Safety Planning Intervention in psychiatric services: A Swedish implementation study- Research plan

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Summary

Suicide is one of the leading causes of premature death and a prioritized public health concern. Safety Planning Intervention (SPI) is a method with strong international research support for reducing suicidal behaviour by enhancing individuals' strategies for crisis management and improving access to support. SPI is a single-session intervention lasting approximately 45 minutes, which any healthcare provider can deliver after a brief training. Despite promising results, the implementation of SPI in Swedish healthcare remains limited. This project examines how SPI can be integrated into various healthcare settings and evaluates its impact on suicide-related emergency visits, psychiatric hospitalizations, and healthcare utilization.

Data and Methods

Stepped-Wedge implementation study in specialist psychiatry, where SPI is gradually introduced in psychiatric units. This study design allows for a robust evaluation of effects while ensuring all units eventually receive the intervention. As part of this study, a survey among healthcare professionals will be conducted to assess their experiences with feasibility, usability, and implementation barriers.

Data will be collected from QlikView healthcare utilization data. Poisson regression models with mixed effects will be used to analyze the impact of SPI on emergency visits and psychiatric hospitalizations. A health economic analysis will be conducted to evaluate the cost-effectiveness of SPI.

Societal Relevance and Impact

The project contributes to Sweden’s national suicide prevention strategy by:

1. Scientifically evaluating the feasibility and effects of SPI in Swedish healthcare.
2. Developing training programs for healthcare professionals in suicide prevention.
3. Informing policy decisions and national guidelines.
4. Analyzing the cost-effectiveness of SPI from a societal perspective.

Implementation

The research team includes experts in suicide prevention, psychiatry, epidemiology, patient safety, and health economics, creating a strong multidisciplinary foundation.

The Stepped-Wedge design ensures an ethically and methodologically sound evaluation of SPI. Gradual implementation allows for time-based comparisons, minimizes selection bias, and ensures all patients receive the intervention.

The project is conducted in close collaboration with healthcare providers and policymakers to ensure that research findings can be integrated into clinical practice and strengthen suicide prevention efforts in Sweden.

Background

Suicide as a Public Health Crisis and the Need for Systemic Interventions

Suicide remains one of the leading causes of premature mortality worldwide, accounting for over 720,000 deaths annually (1). Despite significant advancements in healthcare, efforts to reduce suicide rates have not kept pace with those targeting infectious and chronic diseases. Suicide is a multifaceted issue, influenced by biological, psychological, and social determinants, and often occurs in individuals who have recently interacted with healthcare services.

As previous work by our research group has shown, individuals at risk of suicide frequently seek help across various healthcare settings, including medical emergency care, primary care, and psychiatric services, highlighting the need for effective and integrated interventions (2). Further, research from our group has demonstrated that individuals admitted to medical emergency inpatient units have a 23-fold increased suicide risk compared to the general population, a risk that persists for decades (3, 4).

Suicide Prevention Efforts and Challenges in Swedish Healthcare

Despite Sweden's national suicide prevention strategy, significant gaps remain in suicide risk assessment, intervention accessibility, and follow-up care across hospital care, primary care, and psychiatric services. Reports from the National Board of Health and Welfare and the Public Health Agency of Sweden highlight systemic deficiencies in suicide prevention efforts, emphasizing the need for structured interventions to improve patient safety and care continuity (5, 6).

Hospital Care: High-Risk Periods and Limited Follow-Up

Patients hospitalized for intentional self-harm or suicide attempts face a heightened risk of suicide immediately following discharge. A 2023 report from the National Board of Health and Welfare revealed that only 13% of patients discharged after hospitalization for self-harm received a follow-up appointment within the recommended seven-day period (7). This is concerning, given that the immediate post-discharge period is one of the highest-risk timeframes for suicide.

Moreover, short hospital stays further complicate suicide prevention efforts. 65% of patients admitted for intentional self-harm are discharged within 24 hours, and 80% are discharged within five days, highlighting the limited time available for structured suicide prevention interventions (7). Additionally, only 40% of patients hospitalized for self-harm undergo a structured suicide risk assessment, demonstrating a lack of standardized suicide prevention procedures in hospital care.

