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ORIGINAL PAPER

Towards a Better Use of Safety Planning in Emergency Departments: An Exploratory Study of Patients and Clinicians' Perspectives

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Abstract

Suicidality frequently leads to emergency department (ED) visits, yet few interventions are offered in EDs to mitigate suicide risk. This study uses a descriptive interpretative design to evaluate the key components for a successful use of such an intervention, the Stanley-Brown safety plan, in EDs. Semi-structured interviews were conducted with patients and ED clinicians and were analyzed using a thematic analysis approach. Participants' perspectives revealed 6 key recommendations for a successful use of the safety plan in EDs: (1) personalize the content of the safety plan, (2) offer a variety of formats, (3) avoid periods of high emotional intensity, (4) engage a broad range of professionals in safety planning, (5) use limited time to make meaningful interventions, (6) propose alternative interventions. A change in the ED culture is needed to ensure that the management of suicidal patients in EDs includes brief therapeutic interventions like safety planning, to mitigate suicide risk.

Keywords Emergency department · Suicide · Mental health · Safety planning · Brief intervention · Patient care

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Introduction

Emergency departments (EDs) play an important role in the prevention, evaluation, and care of people with suicidal risk in the general population. While suicidal thoughts and behaviors are frequent reasons for ED visits (Barratt et al., 2016; Gentil et al., 2020; Ministère de la Santé et des Services sociaux, 2022; Vasiliadis et al., 2015), the management of suicidal patients in EDs poses a challenge in terms of balancing efficiency, security and patient care (Pawaskar et al., 2022). Studies have shown that mental health training for emergency clinicians is insufficient or non-existent resulting in ED staff lacking the mental health expertise needed to provide optimal care for suicidal patients (Marian E. Betz et al., 2013; Bolster et al., 2015; Innes et al., 2014; Knesper D. J. et al., 2010; Pawaskar et al., 2022; Rheinberger et al., 2021; Roennfeldt et al., 2021; Sacre et al., 2022). This lack of expertise is alarming considering that suicides often happen in the months following an ED visit (Ahmedani et al., 2019; Da Cruz et al., 2011; Gentil et al., 2020; Goldman-Mellor et al., 2019; Hjorthøj et al., 2014; Olfson et al., 2021; Vasiliadis et al., 2015).

The ED is the only place to intervene on many patients' suicidal risk, as 11–50% of people who attempt suicide will refuse outpatient treatment or dropout rapidly after hospital discharge (Stanley & Brown, 2012). The delay between ED consultation and outpatient follow-up can also be very long, and thus detrimental to suicide prevention (Stanley & Brown, 2012). Therefore, it is crucial to intervene with patients at higher risk of suicide during their ED visit but identifying them is difficult considering that standardized suicide risk assessments most often lead to many false positives (Fowler, 2012). A meta-analysis of the literature has shown that our ability to predict suicidal behavior is only slightly better than chance and has not improved over the last 50 years of research (Franklin et al., 2017). Given this inability to target higher-risk patients, experts recommend that brief interventions intended to lower suicide risk be provided in the ED to all patients at risk of suicide (Wilson et al., 2020).

Although ED brief interventions for suicidal patients are understudied and underused (Gursahani et al., 2022), it has been demonstrated that safety planning interventions reduce suicidality and should be part of ED routine care for people with suicidal ideation (Abbott-Smith et al., 2023; Marshall et al., 2023; Nuij et al., 2021; Stanley & Brown, 2012). A brief safety planning intervention has been created by Barbara Stanley and Gregory K. Brown in 2012 to mitigate suicide risk and has since been used and studied in many settings (outpatient clinics, schools, EDs) and with different populations (mental health patients, military personnel, adolescents) (Stanley & Brown, 2012). The Stanley-Brown safety plan is a 6-step tool that helps people at risk of suicide identify (1) the warning signs of a suicidal crisis, (2) the internal coping strategies they can use, (3) the people and social settings that provide distraction, (4) the people whom to ask for help, (5) the professional or agencies to contact during a crisis, and (6) the ways of making their environment safer. Safety plans have proven to be effective as they can significantly reduce suicidal behaviors (Ferguson et al., 2022; Nuij et al., 2021; Stanley et al., 2018) and help promote outpatient follow-up (Asarnow et al., 2011; Ferguson et al., 2022; Nuij et al., 2021; Stanley et al., 2018). Yet, most nurses and physicians are not confident in their ability to help at-risk patients create a safety plan (M. E. Betz et al., 2013; Higgins et al., 2016). A national survey of 2228 American hospitals revealed that the majority of EDs do not routinely provide the basic aspects of safety planning, with only 2 out of the 6 safety plan elements being discussed with patients at risk of suicide in EDs more than 50% of the time (Bridge et al., 2019). Therefore, the aim of this project is to explore patients and clinicians' perspectives to identify the key components for a successful use of the Stanley-Brown safety plan in EDs.

