
A SUICIDE PREVENTION
TOOLKIT

Safety plans to prevent suicide



centre for
suicide prevention



IN THIS TOOLKIT

What is a safety plan?

When is a safety plan written?

Why does it work?

Suicide safety plan

How to co-develop a Safety Plan

How to implement a Safety Plan

Is a safety plan the same as a no-suicide contract?

References

While some people who consider suicide do so fleetingly or only once in their lives, others experience these thoughts ongoing or off and on over time. Suicidal thoughts can burden people and hold them hostage. Experiencing these thoughts is to experience “absolute darkness, hopelessness, pain,” and nothing matters but stopping that pain.

As friends and caregivers, we may feel at a loss to help or support people with these thoughts; we may feel that taking our loved one to the emergency room is our only option, that crisis medical support is necessary.

If the person at risk of suicide is in immediate crisis, the emergency room is an appropriate level of care. Otherwise, co-developing a safety plan is the best way forward.

This toolkit will show you what a safety plan is and how to create one together with an individual who may be at risk. It will illustrate how safety plans work and why they are one of the best tools to help mitigate future suicidal behaviours.

This toolkit is for people wishing to help someone they know who is struggling with thoughts of suicide. If you're struggling with thoughts of suicide yourself, contact your local crisis centre for support.

A safety plan can also be used to support and guide a person who is self-harming, however, in this toolkit we focus on people with thoughts of suicide.

What is a safety plan?

A safety plan is a document that supports and guides someone when they are experiencing thoughts of suicide, to help them avoid a state of intense suicidal crisis.

Anyone in a trusting relationship with the person at risk can help draft the plan; they do not need to be a professional.

When developing the plan, the person experiencing thoughts of suicide identifies:

- their personal warning signs,
- coping strategies that have worked for them in the past, and/or strategies they think may work in the future,
- people who are sources of support in their lives (friends, family, professionals, crisis supports),
- how means of suicide can be removed from their environment, and
- their personal reasons for living, or what has helped them stay alive.



A suicidal crisis refers to “a suicide attempt or an incident in which an emotionally distraught person seriously considers or plans to imminently attempt to take his or her own life” (Suicide Prevention Resource Center, n.d.).

When is a safety plan written?

A safety plan is written when a person is not experiencing intense suicidal thoughts. It may be written after a suicidal crisis, but not during, as at this time an individual can become overwhelmed with suicidal thoughts and confusion, and may not be able to think clearly. A safety plan is written when a person has hope for life, or even can consider the possibility of

life, so that they can identify their reasons for living, and positive actions they can take to prevent their thoughts from becoming intense and overwhelming.

A safety plan can be developed in one sitting by the person with thoughts of suicide together with you, their caregiver or friend, or over time. The plan can change as the circumstances for the individual change, and can be revised accordingly.

Why does it work?

A safety plan is an assets-based approach designed to focus on a person's strengths. Their unique abilities are identified and emphasized so they can draw on them when their suicidal thoughts become intense. The goal is to draw upon their strengths during subsequent recovery and healing processes (Xie, 2013). Personal

resources are another integral safety plan component. Drawing on strengths is the entry-level activity; reaching out for help may also become necessary (Xie, 2013; Bergmans, personal communication, 2019).

The safety plan is organized in stages. It starts with strategies the individual can implement by themselves at home and ends with 24/7 emergency contact numbers that can be used when there is imminent danger or crisis.

The person with thoughts of suicide can verify, along with their caregiver or friend, whether coping skills are feasible, as well as whether or not the chosen contact people are appropriate. Alternative ideas can be brought forward by either party as needed (Bergmans, personal communication, 2019).

When implemented, safety plans become self-strengthening. For people who experience recurring suicidal thoughts or crises, one strength becomes knowing they have weathered the storm before and have navigated their way out.

Suicide safety plan

To download a pdf of the template, visit bit.ly/2lW4nAJ

To download an app with the template, visit apple.co/2moOOjh

STEP 1: WARNING SIGNS (THOUGHTS, IMAGES, MOOD, SITUATION, BEHAVIOUR) THAT A CRISIS MAY BE DEVELOPING:

1.
2.
3.