Primary Care: Insufficient Risk Assessment and Lack of Standardized Approaches

Primary care plays a crucial role in suicide prevention, as it often serves as the first point of contact for individuals experiencing mental health distress. According to the National Board of Health and Welfare, it is essential that primary care providers identify early signs of mental illness and suicide risk and offer appropriate interventions. However, many primary care clinics lack standardized protocols for suicide risk assessment, leading to inconsistencies in clinical practice and missed opportunities for intervention (7). A literature review on primary care personnel's experiences with suicide prevention highlighted several major barriers, including lack of structured training, resource constraints, time pressure, and the absence of clear guidelines for handling suicidal patients (8).

Psychiatric Services: Resource Limitations and Challenges in Continuity of Care

Despite psychiatric services being a key access point for individuals at high risk of suicide, resource shortages, long waiting times, and a lack of structured follow-up strategies pose significant challenges to effective suicide prevention. The National Board of Health and Welfare (7) reports that one-third of individuals who die by suicide had an active contact with psychiatric services before their death, yet many lacked a structured care plan or documented suicide risk assessment.

A growing body of evidence suggests that suicide prevention strategies should not be limited to psychiatric care but should be integrated into primary and medical emergency care, where many at-risk individuals seek help. The *Lancet Psychiatry* report "Gone Too Soon"(9) highlights that individuals with mental illness or distress experience a significantly reduced life expectancy, with men losing on average 10.2 years and women 7.3 years, due to both suicide and physical health comorbidities. The report identifies fragmented care structures, diagnostic overshadowing, and stigma as key barriers to effective suicide prevention, emphasizing the urgent need for evidence-based interventions that can bridge the gap between primary, medical, and psychiatric care.

Shifting from Risk Prediction to Therapeutic Risk Management

Traditional suicide prevention efforts have often relied on risk stratification models, where individuals are categorized as low, medium, or high risk based on clinical assessments. However, research has increasingly challenged the reliability of risk prediction models. A review by Hawton et al. (10) found that suicide risk assessments lack predictive validity, with many studies demonstrating that risk classification does not accurately distinguish individuals who will attempt suicide from those who will not. Similarly, Fortune & Hetrick (11) argue that even the most sophisticated risk prediction models have a positive predictive value of only 5.5%, meaning that for every 100 individuals classified as high risk, fewer than six will actually attempt suicide. These findings suggest that focusing on risk categorization alone is insufficient and that interventions should instead prioritize therapeutic risk management strategies.

Safety Planning Intervention (SPI): A Brief, Scalable Suicide Prevention Tool

Safety Planning Intervention (SPI), developed by Stanley & Brown (12), is a brief, structured suicide preventive intervention designed to help individuals identify warning signs, develop coping strategies, and establish emergency contact pathways. SPI is a single-session intervention that typically lasts approximately 45 minutes and is delivered in clinical or emergency care settings. It is designed to help individuals identify warning signs, develop coping strategies, and establish a concrete plan for seeking support during a suicidal crisis. Unlike traditional risk assessments that focus on predicting suicide risk, SPI actively engages individuals in managing crises before they escalate. The intervention consists of six core steps:

1. Recognizing warning signs – Helping individuals identify early indicators of a suicidal crisis.
2. Developing internal coping strategies – Encouraging self-management techniques to reduce distress without external intervention.
3. Utilizing social support – Identifying trusted contacts who can provide emotional and practical assistance.
4. Contacting professionals and crisis services – Establishing direct links to mental health providers, crisis hotlines, and emergency services.
5. Restricting access to lethal means – Implementing evidence-based strategies to limit access to firearms, medications, or other means of suicide.

6. Enhancing motivation and commitment – Reinforcing the patient's agency and ability to manage distress effectively.

Empirical Evidence Supporting SPI Effectiveness

1. *Randomized Controlled Trial in Emergency Departments (Stanley et al., 2018, JAMA Psychiatry)*

A multisite randomized controlled trial (RCT)(13) involving 1,640 suicidal patients across 9 Veterans Health Administration emergency departments (EDs) found that SPI+ (SPI with structured follow-up) reduced suicide attempts by 45% over six months compared to usual care. Additionally, SPI+ patients were twice as likely to engage in mental health treatment post-ED visit (OR = 2.06, $p < .001$).

2. *Effectiveness of SPI in Outpatient Care (Zonana et al., 2018)*

Zonana et al. (14) examined the impact of Safety Planning Intervention (SPI) in an outpatient mental health clinic, finding a 69% reduction in total inpatient days ($p = .04$) and a 47% decrease in psychiatric emergency visits ($p = .09$). While the drop in suicide attempts (from five to one, $p = .10$) was not statistically significant, SPI was linked to increased engagement with crisis services and an 18% rise in scheduled outpatient appointments, indicating improved continuity of care. However, missed appointments increased by 34%, particularly among patients with schizophrenia or schizoaffective disorder, suggesting that some groups may need additional support to fully benefit from SPI.