Methods

This study was approved by the human research ethics committee of the Integrated University Health and Social Services Center (CIUSSS) where the study took place (approval number: 2019–2467). This qualitative research uses a descriptive interpretative design (Gallagher & Marceau, 2020) to study the safety plan intervention for patients at risk of suicide in EDs. Researchers conducted individual semi-structured interviews with patients and ED clinicians to discuss their view on the key elements required to effectively use the safety plan in EDs. Patients were also asked to describe their experience of ED care which led to rich testimonials. The results of this last part are discussed in another article (Brousseau-Paradis et al., 2024).

Convenience sampling was employed to recruit both patients and clinicians. Patients were recruited through outpatient facilities, with study details communicated via email to psychiatric clinic managers within the CIUSSS. Project posters were also displayed in these clinics. Managers informed their clinical staff about the project, who then presented it to potential participants under their care. All selected patients were required to have consulted the ED (general or psychiatric) for suicidal ideation or attempt. Patients who were interested contacted the research team by phone for more information. Those who decided to take part were scheduled for an in-person interview at a location that suited them, either at their home or in a CIUSSS

office. Two patients decided to have a relative present during the interviews. As for ED health workers, they were informed of the project via announcements posted on care units. The unit manager also collaborated with the researchers and forwarded information to staff members. During fall 2019, the research team went to a psychiatric ED and met with clinicians who agreed to take part in the study. Free, informed, and ongoing consent was obtained from all participants. Considering the nature of our recruiting method, it was impossible to know how many people were solicited to participate in the study, but no participant withdrew.

A team of three PhD researchers (CG, JR, NM), each holding extensive expertise in qualitative research, collaboratively developed the interview guide. They deliberately chose to include a minimal number of predetermined questions, allowing participants the freedom to dive into aspects of the safety plan they deemed most significant. Each session started with a researcher presenting the safety plan intervention to the participant and answering their questions about the tool. It was followed by open-ended questions such as "In your experience, how could this tool be adapted to the emergency context?". Patients and clinicians were also questioned about the types of patients who would benefit from this intervention, as well as the optimal timing and the most suitable clinician to administer it.

The semi-structured interviews were conducted between August 2019 and January 2020 by the three researchers who created the interview guide, with two of them present at each session. Patient interviews ranged from 34 to 89 min, averaging 62 min, while clinician sessions lasted 12 to 67 min, with an average of 26 min. All sessions were meticulously recorded and transcribed, while field notes were taken to capture emerging reflections and hypotheses during the data collection process. After each interview, researchers met to discuss their impressions using a reflexive iterative approach. Results are presented according to The Consolidated Criteria for Reporting Qualitative Research guidelines (Tong et al., 2007).

Following the interviews, a senior psychiatric resident (CBP) summarized the collected data and crafted an initial codebook, employing Miles, Huberman, and Saldana's thematic analysis approach (Miles et al., 2014). The summaries and codebook underwent a thorough review by three team members (CG, JR, NM), resulting in codes' adjustments. CBP then systematically coded all transcripts using NVivo, iteratively adjusting the codes as part of an ongoing refinement process. Memos targeting the most relevant quotes were utilized to facilitate the analysis, leading to the identification of key themes. Ultimately, CBP, CG and JR convened to scrutinize and finalize the thematic tree.

