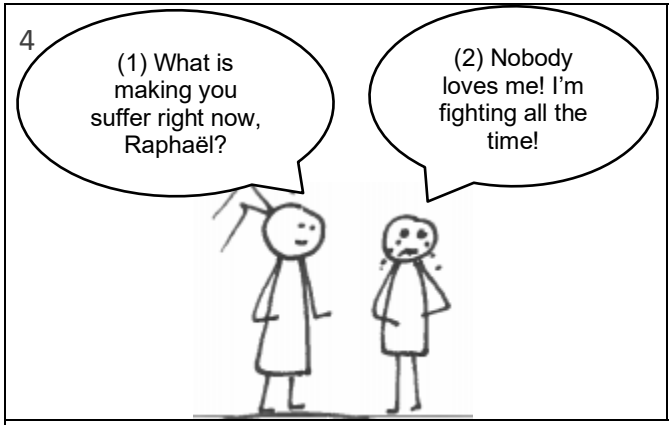
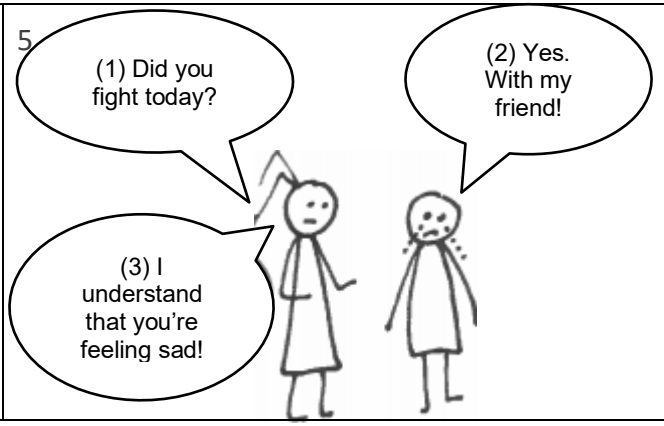
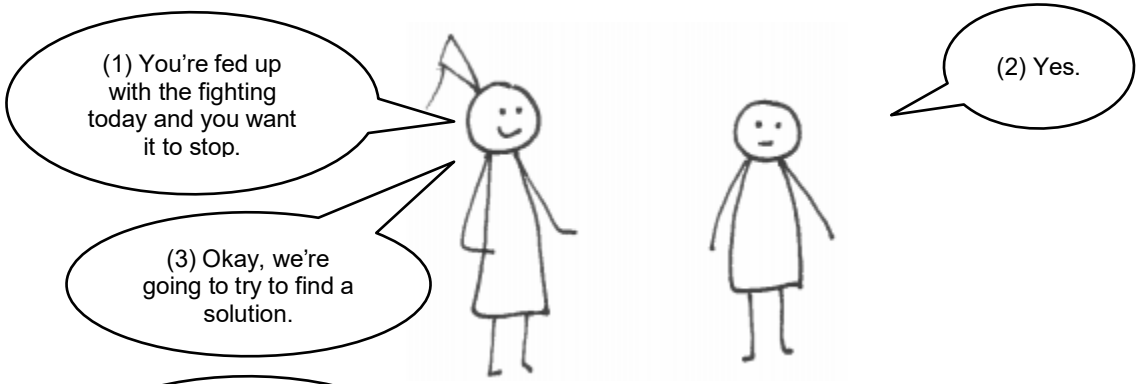
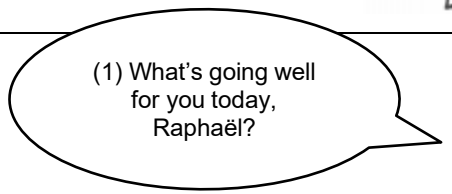
Boxes 7 to 10 bring light to Raphaël's reasons for living, allowing him to reconnect with hope and reduce distress. This exercise also reminds Raphaël of how he feels when things are better, allowing him to project himself into a future situation where he will actually feel better.

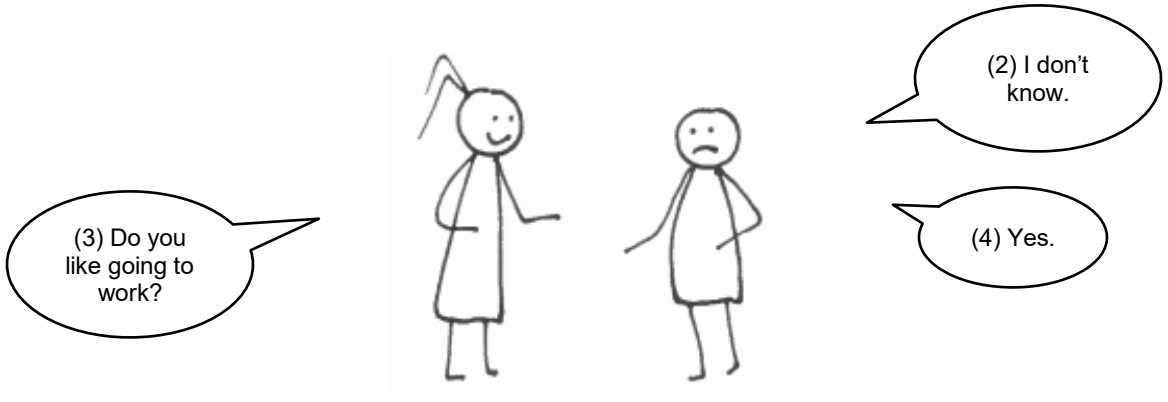
Boxes 11 to 14 illustrate the search for solutions in order to improve the problematic situation. Prospective solutions should use the person's strengths and skills, serving as a reminder. The professional can also make suggestions and accompany the person in the implementation of these solutions.

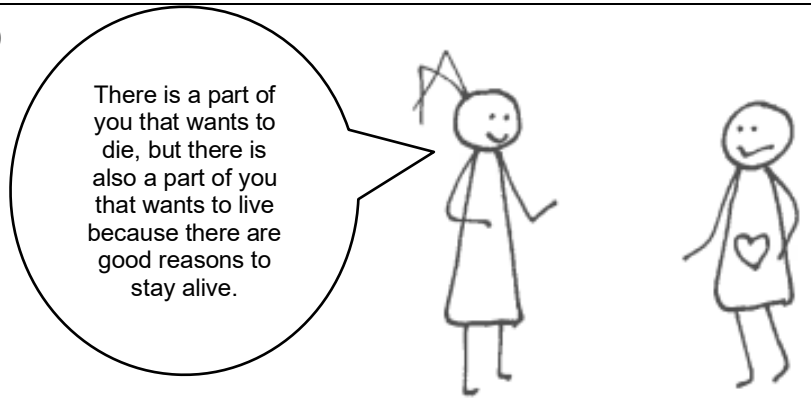
Boxes 15 to 17 show the importance of looking back on the emotions and recognizing the observed improvement, when positive changes occur. It also brings forward the importance of encouraging the person to use the developed strategies. The close monitoring is also part of the discussed themes.