3. *Findings from Fergusson et al. (2022): A Systematic Review of SPI Effectiveness*

Fergusson et al. (15), conducted a systematic review of 26 studies across emergency departments, inpatient psychiatric units, outpatient mental health services, and community-based care, making it one of the most comprehensive evaluations of Safety Planning Intervention (SPI) to date. The review found consistent reductions in suicidal ideation and behaviour, with several studies reporting decreased suicide attempts and lower hospitalization rates, reinforcing SPI's role in preventing crisis escalations. Treatment adherence improved significantly, particularly when SPI was combined with structured post-discharge follow-up. Qualitative findings indicated that SPI was well-accepted by both patients and clinicians, who appreciated its structured, patient-centred approach.

Meta-Analysis of SPI Effectiveness (Nuij et al., 2021)

The meta-analysis by Nuij et al. (16) is one of the most comprehensive evaluations of Safety Planning-type interventions, synthesizing data from six RCTs with 3,145 participants across emergency departments, inpatient psychiatric units, and primary care clinics. The study found that SPI or adaptations of SPI reduced suicide attempts by 43%, significantly improved treatment adherence, and increased engagement with mental health services post-discharge. The greatest effects were observed when SPI was combined with structured follow-up contacts, highlighting the importance of continued support beyond the initial safety planning session. The intervention was particularly effective for high-risk populations with a prior history of suicide attempts. Nuij et al. (2021) concluded that SPI is one of the most effective brief interventions for suicide prevention, reinforcing the need for its integration into routine clinical practice to provide structured and evidence-based support for individuals at risk.

Challenges Related to Feasibility and Healthcare Integration

Chesin et al. (17) examined the feasibility of Safety Planning Intervention (SPI) implementation in five U.S. Veterans Affairs emergency departments (EDs), finding that 98% of ED staff viewed SPI as

acceptable and beneficial, particularly in enhancing patient safety during discharge. However, initial concerns about workload, logistical feasibility, and workflow disruptions were raised. These concerns diminished over time as SPI became routine practice, especially when training and administrative support were provided. This suggests that successful implementation in Sweden's EDs would require structured training, workflow integration, and leadership support to ensure long-term sustainability.

Conclusion: The Need for SPI in Swedish Healthcare

Despite Sweden's well-developed healthcare system and national suicide prevention strategy, significant gaps remain in the identification, management, and follow-up of individuals at risk of suicide. Recent reports from the National Board of Health and Welfare and the Public Health Agency of Sweden (5, 7) highlight major deficiencies across hospital care, primary care, and psychiatric services, including limited suicide risk assessments, inadequate post-discharge follow-up, and a lack of structured suicide prevention protocols. These challenges underscore the need for evidence-based, scalable interventions that can be effectively integrated into routine healthcare practices.

Safety Planning Intervention (SPI) offers a structured, practical, and effective solution to strengthen suicide prevention in Sweden. SPI has demonstrated significant reductions in suicide attempts and improved treatment adherence (Nuij et al., 2021; Stanley et al., 2018; Fergusson et al., 2022). Unlike traditional suicide risk assessments that focus on predicting risk, SPI provides a personalized and actionable safety plan for patients, ensuring they leave healthcare settings with concrete strategies for crisis management and structured follow-up pathways.

By implementing SPI in psychiatric services, Sweden has the opportunity to address critical weaknesses in suicide prevention, improve continuity of care, and reduce the burden of suicide-related hospitalizations and emergency visits. This study will be the first systematic evaluation of SPI in Sweden, providing crucial evidence on its feasibility, effectiveness, and implementation challenges. The results will serve as a foundation for national-scale implementation and contribute to improving Sweden's suicide prevention framework, ensuring that individuals at risk receive timely, structured, and sustained support.

Theoretical framework of the study

The theoretical foundation of this study integrates multiple perspectives on suicide prevention. SPI aligns with the Interpersonal Theory of Suicide (Joiner, 2012), addressing perceived burdensomeness and thwarted belongingness by strengthening social support and self-management skills. Additionally, the Stress-Vulnerability Model (Mann & Arango, 1992) highlights the need for interventions like SPI that enhance resilience in high-risk individuals.