Table 1 Participant demographics and characteristics

Demographics and characteristics	Clinicians	Patients
	mean (range) or *n* (%)	*n* (%)
Age	39.3 (22–54)	-
18–34	2 (33.3)	2 (28.6)
35–49	2 (33.3)	2 (28.6)
50–64	2 (33.3)	2 (28.6)
Over 65	0	1 (14.3)
Male	4 (66.6)	5 (71.4)
Female	2 (33.3)	2 (28.6)
Single	-	4 (57.1)
Interview location		
Participant's home	0 (0.0)	6 (85.7)
CIUSSS office	6 (100.0)	1 (14.3)
Reason for ED visit†		
Suicidal ideation	-	6 (85.7)
Suicidal attempt	-	3 (42.9)
Type of ED‡		
Psychiatric	6 (100.0)	5 (71.4)
General	0 (0.0)	3 (42.9)
Time since last ED visit (months)§		
< 6	-	0 (0.0)
6–12	-	4 (57.1)
> 12	-	2 (28.6)
Level of education completed		
Secondary school	1 (16.7)	-
College	3 (50.0)	-
University (undergraduate)	1 (16.7)	-
University (postgraduate)	1 (16.7)	-
Profession		
Beneficiary attendant	2 (33.3)	-
Nurse	3 (50.0)	-
Psychiatrist	1 (16.7)	-
Years of caregiving experience	13.7 (1–30)	-
Years of emergency experience	9.7 (1–20)	-

†Two participants consulted once for suicidal ideation and once for suicidal attempt, ‡One participant consulted both EDs, §One missing data

Results

The sample included 13 participants, 7 patients who had consulted an ED for suicidal ideation or attempt and 6 ED clinicians. All clinicians worked in the psychiatric section of the same ED. The participants' demographics are shown in Table 1.

The analysis incorporated the perspectives of all 13 participants, including both patients and clinicians, resulting in 6 key recommendations for the successful use of the safety plan in EDs. This section will present the recommendations, which are also summarized in Table 2.

Personalize the Content of the Safety Plan

A diverse range of needs and opinions regarding safety planning emerged from patients' testimonials. For instance,

Table 2 Key recommendations emerging from the analysis for a successful use of the safety plan in emergency departments

1. Personalize the content of the safety plan
2. Offer a variety of formats
3. Avoid periods of high emotional intensity
4. Engage a broad range of professionals in safety planning
5. Use limited time to make meaningful interventions
6. Propose alternative interventions

while half of patients expressed skepticism about including helplines in their safety plans, with one of them stating "It's just that, for me personally, talking [on the phone] to a stranger about my problems is not what's going to help me." (patient 7), the other half found helplines to be beneficial, with one asserting "Follow-up phone calls from helplines are essential, even if you're just going to tell them that everything is fine and all that. I still think it's essential." (patient 6). Additionally, some patients noted the importance of relying on loved ones during times of distress: "The people around you have a role to play in bringing you back down to earth. […] So yes, it would be a good idea to involve them in a safety plan." (patient 4). In contrast, others expressed discomfort with including their support network in their safety plan: "Calling friends, […] I'm not really comfortable with that." (patient 3). Given the varied needs articulated by patients concerning the resources and individuals to include in their safety plan, it is essential to customize the content of each plan according to the individual patient's context. This tailored approach ensures that the safety plan includes relevant, personalized resources, thereby minimizing barriers to its effective utilization.

Offer a Variety of Formats

The paper format of the safety plan was not unanimously approved by patients, with some appreciating the ability to display it (on their fridge, for example), while others were quick to say that they would never look at the paper once they got home. Some participants said they would use a cell phone app for safety planning: "Of course [an app] is better. You carry your phone with you all the time. Then you'll have a reference when things aren't going well, you'll have your checklist." (patient 6). Some clinicians disagreed, stating that the paper format would be preferable because not all patients own a cell phone. One clinician proposed using "a small wallet-sized card with, say, two lines of people to call. It's quick. You make sure the person puts it in their wallet before you leave." (clinician 3). The diversity of ideas and opinions underscores the inadequacy of a universal format, emphasizing the necessity to provide a range of options and let patients select the one that aligns most effectively with their individual needs. As a participant said, "what would be nice is if it were customizable" (clinician 6).

Avoid Periods of High Emotional Intensity

The patients in our study agreed that moments of high emotional intensity were to be avoided in order to efficiently complete a safety plan: "Honestly, when you're in crisis, there's nothing you can do. […] You're really not there, even if people are trying to do something… as long as you're not back in your… a bit calmer, there's nothing to do." (patient 4). Many participants identified arrival at the ED as a moment of heightened emotional intensity, suggesting that it may not be an optimal time to discuss the safety plan. Two patients mentioned that the day after arrival would be ideal to complete the tool as they would have had time to regain emotional control.