Raphaël regains hope and finds solutions.

1 	Raphaël is frustrated. Too many things are going wrong for him right now.
2 	Raphaël is unhappy. He doesn't know what to do to feel better. He thinks it will always be like this.
3 	Raphaël speaks with his counselor. He tells her that he's angry, unhappy and that he wants to kill himself.

4  5 	The counselor is happy Raphaël is talking to her. She asks him questions to understand what's wrong.
6  	The counselor wants to help Raphaël feel better. They find out that what is making Raphaël unhappy today, what is making him think about dying. It's important to feel better.

7 	There are also things in Raphaël's life that are going well, so it's worthwhile to keep living. The counselor asks Raphaël questions to understand what is going well.

8 	It's important to also concentrate on the things that are going well right now. They help us feel better and live.
9 	Also, when we think about all the things that are going well, it makes us want to find solutions to make our heart happy.
10 	Raphaël and his counselor remember the reasons that make Raphaël want to live. Raphaël regains the will to live. He regains hope.

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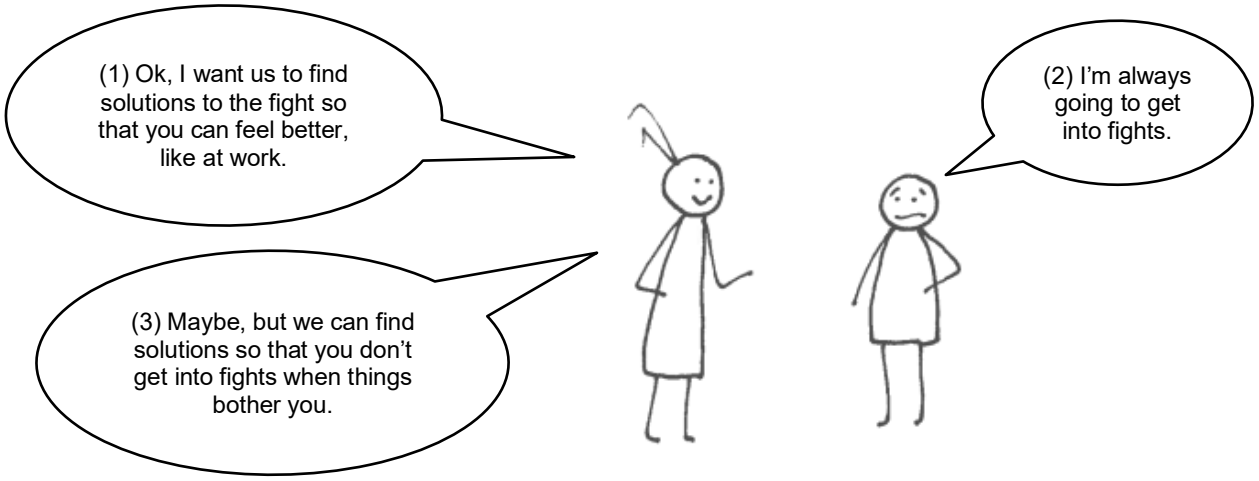
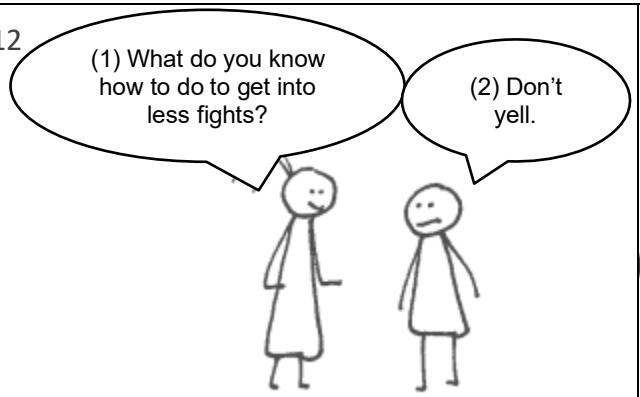
<td colspan="2">11
 
</td>
<td>They also have to find solutions to Raphaël's problem so that he doesn't want to die anymore.

Some problems are there for a long time, but we can still find solutions to be unhappy less often.

There is always something to do to feel better.</td>
</tr>
<tr>
<td>12
 
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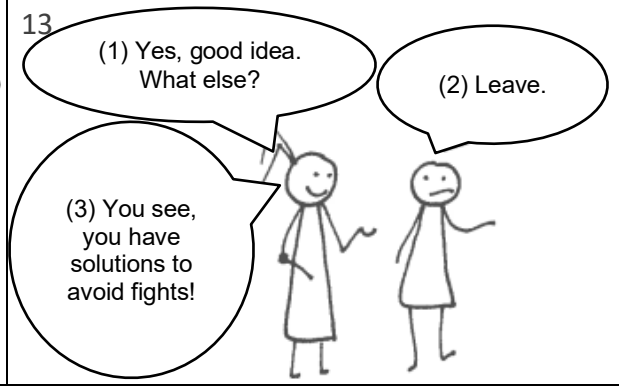
<td>13
 
</td>
<td>Raphaël already knew about good solutions, but he wasn't thinking about them anymore.