STEP 2: INTERNAL COPING STRATEGIES - THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON (RELAXATION TECHNIQUE, PHYSICAL ACTIVITY):

1.
2.
3.

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTIONS:

- | | |
|----------|----------|
| 1. NAME | PHONE |
| 2. NAME | PHONE |
| 3. PLACE | 4. PLACE |

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP:

- | | |
|---------|-------|
| 1. NAME | PHONE |
| 2. NAME | PHONE |
| 3. NAME | PHONE |

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

- | | |
|---|-------|
| 1. CLINICIAN NAME | PHONE |
| EMERGENCY CONTACT PHONE | |
| 2. CLINICIAN NAME | PHONE |
| EMERGENCY CONTACT PHONE | |
| 3. LOCAL EMERGENCY SERVICE | |
| EMERGENCY SERVICE ADDRESS | |
| EMERGENCY SERVICE PHONE | |
| 4. CRISIS SERVICES CANADA PHONE: 1-833-456-4566 | |

STEP 6: MAKING THE ENVIRONMENT SAFE:

1.
2.

The one thing that is most important to me and worth living for is:

1

STEP ONE: List warning signs that indicate a suicidal crisis may be developing.

GUIDING QUESTION(S) FOR THE PERSON THINKING ABOUT SUICIDE:

What (situations, thoughts, feelings, body sensations, or behaviours) do you experience that let you know you are on your way to thinking about suicide, or that let you know you are mentally unwell generally? Think about some of the more subtle cues.

EXAMPLES:

Situation: *argument with a loved one*

Thoughts: *“I am so fed up with this and I can't handle it anymore”*

Body sensations: *Urge to drink alcohol*

Behaviours: *Watch violent movies, irregular eating schedule*

WHEN TO IMPLEMENT?

At any time before a suicidal crisis.

HOW TO IMPLEMENT?

Being aware of one's own warning signs can alert the person to the fact that they may be at high risk of thinking about suicide when these situations/thoughts/body sensations arise. They can put the plan in action and move onto the next step: coping strategies.

Being aware of personal warning signs can help friends/caregivers identify when that person may need more support, even before they've asked for it.



2

STEP TWO: List the coping strategies that can be used to divert thoughts, including suicidal thoughts.

GUIDING QUESTION(S) FOR THE PERSON THINKING ABOUT SUICIDE:

What (distracting activity, relaxation or soothing technique, physical activity) helps take your mind away from thought patterns that feel scary or uncomfortable, or thoughts of suicide?

EXAMPLES:

Distracting activity: *Watch a funny movie*

Relaxation technique: *Deliberate breathing*

Physical activity: *Go for a bike ride*

WHEN TO IMPLEMENT?

At any time before a suicidal crisis, or when suicidal thoughts emerge but are not intense.

HOW TO IMPLEMENT?

The person with thoughts of suicide can use these coping strategies to help distract them from their thoughts and move them to a more positive mental space.

Friends/caregivers can suggest to the person that they use one or more of their coping strategies and support them if needed.

3

STEP ONE: List the places and people that can be used as a distraction from thoughts of suicide.

GUIDING QUESTION(S) FOR THE PERSON THINKING ABOUT SUICIDE:

Where can you go to feel grounded, where your mind can be led away from thoughts of suicide? Who helps take your mind away from these thoughts?

EXAMPLES:

Places: *Go to a movie, sit in a park*

People: *Text friend (name, phone), go for coffee with a co-worker (name, phone)*

WHEN TO IMPLEMENT?

At any time before a suicidal crisis, or when suicidal thoughts emerge but are not intense.

HOW TO IMPLEMENT?

The person with thoughts of suicide can go to these places or contact these people to help distract them from their thoughts of suicide and move them to a more positive mental space.

4

STEP FOUR: List all the people that can be contacted in a crisis, along with their contact information.

GUIDING QUESTION(S) FOR THE PERSON THINKING ABOUT SUICIDE:

Who among your friends, family, and service providers can you call when you need help (when your thoughts become overwhelming or you're thinking about suicide)?

