Safety Plan

If you struggle with suicidal thoughts or urges then complete this form with a mental health professional.
The goal is to develop a plan you feel confident that you could use in a crisis.

① Warning signs

How will you know when the safety plan should be used?

Things I can do to distract myself and cope...

② ...on my own

- If you become suicidal *what can you do on your own* to help you not to act on your thoughts or urges?
- What activities could you do to take your mind off your problems, even if it is for a brief period of time?

③ ...with other people / socially

- Who helps you take your mind off your problems, even for a little while?
- What people or places can help you to distract yourself from suicidal thoughts or urges?

People who I can ask for help during a crisis:

④ Friends & family

- Among your family or friends, who do you think you could contact for help during a crisis?
- What would you need to tell them?

⑤ Professionals / services

- Which mental health professionals should we identify to be on your safety plan?
- Which services might be able to help if you are having a crisis?

⑥ Making my environment safe

- What means do you have access to – and are likely to use – to make a suicide attempt or to kill yourself?
- What can we do to limit your access to these means?

Safety Plan

A safety plan is best developed collaboratively with a patient following a comprehensive suicide risk assessment. Clinicians unfamiliar with the safety planning intervention from which this is adapted are strongly advised to read *Safety Plan Treatment Manual to Reduce Suicide Risk* by Stanley & Brown (2008) for a comprehensive clinical guide.

Step 1: Recognizing triggers and warning signs

Rationale: It is a helpful intervention to identify the signs which immediately precede a suicidal crisis. These might include situations, thoughts, images, thinking styles, mood, or behavior. They should be recorded using the patient's own words.
Prompts: *"How will you know when the safety plan should be used?", "What do you experience when you start to think about suicide or feel extremely distressed?"*

Step 2: Using internal coping strategies

Rationale: It is a useful therapeutic intervention to have patients try to cope on their own with their suicidal feelings, even if it is for a brief time. Identify: (i) coping strategies, (ii) the likelihood of using these strategies, (iii) barriers & problem solving.
Prompts: *"What can you do on your own if you become suicidal, to help you not to act on your thoughts or urges?", "What activities could you do to take your mind off your problems, even if it is for a brief period of time?"*
Check: *"How likely do you think you would be able to do this step during a time of crisis?"*
If the client expresses doubt about using coping strategies: *"What might stand in the way of you thinking of these activities or doing them if you think of them?"*

Step 3: Using social contacts who may distract from the crisis

Instruct patients: To use Step 3 if Step 2 does not resolve the crisis or lower their risk.
Rationale: Socializing with friends or family members without explicitly informing them of their suicidal state may assist in distracting patients from their problems. A suicidal crisis may be alleviated if an individual feels connected with others. Ask patients to list several people and social settings, in case the first option is unavailable.
Prompts: *"Who helps you take your mind off your problems, even for a little while?", "Where can you go where you'll have the opportunity to be around people in a safe environment?"*

Step 4: Social contacts for assistance in resolving suicidal crises

Instruct patients: To use Step 4 if Step 3 does not resolve the crisis or lower their risk.
Rationale: This step is distinguished from the previous step in that patients explicitly identify that they are in a crisis and need support and help. The people identified may not be the same as those identified in Step 3. Ask patients to list several people, in case they cannot reach the first person on the list. This step is not mandatory if the patient is uncomfortable sharing the plan with friends / family.
Prompts: *"Among your family or friends, who do you think you could contact for help during a crisis?", "Who can you contact if you're struggling?", "What would you tell them?"*
Check: *"How likely would you be willing to contact these individuals?".* If doubt is expressed about contacting individuals, identify potential obstacles and problem solve ways to overcome them.

Step 5: Professionals and agency contacts to resolve suicidal crises

Instruct patients: To use Step 5 if Step 4 does not resolve the crisis or lower risk.
Rationale: Patients are instructed to contact a professional or agency if the previous strategies have not been effective in resolving the crisis. List names, numbers and/or locations of clinicians, local urgent care services, including out-of-hours services.
Prompts: *"Which mental health professionals should we identify to be on your safety plan?"*
Check: *"How likely would you be willing to contact these services?".* If doubt is expressed identify potential obstacles and problem solve ways to overcome them.

Step 6: Risk reduction / means safety

Rationale: Suicide risk is amplified if a patient reports a specific plan to kill themselves that involves a readily available lethal method. Even if no specific plan is identified, a key component in a safety plan involves **collaboratively** eliminating or limiting access to potentially lethal means in the patient's environment. For methods with low lethality, clinicians may ask clients to remove or restrict their access to these methods themselves. Restricting the client's access to a highly lethal method should be done by a designated, responsible person – usually a family member or close friend, or the police.
Prompts: *"What means do you have access to and are likely to use to make a suicide attempt or to kill yourself?"*, *"How can we go about developing a plan to limit your access to these means?"*

Step 7: Implementation of the safety plan

Rationale: After the safety plan has been completed the clinician should assess the patient's reactions to it, and the likelihood that they will use the safety plan. If the patient reports (or if the clinician determines) that they are reluctant or ambivalent to use it then the clinician should collaboratively identify and problem solve barriers to using the safety plan effectively. Clinicians might consider using motivational-interviewing style questions such as *"You said that you were about 5/10 likely to use the plan. What would have to happen to move it to 7/10?"*. Once patients indicate that they are willing to use the safety plan during a crisis they are given the original document and a copy is kept in their clinical notes.
Prompts: *"How likely is it that you will use the safety plan when you notice the warning signs we have discussed?"*, *"Can you rate on a scale from 0 to 10 how likely you are to use this safety plan when you notice the warning signs?"*.