With his counselor, they discuss what Raphaël knows on how to avoid fights.</td>
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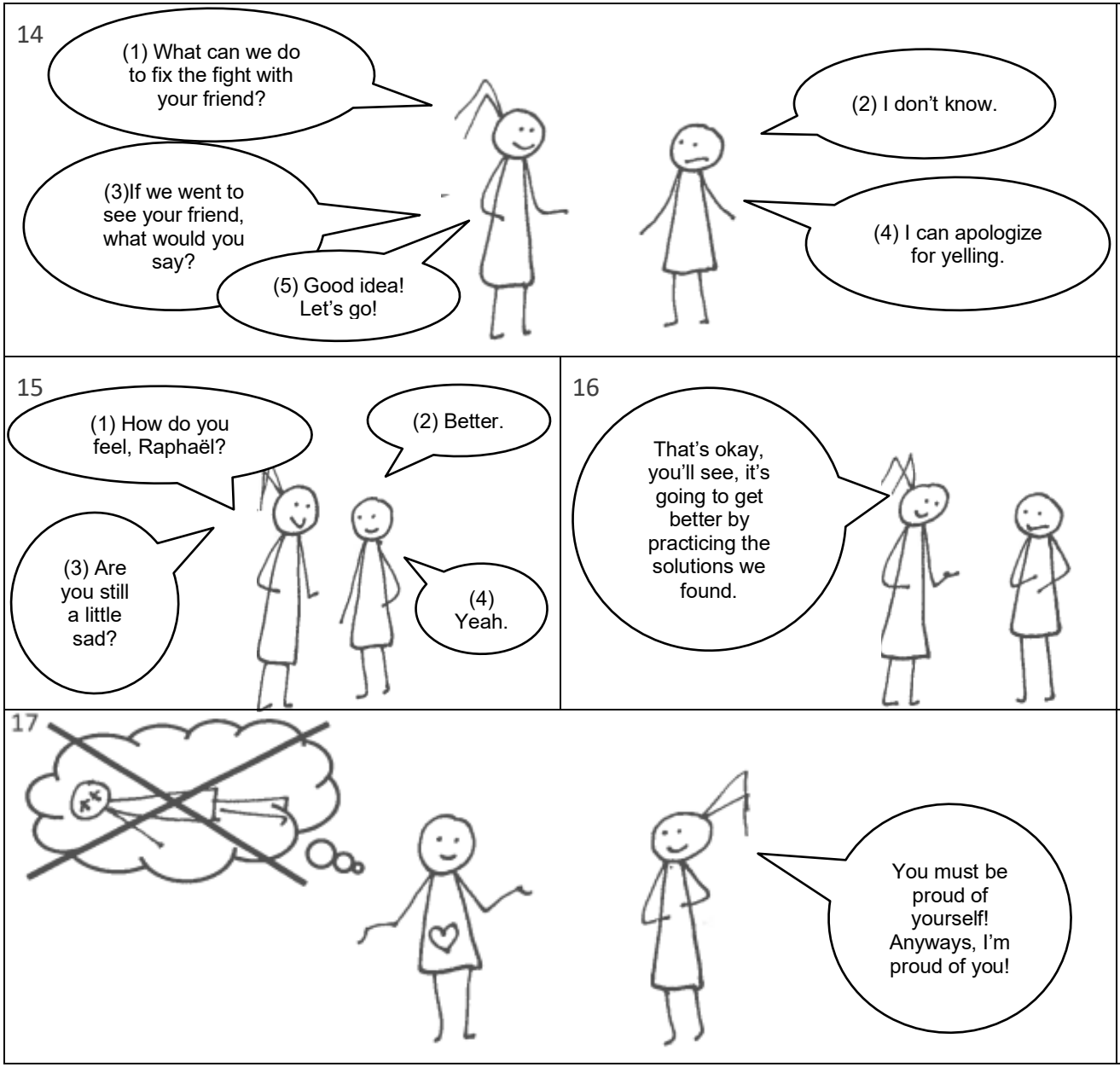


With his counselor, Raphaël finds new solutions to the problem.

Raphaël is doing a little bit better. He knows there will sometimes be harder moments, but that he will be better afterwards.

Raphaël continues using the solutions until he feels better. He doesn't want to die anymore.

He smiles again. He feels proud.

2.3 Story: Dominique has suicidal thoughts without really knowing why

This story aims to develop an intervention strategy for a person with whom we cannot identify a trigger event. Sometimes, suicidal ideations arise from a diffused feeling of unease that is difficult to identify clearly. In this case, the solution-oriented approach does not aim to find ways of managing a problem or event, but instead to identify and reduce the feeling of unease by attempting to affect their general mood in a positive way.

This intervention obviously cannot guarantee the resolution of every problem. The objectives should be realistic based on the situation and the person's skills in the context of the current crisis.

Boxes 1 to 3 present the situation in which Dominique thinks of suicide with no apparent reason. The intervention here aims to open a discussion with a person who is also in this situation.

In **box 4**, the counselor still explores different possible trigger events in Dominique's life. When intervening, it is important to explore what could have caused these recent ideations with the person. Be careful, however, to not give precise potential trigger examples. In fact, this could worry the person or suggest that they should be having suicidal ideations when they experience a certain event. Referencing box 4, the counselor could say: "And you, did something happen that made you sad, angry or bothered you today?"

Box 5 is an example of validating a person's experiences.

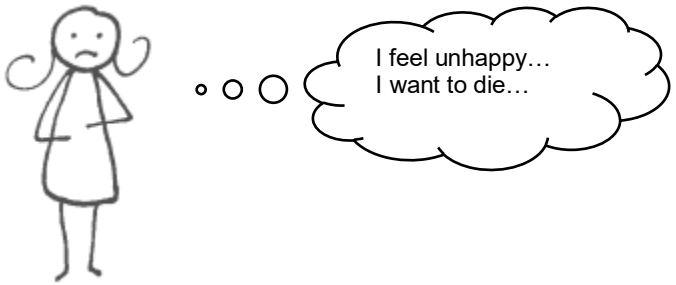
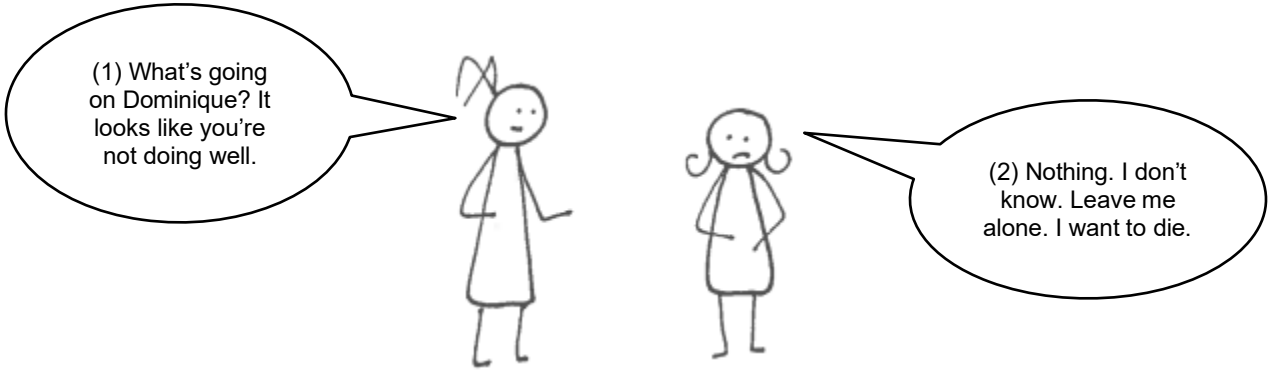
In **boxes 6 to 8**, the counselor explores the person's emotions to identify the moods accompanying their suicidal ideations. This can be helpful to identify with the person moments when things are not going well and when the ideations appear. Box 8 also includes validation of the person. Even if the unease is diffused with no apparent trigger event, it is important to use words that represent the person's ideas and emotions so that they can further express how they feel when they have suicidal ideations. The counselor could say: "How do you feel when you think about killing yourself? Do you feel discouraged like Dominique? Different?"