The ED staff agreed that administering the safety plan upon arrival at the ED was not ideal "because if [the patient] is in crisis, it's not the time for teaching" (clinician 5). They recommended giving priority to quiet moments or systematic rounds and thought "it would be more appropriate when [patients] were closer to discharge" (clinician 3). Clinicians also mentioned that states of psychiatric decompensation would prevent a proper completion of the safety plan: "It's a formula that could work in general, for patients who don't have an acute psychiatric disorder. If a patient listens to the voices he hears… [It's useless.]" (clinician 6). Overall, the findings suggest that periods of acute crisis, which are frequently encountered upon arrival at the ED, must be prevented in order to effectively complete the safety plan.

Engage a Broad Range of Professionals in Safety Planning

The results of our study show that staff disagree about who should administer the safety plan in the ED. According to some participants' point of view, nurses should be responsible to do it: "It's really worth it, that it's our role, in teaching, as nurses, to give [the safety plan] to the patient." (clinician 5). Another participant stated that "for patients with active psychiatric pathologies, it should be a doctor who does it, general practitioner or psychiatrist" (clinician 6). However, clinicians agreed that a broader range of professionals should engage in safety planning (emergency physicians, family doctors, general emergency nurses, community workers, etc.) rather than limiting the use of the safety plan to psychiatric emergency staff: "For patients in [suicidal] crisis, […] I see it in the hands of [the primary care] and general emergencies. […] If the primary care uses the [safety plan], I would be seeing 50% fewer patients unnecessarily in the ED." (clinician 6). One clinician also deplored that mental health care relies solely on psychiatric personnel: "It's important that it's not just mental health nurses who do [safety plans], but nurses in general. Because

the big problem is that […] the patient education is done only by mental health nurses." (clinician 5). Some patients also expressed being helped by discussions about aspects of the safety plan with their outpatient clinician during post-ED follow-ups. Hence, according to participants, safety plans should be used by various types of caregivers, including general emergency staff, primary care providers, and other community workers.

Use Limited Time to Make Meaningful Interventions

Clinicians were often concerned that the safety plan would add to their already overburdened workloads: "I'm not sure it's realistic, because there's a lot going on. […] Yesterday we had two [patients] who were agitated, one who was transferred [to another hospital] and one who was transferred to [another] floor. Forget it, they wouldn't have had time." (clinician 1). Indeed, many clinicians mentioned being already short of time to intervene with psychiatric emergency patients: "We're often overwhelmed these days, but in theory, what we should be doing is talk […] about resources, but sometimes […] there's no time to do that. […] The nurses do what they can, but often they don't necessarily give out the leaflets or do the teaching." (clinician 5). Patients echoed this sentiment, noting that staff appeared overworked and lacked sufficient time for them. It is worth noting that a misunderstanding of the tool may have led clinicians to overestimate the time required to carry out the intervention as showed by this concern: "Two or three questions is fine, but maybe not 15 pages." (clinician 4).

Despite clinicians limited time, patients made it clear that the most helpful intervention would be to take time to listen: "When you don't feel well, I think it's more about being listened to than taught." (patient 2). A key finding from our analysis of patients' testimonies regarding their ED care experience for suicidal behaviors was the paramount importance of being compassionately listened to, provided with information and resources, and infused with hope (Brousseau-Paradis et al., 2024). After being presented with the safety plan by a research team member, one participant said: "That's what I wanted to hear, it's not 'go back to your place, and uh… you know… it'll pass'. […] But yes, I think that you need concrete, short-term things […] To hang on to. […] It's important to have a plan when you get out of the emergency." (patient 4). This underlines that the safety plan holds the potential of fulfilling patients' needs to be heard, informed, and given hope. Therefore, efficiently incorporating the safety plan into the ED caregiving practices could minimize additional burdens on already overworked staff by using the limited time available to make a meaningful intervention that have the potential of empowering patients.

Propose Alternative Interventions

While some patients were convinced of the usefulness of the safety plan: "In an emergency, it's stuff like this that it takes to get you out of the crisis." (patient 4), others had reluctances: "By the time you've done all the [safety plan] steps, you've had time to kill yourself four times." (patient 7). It also needs to be mentioned that some patients were adamant that the safety plan would not work for them: "I'm not going to start reading a paragraph while I'm crying a deluge, […] it won't help me." (patient 3). Given this consideration, mandating the completion of a safety plan for all suicidal patients in the ED may prove counterproductive and could potentially undermine the therapeutic alliance with certain patients. Clinicians also had different opinions about the safety plan: "I'm a 100% bought in!" (clinician 5), "If I feel that the person has no social network, […] no longer has a reason to live, then it becomes more or less relevant." (clinician 4), "Wouldn't it be easier to go through [a suicide prevention center]? It's an organism that's already there for that." (clinician 1). Considering the diversity of perspectives regarding the safety plan, it is crucial to provide alternative interventions to ensure the safety of those for whom the safety plan is less suitable.

