Safety Plan Worksheet: 
Brief Instructions for Providers

Providers: Complete semi-structured interview of recent suicidal crisis before proceeding to Step 1. Print copy of completed Safety Plan for patient and place a duplicate copy in medical record.

Step 1. Recognizing warning signs

___ Ask patient “How will you know when the Safety Plan should be used?”
___ Ask patient “What do you experience when you start to think about suicide or feel extremely distressed?”
___ List warning signs, including thoughts, images, thinking processes, mood, and/or behaviors, using the patient’s own words. (Ex: “I feel really numb,” “I think ‘nobody even cares about me,’” “I stop answering calls and texts”)

Step 2. Using internal coping strategies

___ Ask patient “What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?”
___ Ask patient “How likely would you be able to do this step during a time of crisis?”
___ If doubt about using coping strategies is expressed, ask “What might stand in the way of you thinking of these activities or doing them if you think of them?”
___ Use a collaborative, problem-solving approach to ensure that potential roadblocks are addressed and/or that alternative coping strategies are identified.

Step 3. Social contacts who may distract from the crisis

___ Instruct patient to use Step 3 if Step 2 does not resolve the crisis or lower risk.
___ Ask patient “Who or what social settings help you take your mind off your problems, at least for a little while?” and “Who helps you feel better when you socialize with them?”
___ Ask patient to list several people and social settings, in case the first option is unavailable.
___ Ask patient for safe places they can go to be around people, e.g., coffee shop.
___ Remember, in this step, suicidal thoughts and feelings are not revealed to their social contacts.

Step 4. Contacting family members, friends, caregivers or others who may offer help to resolve a crisis

___ Instruct patient to use Step 4 if Step 3 does not resolve the crisis or lower risk.
___ Ask patient “Among your family or friends, who could you contact for help during a crisis?” or “Who is supportive of you and who do you feel you can talk with when you’re under stress?”
___ Ask patient to list several people and social settings, in case the first option is unavailable.
___ Ask patient which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means. Use non-judgmental tone and language with open-ended questions.
___ Restricting the patient’s access to a highly lethal method should be done by a designated, responsible person — usually a family member, caregiver, close friend, military command, or the police.
___ Examples: Keep medications locked in a safe place, properly dispose of medications you no longer need, never keep lethal doses of any medication on hand, keep firearms locked in a safe with ammunition stored separately, have a trusted individual temporarily store firearm until safety is re-established.
___ Consider prescribing naloxone for patients at risk for opioid overdose (See VA/DoD opioid therapy clinical practice guideline).

Step 5. Contacting professionals and agencies

___ Instruct patient to use Step 5 if Step 4 does not resolve the crisis or lower risk.
___ Ask patient “Who are the behavioral health professionals who should be on your safety plan?” and “Are there other health care providers?” In this step, suicidal thoughts and feelings are discussed with health professionals/agencies.
___ List names, numbers and/or locations of clinicians, local urgent care services, military service/command or VA suicide prevention coordinator, Military/Veterans Crisis Line and/or National Suicide Prevention Helpline (800-273-TALK (8255)).
___ If doubt is expressed about contacting health professionals/agencies, identify potential obstacles and problem solve ways to overcome them.

Step 6. Reducing the potential for use of lethal means

___ Ask patient which means they would consider using during a suicidal crisis and collaboratively identify ways to secure or limit access to these means. Use non-judgmental tone and language with open-ended questions.
___ For patients who identify methods with low lethality, clinicians may ask patients to remove or restrict access themselves or with assistance.
___ Restricting the patient’s access to a highly lethal method should be done by a designated, responsible person — usually a family member, caregiver, close friend, military command, or the police.
___ Examples: Keep medications locked in a safe place, properly dispose of medications you no longer need, never keep lethal doses of any medication on hand, keep firearms locked in a safe with ammunition stored separately, have a trusted individual temporarily store firearm until safety is re-established.
___ Consider prescribing naloxone for patients at risk for opioid overdose (See VA/DoD opioid therapy clinical practice guideline).

Step 7. Remembering reasons for living

___ Ask patient to list their reasons for living, including answers to the following: “The things that are most important to me and worth living for are:”

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