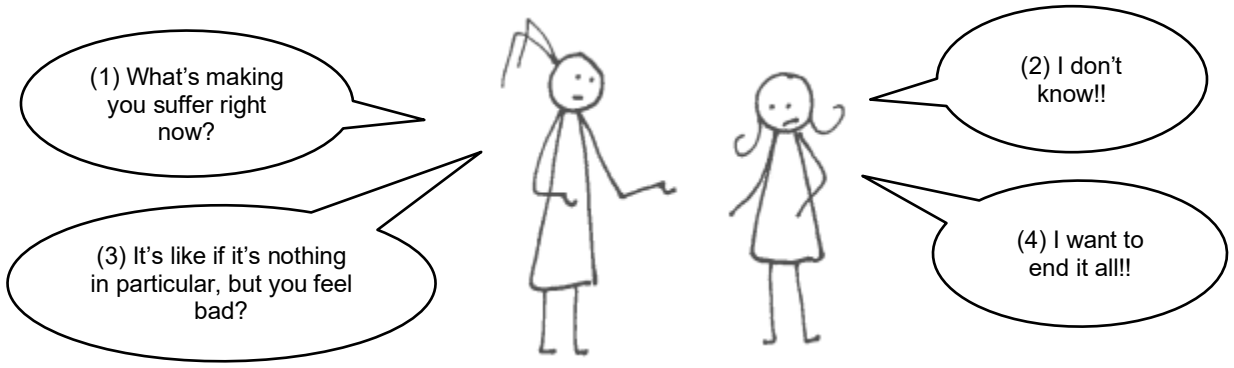
Boxes 9 to 12 illustrate the way in which the counselor also explores the things that are positive in Dominique's life and her reasons for living. The goal is to remind the person that when we feel bad, we can also think about the good things in our life. Be mindful however not to minimize the person's suffering or replace the emotions of sadness and hopelessness with other, potentially artificially positive ones. It is also important to avoid negating the person's experience and invalidating them. This intervention essentially aims to show that there also exists, in the person's life, positive things on which they can rely on when they feel bad.

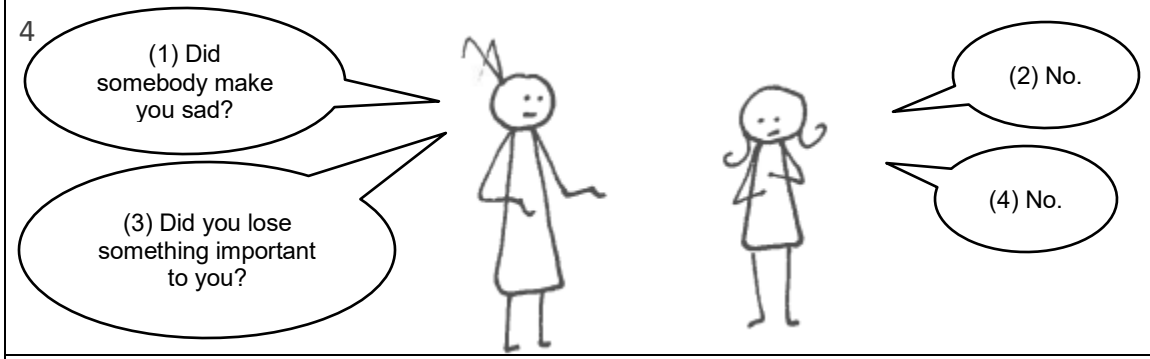
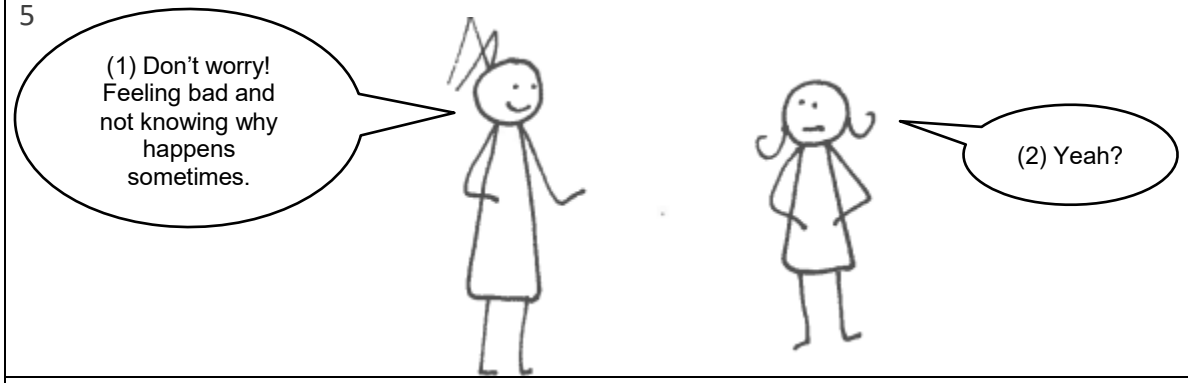
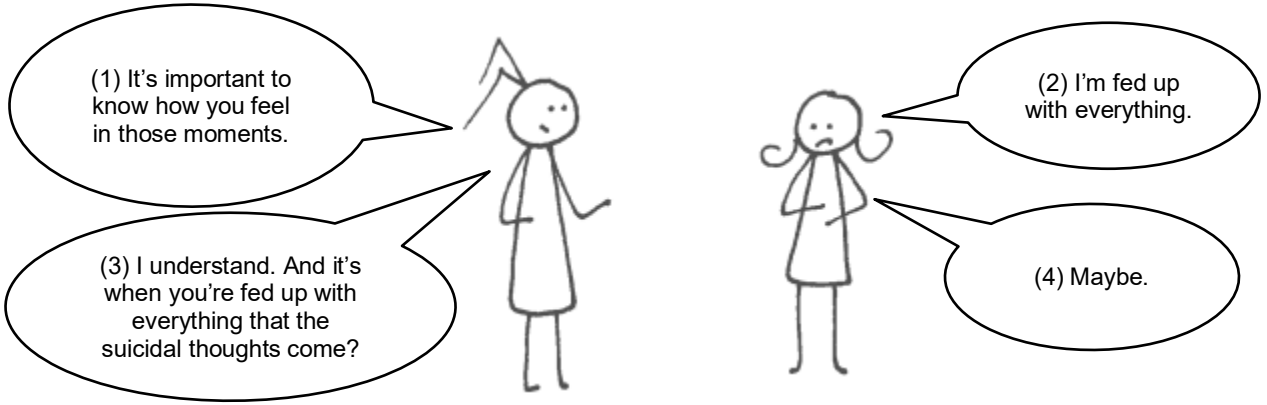
In **boxes 13 to 15**, the counselor proposes that Dominique does the Hope garden exercise described in the intervention manual. Together, they implement a strategy adapted to Dominique to identify the moments when she feels bad and has suicidal ideations for no apparent reasons, and to help positively modify her mood. In an intervention context, it is possible to develop a similar strategy with the person, taking into account their self observation and communication skills.