EXAMPLES:

Mom: *work phone, cell phone*

Spouse: *work phone, cell phone*

WHEN TO IMPLEMENT?

At any time before a suicidal crisis, or when suicidal thoughts emerge and are becoming intense.

HOW TO IMPLEMENT?

The person with thoughts of suicide can call these people at any time, to distract them from their thoughts or to let them know when their thoughts are becoming more intense, signaling that they need support.

Friends and caregivers can respond to the person by supporting them through this difficult time: listening to them, going to visit them, making sure to check in often, asking what specifically they can do to help.



5

STEP FIVE: List mental health providers and the hours they can be reached, as well as 24/7 emergency contact numbers that can be accessed in a crisis.

GUIDING QUESTION(S) FOR THE PERSON THINKING ABOUT SUICIDE:

Who are the professionals you've worked with who can be helpful to you in a crisis? What other professionals or organizations could you call?

EXAMPLES:

Therapist: *work phone, cell phone, hours available*

Closest hospital: *Regions Hospital, 640 Jackson Street*

Crisis Line: *1-833-456-4566*

WHEN TO IMPLEMENT?

When suicidal thoughts have become very intense, and the person experiencing the thoughts believes they cannot cope on their own.

HOW TO IMPLEMENT?

The person with thoughts of suicide should immediately call or visit these crisis contacts.



6

STEP SIX: List the steps to be taken to remove access to means of suicide from the environment.

GUIDING QUESTION(S) FOR THE PERSON THINKING ABOUT SUICIDE:

What could be used to die by suicide in your environment (home, work)? How have you thought about dying by suicide before, and how can you make that method more difficult to access?

EXAMPLES:

Pills: *Give to pharmacist or friend for disposal*

Guns (or rope): *Remove from home (give to a friend, etc.)*

WHEN TO IMPLEMENT?

Before a suicidal crisis, preferably immediately after safety plan is developed.

HOW TO IMPLEMENT?

The person with thoughts of suicide can remove these items from their environment themselves, giving them to friends or caregivers. **The person working with them on their safety plan should confirm that all means have been removed from the home.**

Friends/caregivers can offer to keep or throw away these items. Keeping a person safe from a method of suicide can mean different things for each person and method. Firearms in particular should always be removed from the home, regardless of whether or not they have been noted as a means of suicide.

7

STEP SEVEN: List important reasons to live, or how/why that person is still alive.

GUIDING QUESTION(S) FOR THE PERSON THINKING ABOUT SUICIDE:

When do you feel most at ease during the day? Who do you love? What do you enjoy doing? What did you used to enjoy doing? What is important to you, or used to be important to you? What has kept you alive up until now?

Note: These reasons can become apparent through conversation with the person, and through the process of a suicide intervention. You may need to identify these for the person, based on what they've told you.

EXAMPLES:

My dog is important enough to me that I want to stay alive to take care of him.

WHEN TO IMPLEMENT?

At any time before or during a suicidal crisis.

HOW TO IMPLEMENT?

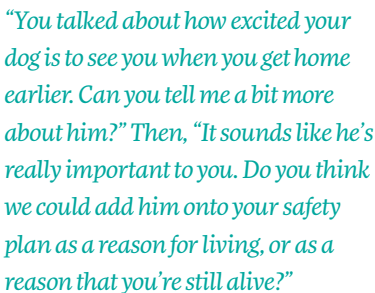
A person with thoughts of suicide can refer to these reasons for living at any time, as often as they want, to remind them of the positive aspects of their lives.

Friends/caregivers can use these reasons in organic conversation, to help gently remind that person of their reasons for living.

How to co-develop a safety plan

Co-developing a safety plan involves a collaborative, in-depth conversation between the person experiencing thoughts of suicide and their caregiver or friend.

Go over each step together, thoroughly and thoughtfully (Berk & Clarke, 2019). There may be times where, through organic or structured conversation, you will identify potential safety plan items for the person - bring these into the plan! For example, if someone mentions that they need to get home to spend time with their dog, that is a potential reason to live. You can suggest adding the positive things you hear coming from that person at any point.