The Stress-Vulnerability Model (18) posits that suicidality arises from an interplay between individual vulnerabilities and environmental stressors. When an individual's coping capacity is overwhelmed, the risk of suicidal behaviour increases. SPI mitigates this risk by equipping individuals with strategies to recognize early warning signs, develop coping mechanisms, and establish supportive networks, thereby enhancing resilience and reducing vulnerability to stress-related triggers.

Complementing this, the Interpersonal Theory of Suicidal Behavior (19) highlights the role of social disconnection and perceived burdensomeness in the emergence of suicidality. Individuals who feel alienated or believe they are a burden on others may develop a stronger desire for death. SPI directly counters these factors by fostering connections with supportive individuals, reinforcing a

sense of belonging, and guiding individuals toward resources that reaffirm their value and role in their social environment.

Another key perspective is the Evolutionary Theory of Defeat and Entrapment (20) which suggests that suicidal behaviour is driven by a perceived inability to escape distressing circumstances. When individuals feel trapped in unbearable situations without viable solutions, suicidality may emerge as a perceived escape route (21). SPI provides structured pathways for breaking these negative cycles by helping individuals shift their perspective, identify alternative coping strategies, and create actionable steps that instil a renewed sense of agency and hope.

Furthermore, the Person-Centred Care Approach strengthens the foundation of SPI by emphasizing the importance of treating individuals as active participants in their own care. Rooted in Carl Rogers' theory of person-centred therapy, this approach prioritizes empathy, authenticity, and respect for the individual's lived experience (22). By aligning with the biopsychosocial model (23) SPI ensures that suicide prevention efforts extend beyond symptom management to include psychological and social determinants of well-being. Person-centred care also reinforces the necessity of tailoring interventions to the individual's unique context, recognizing that effective suicide prevention must address the whole person rather than just the crisis moment (24).

Originality

This is the first study in Sweden to evaluate the implementation of Safety Planning Intervention (SPI) filling a critical gap in suicide prevention research. Despite strong international evidence for SPI, no Swedish studies have examined its feasibility or effectiveness in any healthcare setting. Given that many individuals who die by suicide have had recent healthcare contact, ensuring effective suicide prevention strategies in these settings is crucial.

This study adopts a stepwise implementation strategy, allowing SPI to be introduced progressively while enabling structured evaluation. In specialist psychiatry, a stepped-wedge approach ensures all service areas receive SPI while permitting comparisons across different implementation phases.

The study will identify barriers and facilitators to implementation, assess SPI's real-world applicability, and generate evidence to inform policy and clinical practice in Sweden.

The results will not only enhance Sweden's national suicide prevention framework but may also serve as a model for broader international adaptation and implementation of SPI in diverse healthcare contexts, ultimately preventing unnecessary loss of life.

Objective

The project aims to assess the feasibility, implementation, and outcomes of Safety Planning Intervention (SPI) within psychiatric services. The study will evaluate the impact of SPI on suicide-related healthcare utilization in psychiatric services.

Research Questions

Effectiveness and Outcomes in Psychiatric Services

RQ1: What effect does SPI have on emergency visits and inpatient admissions due to suicide attempts in psychiatric services, when introduced using a stepped wedge implementation?

RQ2: What is the health-economic impact of implementing the Safety Planning Intervention (SPI) in psychiatric services, in terms of budget impact and cost-effectiveness based on healthcare costs, productivity gains and prevented suicide attempts compared to usual care?

Study design and methods

Stepped Wedge Implementation Study in Adult Specialist Psychiatry

SPI is currently used in psychiatric services within Region Skåne by some practitioners. The intervention is planned to be introduced more broadly to all psychiatric units. The Stepped-Wedge implementation study is designed to systematically introduce SPI in adult psychiatric services while ensuring rigorous evaluation of its effectiveness. This approach allows for phased implementation while simultaneously generating high-quality data on clinical and economic outcomes. In this project, we will investigate the effect of SPI on emergency visits, conduct a cost-effectiveness analysis and a staff survey of implementation.

Research Question Addressed

RQ1: What effect does SPI have on emergency visits and inpatient admissions due to suicide attempts when introduced using a stepped wedge implementation?

RQ2: What is the health-economic impact of implementing the Safety Planning Intervention (SPI) in psychiatric care, in terms of budget impact and cost-effectiveness based on healthcare costs, productivity gains and prevented suicide attempts compared to usual care?