Discussion

In this study, we explored patients' and clinicians' perspectives on the key components for a successful use of the Stanley-Brown safety plan in EDs and found 6 main recommendations. No consensus was reached regarding the content or format of a safety plan, underscoring the importance of tailoring the content to each patient's needs and providing a range of formats. In their original description of the safety plan, B. Stanley and G. K. Brown emphasized the importance of personalizing the intervention, noting that identifying triggers for suicidal thoughts is only useful if these triggers are personally relevant, and that a clinician-generated list of coping strategies is unlikely to be effective unless it aligns with the strategies that resonate most with the patient (Stanley & Brown, 2012). Studies have shown that the relevance of the intervention increases when the safety plan is personalized to the patient's current needs (Ferguson et al., 2022; Levandowski et al., 2017). It is also important to note that these needs can change over time and require different interventions. The versatility of formats, whether through a written template, a website, or a mobile application, also facilitates the individualization of responses to the diverse needs and circumstances of patients. This approach, which allows patients to choose the format and content that best suits them, can enhance their sense of empowerment

(Ferguson et al., 2022; Levandowski et al., 2017). O'Conner et al. mention the importance of keeping a simple and flexible format and suggest using a layout that consolidates all key information onto a single sheet of paper (O'Connor et al., 2022). Tricks like keeping a photo of the plan in the patient's cell phone, sharing copies with relatives, and recording the plan in the patient's medical file can also be helpful in increasing the use of the safety plan (Ferguson et al., 2022; Levandowski et al., 2017).

Participants recommended completing the safety plan later in the ED stay once emotions have settled as they thought high emotional intensity can impair patients' ability to complete the tool effectively. In a 2020 study, the safety plan was used by crisis hotline counselors who reported that the intervention was both feasible and helpful on crisis calls, suggesting that individuals in active suicidal crises states can effectively complete the plan (Labouliere et al., 2020). Therefore, although utilizing the plan during calmer periods appears optimal based on our findings, employing the intervention during moments of heightened emotional intensity could also be viable. Completing the safety plan before ED discharge has shown to be valuable as it enhances the safety of the discharge process. Indeed, a study involving 1640 adults seeking care at the ED for suicidal concerns demonstrated that individuals who received the safety plan intervention in the ED before discharge, coupled with brief telephone follow-ups, exhibited a 45% reduction in suicidal behaviors in the 6 months following the ED visit compared to individuals receiving treatment as usual (Stanley et al., 2018). Additionally, individuals who received the intervention had more than twice the likelihood of attending at least one outpatient mental health visit. Therefore, completing the safety plan before discharge allows to initiate a reflective process that can be continued and tailored to incorporate the development of new coping skills during outpatient follow-up (Stanley & Brown, 2012).

Clinicians interviewed in this study disagreed regarding which professional should be responsible for administering the safety plan in the ED. Literature shows that safety plans can be delivered by a vast range of personnel including nurses, primary care physicians, psychiatrists, social workers, psychologists, crisis lines counselors, school counselors as well as trained peers with lived suicidality experience (Chesin et al., 2017; Currier et al., 2015; Dueweke & Bridges, 2018; Ferguson et al., 2022; Labouliere et al., 2020; Stanley & Brown, 2012; Stewart et al., 2020; Wilson et al., 2022). Thus, the most suitable personnel for administering safety plans in the ED may differ across settings, but the quality of the interactions between patients and clinicians was proven to be central in establishing a helpful and meaningful safety plan (Kayman et al., 2015; O'Connor et al., 2022). Clinicians in our study emphasized the importance of engaging a broad range of professionals in safety planning, a view supported by existing literature (Ferguson et al., 2022). As general emergency staff often feel helpless when faced with patients exhibiting suicidal tendencies (Marian E. Betz et al., 2013; Clarke et al., 2007; Innes et al., 2014; Knesper D. J. et al., 2010; Roennfeldt et al., 2021; Santucci et al., 2003), the safety plan has the potential to enhance the capabilities of these clinicians in supporting such individuals. Research has shown that offering adequate training to staff responsible for administering the safety plan is crucial as it helps them grasp their role in the safety planning process and increases their confidence in managing suicide risk (Bender et al., 2022; Moscardini et al., 2020; Stewart et al., 2020). Hence, through appropriate training, professionals with or without a mental health background could effectively administer the safety plan intervention.