“You talked about how excited your dog is to see you when you get home earlier. Can you tell me a bit more about him?” Then, “It sounds like he’s really important to you. Do you think we could add him onto your safety plan as a reason for living, or as a reason that you’re still alive?”

How to implement a safety plan

Once complete, you and the person who has had thoughts of suicide should keep copies of the safety plan in an accessible place. The safety plan needs to be handy so that the person can always find it when they are experiencing intense thoughts of suicide. Some people choose to always keep their plan with them, e.g. on their phone or in their wallet.

Each step in the safety plan plays a role in supporting the person with thoughts of suicide, as well as yourself, and other friends and caregivers. Refer to the “Suicide safety plan” for how and when to implement each step.

Keep in mind that the safety plan is not written in stone: it can be revised as often as is needed. The plan can be reviewed at any time, and especially if the person experiencing thoughts of suicide has found any portion of it ineffective in helping them cope with their thoughts. For example, if one contact person was found to be difficult to get in touch with on several occasions, or if a coping strategy is no longer effective or accessible.

Is a safety plan the same as a no-suicide contract?

A no-suicide contract is different from a safety plan in that it is “an agreement, usually written, between a mental health service user and clinician, whereby the service user pledges not to harm himself or herself” (McMyler & Prymachuk, 2008, p.512). It was introduced in 1973 by Robert Drye, Robert Goulding and Mary Goulding. Mental health service users are expected to seek help when they feel they can no longer honour their commitment to the contract (Rudd, Mandrusiak & Joiner, 2006).

The no-suicide contract has been widely used by clinicians working with patients at risk of suicide (Rudd, Mandrusiak & Joiner, 2006). However, there is a lack of evidence to support contracts as clinically effective tools.

Both service users and clinicians have voiced strong opposition to their use. Moreover, important ethical and conceptual issues in the use of such contracts have been identified, including the potential for coercion from the clinician for their own protection and the ethical implications of restricting a service user’s choices when they may be already struggling for control. A strength-based approach like a safety plan, on the contrary, not only encourages the service user’s input and agency, it is a true partnership with the physician or caregiver, bound by hope (McMyler & Prymachuk, 2008; Rudd, Mandrusiak & Joiner, 2006).

REFERENCES

- Berk, M. & Clarke, S. (2019). *Safety planning and risk management*. In M. Berk (Ed.), *Evidence-based treatment approaches for suicidal adolescents: Translating science into practice* (63-84). Washington, D.C.: American Psychiatric Association Publishing.
- Drye, R., Gouling, R. & Goulding, M. (1973). No-suicide decisions: Patient monitoring of suicidal risk. *American Journal of Psychiatry*, 130(2), 171-174.
- McMyler, C. & Prymachuk, S. (2008). Do “no-suicide” contacts work? *Journal of Psychiatric and Mental Health Nursing*, 15(6), 512-522.
- Rudd, M., Mandriusiak, M. & Joiner, T. (2006). The case against no-suicide contracts: the commitment to treatment statement as a practice alternative. *Journal of Clinical Psychology*. DOI:10.1002/jclp.20227
- Stanley, B. & Brown, G. (2011). *Safety plan*. Retrieved from http://suicidesafetyplan.com/uploads/SAFETY_PLAN_form_8.21.12.pdf
- Stanley, B. & Brown, G. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19(2), 256-264.
- Suicide Prevention Resource Center. (n.d.) *Topics and terms*. Retrieved from <https://www.sprc.org/about-suicide/topics-terms>
- Xie, H. (2013). Strengths-based approach for mental health recovery. *Iranian Journal of Psychiatry and Behavioral Science*, 7(2), 5-10. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3939995>

We are the Centre for
Suicide Prevention, a branch
of the Canadian Mental
Health Association. For
35+ years we have been
equipping Canadians with
knowledge and skills to
respond to people at risk
of suicide.

We educate for life.



Canadian Mental
Health Association
Mental health for all

Centre for Suicide Prevention
T 403 245 3900
csp@suicideinfo.ca

suicideinfo.ca
@cspyyc