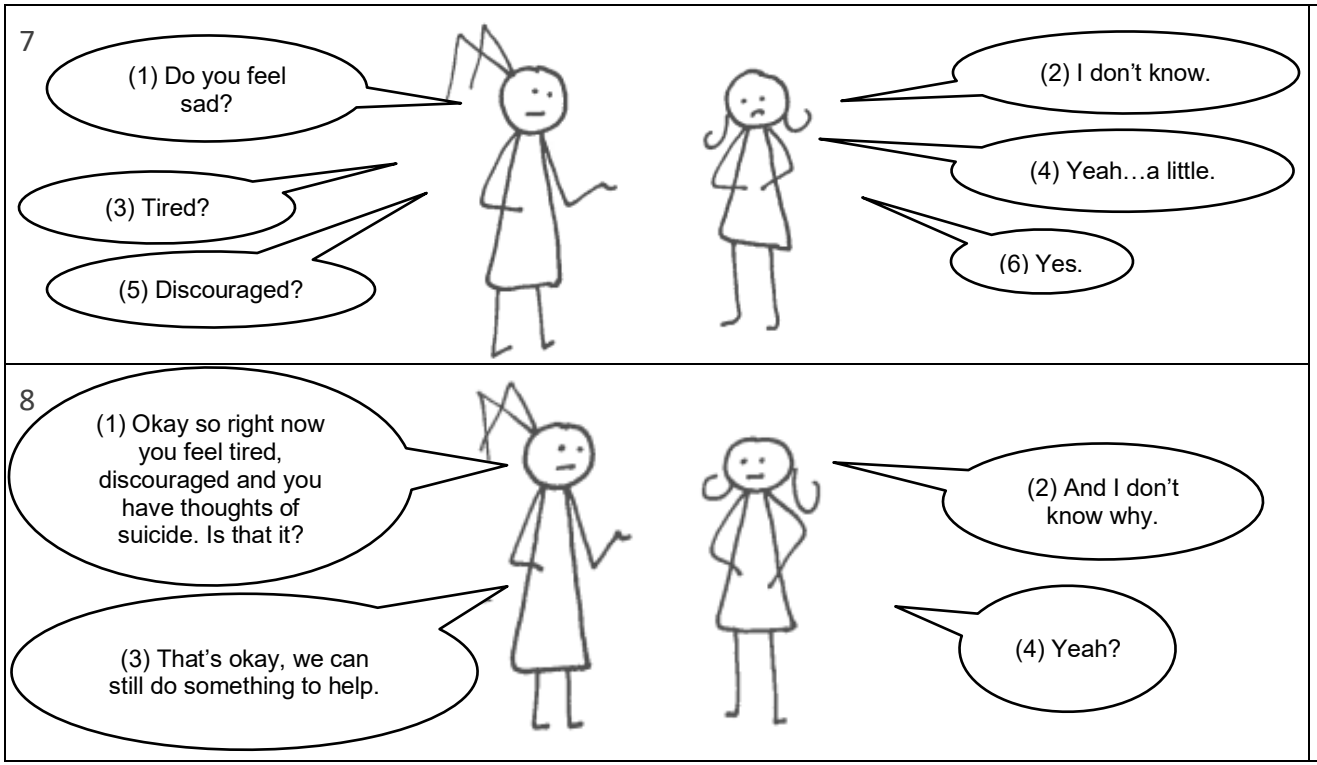
Box 16 concludes the story by validating the person's feelings and experience.