A major concern for this study's clinicians was the lack of time with patients to complete the safety plan, which was also reported in other studies (De Ganay et al., 2023; Levandowski et al., 2017; O'Connor et al., 2022). According to B. Stanley and G. K. Brown, completing the safety plan can take as little as 20 min and be done almost anywhere (Stanley & Brown, 2012). It has been shown that using safety plans in EDs reduces the duration of ED stays by 7.7 h and decreases ED revisits and hospitalizations, thus reducing the overall workload of hospital staff (Boudreaux et al., 2017; Cullen et al., 2024; Ferguson et al., 2022; Kar Ray et al., 2023). Therefore, a misunderstanding of the intervention might contribute to clinicians' overestimation of the time required to complete a safety plan. Our study as well as many others have emphasized patients' need to be listened to and cared with respect while presenting to the ED for suicidal concerns (Brousseau-Paradis et al., 2024; Roennfeldt et al., 2021; Vandewalle et al., 2020). Assisting patients through the making of their safety plan is an opportunity to listen to patients' concerns while discussing suicidality. The safety plan intervention also allows clinicians to complete tasks that must in any case be undertaken to appropriately care for suicidal patients, such as providing psychoeducation and resources, involving relatives, and giving hope (Rassy et al., 2022). Overall, if integrated efficiently into ED care practices, the safety plan intervention has the potential to reduce staff workload while enhancing the safety of suicidal patients.

Participants' hesitations toward the safety plan underscore that a "one size fits all" approach is unlikely to be effective. Shah et al.(2024) found that the success of crisis interventions in the emergency setting relies on the clinician's ability to center the intervention on the patient, allowing them to express themselves and guide the process (Shah et al., 2024). Clinicians should therefore adopt a patient-centered approach and remain open to suggesting

alternative therapeutic interventions if the safety plan does not align with certain patients' needs.

Strengths and Limitations

Some strengths and limitations were identified in our research. The small sample size allowed for a detailed verbatim analysis but limited the diversity of perspectives. Incorporating input from other emergency responders such as social workers and general emergency staff could have enhanced the study by providing a more comprehensive perspective. Despite presenting the safety plan to clinicians in the beginning of the interviews, our results revealed that their understanding of the tool was limited, potentially influencing their responses regarding safety planning in emergency settings. Additionally, all patients recruited had outpatient follow-up, preventing insights from individuals who did not receive or were less likely to seek follow-up care. Finally, each interview was conducted by a duo of researchers who convened afterward to discuss their impressions. This reflective process allowed them to distinguish their own perspectives from those of the participants, leading to a more nuanced analysis.

Conclusion

In conclusion, our study delved into the perspectives of patients and clinicians regarding the use of safety plans for suicidal patients in EDs, revealing 6 key elements for a successful use of this intervention in emergency settings. Participants' testimonials highlight diverse needs and opinions regarding safety planning, emphasizing the importance of personalized and adaptable approaches and formats. They advised against completing the safety plan during periods of heightened emotional intensity, such as upon arrival at the ED. Clinicians agreed that the responsibility of safety plans should not rest solely on mental health professionals, advocating for its extension to a broader range of professionals. Given patients' primary need for attentive listening and provision of tools and resources, alongside clinicians' heavy workloads, it is imperative to use staff's limited time to make meaningful interventions that can empower patients. For individuals for whom the safety plan is less suitable, alternative interventions should be provided to ensure their safety.

Beyond these recommendations, a change in the ED culture is needed to ensure that the management of suicidal patients in EDs includes brief therapeutic interventions like safety planning, to mitigate the risk of suicide. Rather than mental health care, the ED's current focus is risk assessment to quickly determine disposition. This leads to either admitted patients who are left on their own in ED beds or discharged individuals who remain unequipped to deal with their suicidal thoughts. The safety plan has the potential to enhance the usefulness and effectiveness of ED care by improving communication between patients and clinicians and equipping patients with empowering tools. There is a need for ongoing exploration and adaptation of safety plans and other brief ED interventions to better align with the complex needs of suicidal patients and to change practices in emergency care settings.

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Declarations

Competing Interests The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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