Study 1: The effect of SPI on emergency visits and inpatient admissions due to suicide attempts

SPI will be implemented progressively across the four public psychiatric clinics in Skåne, comprising all adult psychiatric emergency care and inpatient care in the county. A stepped wedge implementation design will be used so that the implementation occurs at 6-month intervals (Table 1). During the first four weeks of the implementation phase at each site, SPI training will be provided in groups to the staff of all inpatient units and emergency units at the site. The study design is illustrated in **Figure 1** below.

Data extraction

Data on emergency unit visits and inpatient admissions coded with diagnoses that indicate suicidal behaviour (ICD-10: X60-84) and their ICD-11 counterparts if ICD-11 is implemented in Sweden during the study) will be extracted from the electronic registry system used in Skåne through QlikView. Through this program, such data can be extracted on the aggregate level (only) per month, per site, per sex, and age category. We will extract such data for the entire study period of 45 months as well as for 48 months before the start of the study to increase the statistical power of the analyses.

The following data will be collected in aggregated form per month for each participating clinic (Malmö, Lund, Helsingborg, Kristianstad) and stratified by gender and age group:

- Number of emergency visits with ICD-10 diagnoses for suicide attempts (X60–X84) and events of undetermined intent (Y10–Y34).
- Number of psychiatric inpatient admissions with the same diagnoses.
- Re-visits to the emergency department due to suicide attempts and events of undetermined intent within 30 days, six months, and one year.
- Re-admissions to psychiatric inpatient care due to suicide attempts and events of undetermined intent within the same three time periods

Study 2: Cost-Effectiveness Analysis

A comprehensive cost-effectiveness and budget impact analysis will be conducted to evaluate the health-economic value and financial impact of SPI implementation within psychiatric services. This analysis will compare intervention costs with potential savings generated from reduced hospital admissions, emergency department visits, and outpatient psychiatric care and relate these to estimated health outcomes.

Analysis Methods

The effect of SPI on emergency visits and inpatient admissions due to suicide attempts

We will employ mixed-effect Poisson regression models to analyse the effect of the implementation on emergency visits and inpatient admissions for suicidal behaviour. The models will use the total number of such events for each month as the outcome measure, using the total population in the catchment area of each site as an offset variable in order to consider demographic changes and to be able to calculate rate ratios. The main variable of interest is the intervention variable, which in the basic analysis will take the value 0 for all months prior to the implementation at each site and 1 for all months from the intervention and onwards. Each site will be given a random intercept to model different baseline levels of suicidal behaviour prevalence. We will control for seasonal variation by using calendar month as a random intercept, and we will also control for secular time trends by using chronological time as an independent variable.

In more elaborate models, we will use random slopes for sites, as well as study a slope effect during the first 6 months after implementation in each site. Such models will be compared to the basic model using the likelihood ratio test for nested models and through the use of Akaike and Bayesian Information Criteria (AIC and BIC, respectively) for non-nested models.

In secondary analyses of a more explorative character, we will include interaction effects between intervention effect and sex and age group, respectively. This will allow us to assess whether the effect of the implementation varies across different demographic groups. We will also broaden the outcome measure to include self-harm events of undetermined intent, including poisoning with undetermined intent (ICD 10: Y10–Y34) because, arguably, some of those events are in fact suicide attempts.

Calculations of statistical power

Calculating statistical power in a study design such as this is far more complex than statistically simpler studies. However, it can readily be done by simulating data in R and running the analyses on simulated data repeatedly (R code available on request). The total number of patients admitted to inpatient units for suicide attempts in Sweden was 7383 in 2022 (25). Assuming that the rate of suicide attempts is the same in the four catchment areas of the psychiatric clinics in Skåne, and assuming that implementation of the SPI intervention reduces this amount by 10%, the statistical power can be calculated to 92.6 %. The simulation does not include variations of suicide attempts over time or any seasonal variation, but this is expected to lower the estimated statistical power only marginally. We thus conclude that the statistical power is sufficiently high for the planned study.

Cost-effectiveness analysis

A comprehensive cost-effectiveness and budget impact analysis will be conducted to evaluate the health-economic value and financial impact of SPI implementation within psychiatric services. This analysis will compare intervention costs with potential savings generated from reduced hospital

admissions, emergency department visits, and outpatient psychiatric care and relate these to estimated health outcomes.