Dominique has suicidal thoughts without really knowing why

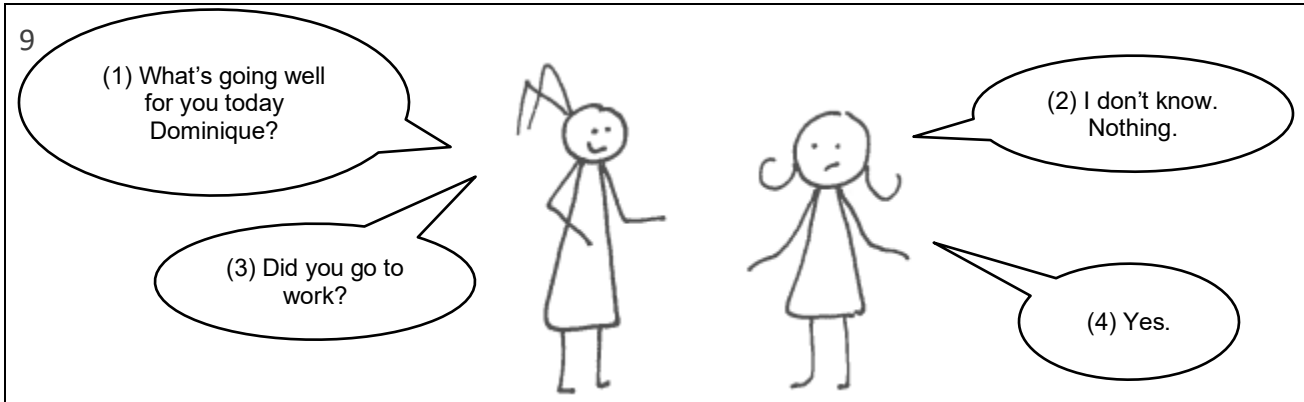
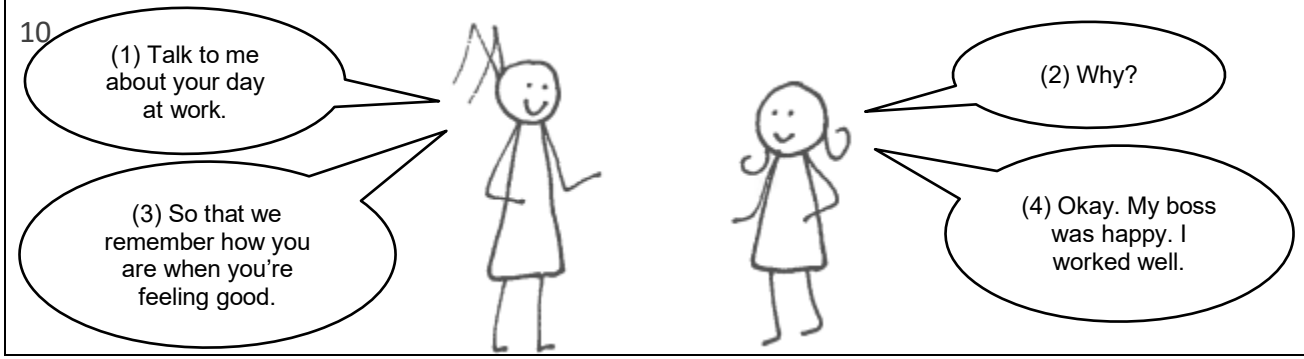
1 	Dominique feels unhappy. She has suicidal thoughts.
2 	Dominique does not know why she feels this unhappy. When her counselor asks her, she doesn't know what to say.

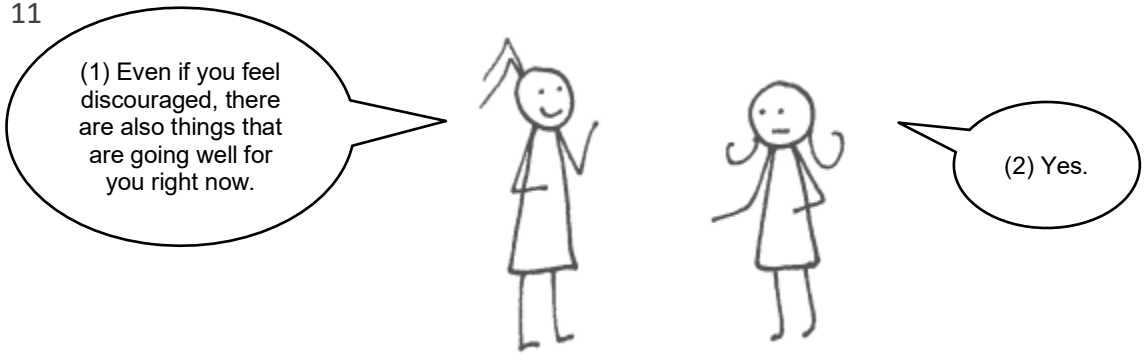
3  	Dominique can only think that she wants to die so it all ends.

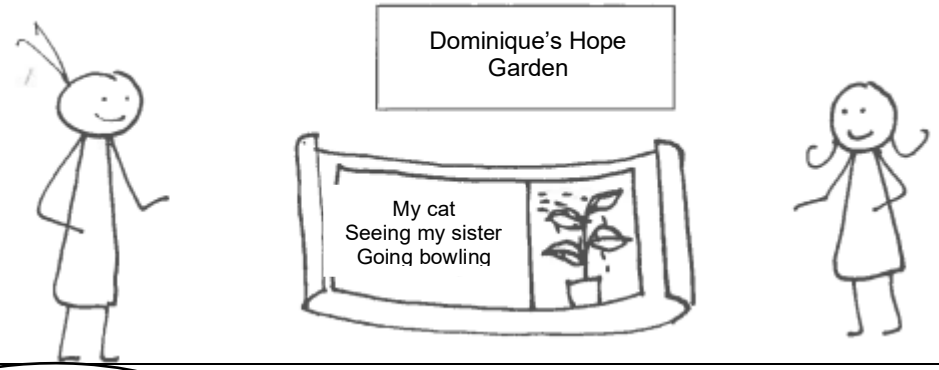
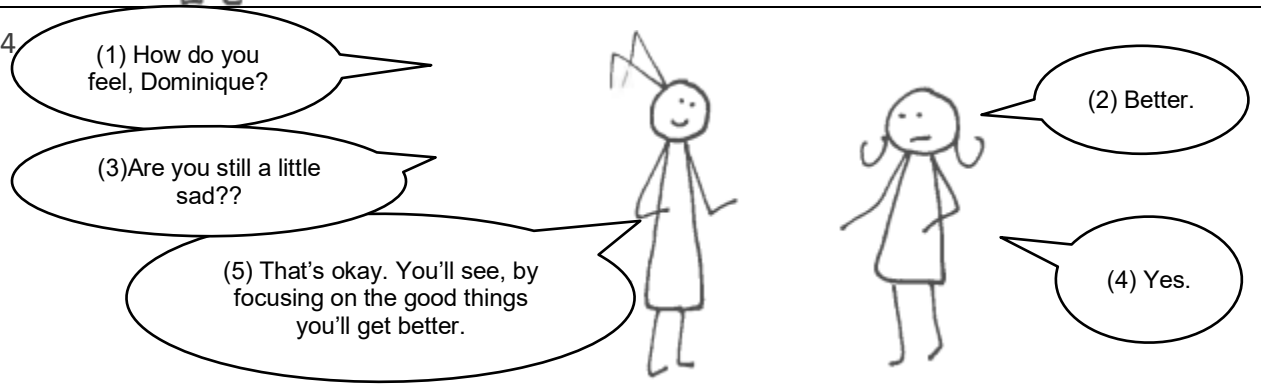
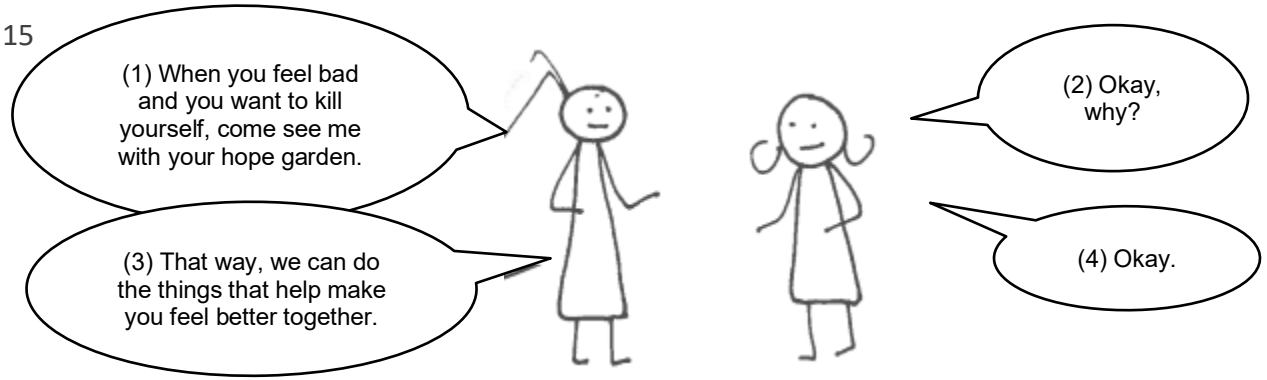
4 	The counselor asks Dominique questions to see if there is something making Dominique feel sad and want to kill herself. They don't find anything!
5 	The counselor explains to Dominique that it's okay to not know why we feel bad sometimes. It can happen to anyone.
6 	The counselor also explains that it's important to talk about it to learn to recognize the moments when we feel bad without knowing why.

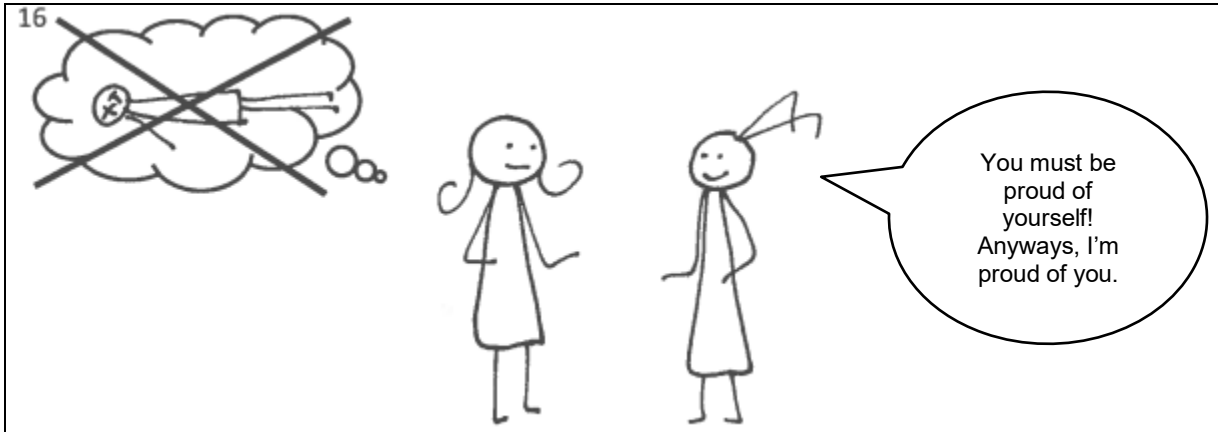


So that way, in those cases, Dominique can do something to feel better anyway.

9 	There are things in Dominique's life that are going well too. So, it's worth it to go on living. The counselor asks Dominique questions to understand what is going well.
10 	It's important to also focus on the things that are going well right now.

11 	They help us feel better and to live in the moments where we feel bad without knowing why.
12 	Dominique and the counselor remember the things that make Dominique want to live. Dominique finds her will to live again. She is less sad and discouraged.

13 	Dominique and the counselor make a hope garden for Dominique. It contains everything that Dominique loves and that makes her feel good.
14 	Dominique feels a little bit better. She knows that there will sometimes be difficult moments where she'll feel bad, but she'll feel better after.
15 	Dominique and the counselor make a strategy to help Dominique when she has suicidal thoughts and doesn't know why.

	Dominique is able to see how she feels thanks to the tools she has learned to use with the counselor. She works to try to think about the things that are going well and her reasons to live when she feels bad. Then, her smile comes back. She feels proud.

2.4 Calendar of Hope and the Timeline of Hope

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

The Calendar of Hope

Objective

In a situation where the person has difficulty orienting themselves in time and is experiencing a specific difficult situation (even if the situation can present itself multiple times), the calendar of hope can help them project themselves into the future to anticipate a future improvement. It can also allow to identify possible actions to accelerate this process. This exercise is particularly adapted to people who already use calendars to manage their daily lives and those who have a good capacity to identify their own emotions.

Justification / rationale

This intervention aiming to increase hope relies on the key presence of hopelessness within the suicidal dynamic. This hopelessness is modelled into triads as shown in figure 8.

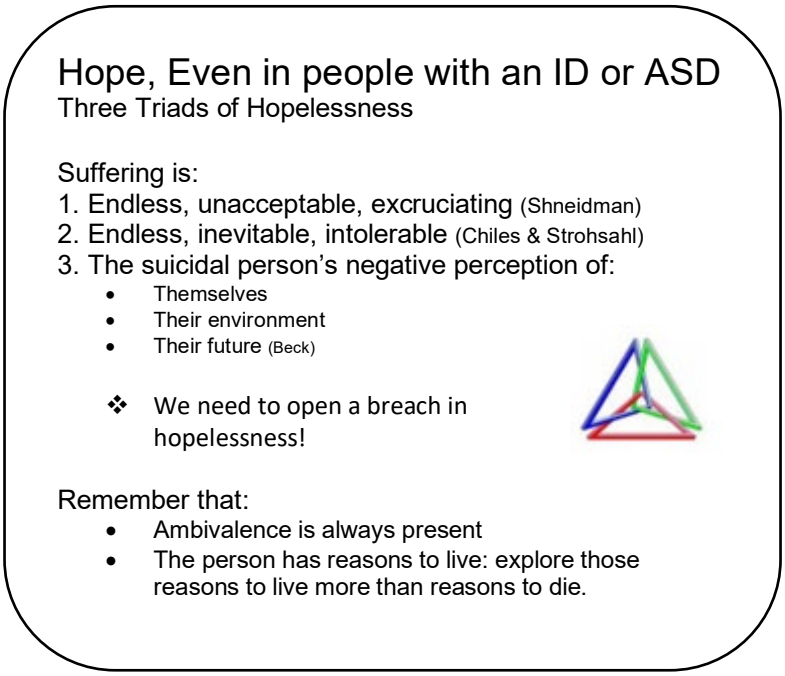


Figure 8 – The triads of hopelessness

The Calendar of Hope is also based on helplessness and the feeling of not having control on themselves and the things they experience. This component is an important element of the suicide model of people having ID or ASD. Working to bring back hope,

therefore identifying things that are going well and that the person can do in the near future, helps them take control of the situation. Having a better understanding of what they are experiencing can also give the person a sense of control on the process they are going through and on the actions to take to change the process if they wish to reduce their hopelessness.