Key components of the cost-effectiveness and budget impact analysis:

- Direct healthcare costs: Expenses related to SPI implementation, training, and healthcare resource utilization.
- Indirect costs: Potential productivity gains from reduced suicidality and improved mental health.
- Cost-effectiveness ratio: The incremental cost per prevented suicide attempt or psychiatric hospitalization.
- Sensitivity analysis: Examining variations in costs and outcomes under different implementation scenarios.
- Budget impact analysis: Assessing the financial feasibility of scaling up SPI across multiple psychiatric units.

Analysis Method

- Cost-effectiveness analysis: Evaluating health-economic impact using cost-effectiveness ratios, budget impact assessments, and sensitivity analyses following standard methods for economic evaluation of healthcare (26).

and outcomes in standard clinical practice remain underexplored. By using a stepped-wedge model, this study can provide crucial insights into how SPI functions across diverse healthcare environments, informing national implementation strategies and ensuring long-term sustainability.

Ethical Considerations

In this research project, only aggregated data (number of healthcare contacts per clinic, readmissions, gender, and age category) from Region Skåne's administrative registration systems will be analyzed (note: not from medical records). No individuals will be actively included, and no personal or individual-level data will be collected or processed.

The intervention itself, the Safety Planning Intervention (SPI), is being implemented as part of routine psychiatric care in Region Skåne, independently of the research project. Any patient reactions or other clinical consequences related to SPI will therefore be managed within the framework of standard procedures and clinical pathways in psychiatry.

A potential indirect risk associated with the stepped-wedge implementation design is that some patients may gain access to the Safety Planning Intervention (SPI) later than they would have if a simultaneous rollout had occurred across the entire region. However, we consider this temporal variation not to constitute a significant risk to patients, as psychiatric services already offer a wide range of treatment options and structured interventions aimed at reducing suicide risk. Consequently, patients will continue to receive care in accordance with existing routines and standard clinical practice, regardless of access to SPI at any given time.

At the same time, the potential benefits of the project are considerable. By scientifically evaluating the implementation of SPI in routine clinical settings, the study may contribute to improved suicide

prevention, more appropriate care, and enhanced patient safety. Moreover, the results have the potential to inform practice both nationally and internationally, further increasing the value of the project.

In summary, the scientific and societal value of the project clearly outweighs the minimal risks identified, as no identifiable individual data will be processed, and no research-specific procedures or treatments will be conducted at the individual level. The project thus meets the requirements of the Swedish Ethical Review Act, in which the anticipated benefits must clearly exceed any potential risks.

Relevance for society

Suicide is a major public health concern, with severe consequences for individuals, families, and society at large. Effective suicide prevention strategies are critical to reducing unnecessary loss of life and alleviating the emotional and economic burden associated with suicide and suicide attempts. This project contributes to these efforts by implementing and evaluating Safety Planning Intervention (SPI) across psychiatric healthcare settings, ensuring that individuals at risk receive structured, evidence-based support at critical points in their care journey.

By integrating SPI into psychiatric services, the project directly addresses a gap in suicide prevention efforts in Sweden. Research has shown that many individuals who die by suicide have had recent contact with healthcare services, yet opportunities for intervention are often missed. This study aims to bridge that gap by embedding SPI into routine healthcare workflows, improving early identification and crisis management for suicidal individuals.

Beyond its direct impact on patient care, the project has broader societal implications:

- Enhancing healthcare providers' ability to intervene effectively: By training staff across different healthcare contexts, the project strengthens the capacity of the healthcare system to respond to suicidality in a structured and proactive manner.
- Reducing healthcare costs associated with suicide attempts: Suicide attempts often lead to repeated hospitalizations, emergency visits, and long-term mental health issues. By preventing suicide attempts, SPI may contribute to lower healthcare expenditures and more efficient resource allocation.
- Informing national suicide prevention strategies: The study's findings will generate evidence-based recommendations for the broader implementation of SPI in Sweden's healthcare system. This can guide policymakers in scaling up effective suicide prevention interventions at a national level.

By integrating research into real-world healthcare settings, this project ensures that its findings are directly applicable and can be translated into concrete policy recommendations and clinical practice improvements. Ultimately, the project contributes to reducing suicide rates, improving mental health outcomes, and fostering a more resilient and responsive healthcare system that prioritizes suicide prevention as a fundamental component of patient safety and public health.

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