It can also help to visualize the way in which the suicidal episode is playing out as well as the associated emotions and it can help the person project themselves into a moment where they will feel better than they do now and the steps to take to get there.

Intervention process

The first step consists of validating the truth and legitimacy of the emotions felt by the person. Many emotions can be identified in relation to the situation over time. For example, after feeling sad, the person could be tired or feel the need to be alone. It is important to validate with the person that the tiredness or need to be alone could be present for a period of time before wanting to see other people. In this sense, the aim is to show the person that the sequence of emotions is normal and legitimate (see Table 5 below).

Next, the professional would identify with the person the moment that should correspond to a return to calm or relief in the sequence of emotions. The professional could express this thought in this way: “Tomorrow, you’ll feel better.” We must reinforce the fact that the person will feel better compared to how they currently feel, while making them understand that the process takes a certain time. This time should be illustrated with the calendar, in column 2 of table 5.

The third step consists of identifying what we can do between the present moment and the one 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 results are the following : 1) Helping the person understand and recontextualize what they are experiencing; 2) Anticipating and acting in order to improve their state; and 3) For the person, taking back control over what they are experiencing.

An adaptation of the calendar of hope can be done when the person is experiencing particular periods of fragility during the year (for example, during the holidays or back to school) or when an expected event represents a possible trigger event (for example, a planned activity with a parent who rarely visits). In this case, it may be useful to prepare a monthly or weekly calendar with the person that indicates when the event will occur so as to plan positive activities in the calendar during this more difficult period. The professional should also ensure a follow up on the progress of

these planned activities, by emphasizing the positive elements that will allow the person to more easily make it through this difficult period.

Table 8 - The Calendar of Hope

Timeline similar to the one usually used by the person	What is happening	How we feel- by using signs normally used with the person	What we are going to do to feel better
Questions and themes to address to construct the calendar:	• I think what is making you (perceived emotion) is… • What do you think?	• How do you feel? Do you feel sad or angry? • It's okay and normal to feel like… • After a while, emotions like…. go away and after we feel… • How do you think you'll feel in (amount of time adapted to the person) • After a while we feel better. • What is feeling good for you? • How are you going to feel when you feel better?	• What can we do so you feel better more quickly? • What are the things we already know how to do that make us feel better that we can reuse?
Now			
In a few minutes			
In an hour			
Tomorrow			

The Timeline of Hope

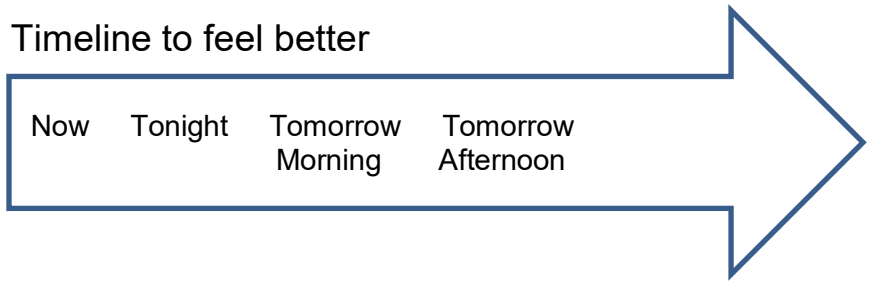
The timeline of hope is a simpler option than the calendar and is better suited to people with a reduced understanding of their emotions. It fulfills the same objectives and is based on the same principles.

Objective

The timeline is built from actions. It allows the planning of events and actions that will help the person feel better. The visual representation of these events and actions on a timeline helps the person to regain hope and notice a positive change in their life and mood.

Intervention process

The method is similar to the calendar, except that the emphasis is put on the activities that are going to take place, the actions needed to feel better, the planned social contacts, or even the positive or gratifying activities the person will participate in during the following hours or days. Before building the timeline of hope, it is important to recognize, validate and relieve the current distress.



Below is an example of a timeline:

2.5 The Hope Garden: Focusing on the good things

Objective

The objective of this intervention is to bring out the positive elements in a person's life, despite their difficulties and the things that are not going well in their life. This exercise helps foster hope and anticipate positive things.

Justification / rationale

Hopelessness is a key component in MAAS development (see 2.4.1 below for further details). Thus hope is an important element on which we can build a suicide prevention intervention. Reinforcing hope can be done in the short and long term.

Intervention Process

The identification of elements to put in the list of good things must be done with the person. The retained elements should be reproduceable and attainable. For example, if we include a good relationship with a family member, we should also include the possibility of a future contact that will reinforce the positive feeling.

The first step consists of writing or drawing the things that are good in the left panel. We can also glue pictures of people, animals or loved objects.

It is the second step that solidifies the Hope garden metaphor: We *cultivate* and *water* the good things. Every time an identified element happens, we make a note of it in the right panel by applying stickers to the plant, coloring one of the leaves, applying tactile objects or by using any other method that helps the person notice they are helping their garden grow.

If the right panel fills up completely, we can start another one while keeping the old one and continuing to cultivate the garden of good things. When the person feels bad or expressed despair, we can consult the garden and discuss the things that are going well. We must not deny what is going badly or too quickly resort to the garden. It is important to validate the distress or frustration before being able to talk about the good things.

The expected results are the following: 1) support in reframing negative perceptions; 2) visualisation of the positive to counterbalance the perception of the negative; 3) improvement of humor; 4) a base to develop other good things.

_____'s Hope Garden

Made on_____

The list of things that are good, that are going well, that we want to start again, that make us proud	Watering