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# State Policy Can Improve Suicide Prevention in Health Care Settings

Promising policies highlighted in 4 U.S. states

## Overview

Suicide is a complex public health issue that affects millions of Americans every year. The U.S. suicide rate rose by 30% from 2000 to 2020, with disproportionately large increases among young adults, veterans, and certain racial and ethnic groups.[1] The total number of suicides climbed to more than 49,000 deaths in 2022—the highest number ever recorded in the country.[2] An estimated 1.6 million adults attempted suicide that same year.[3]

Multiple factors at the individual, social, and structural levels influence suicide and require comprehensive public health solutions.[4] One approach focuses on health care settings, because research shows that most people who die by suicide visited a health provider in the prior month or year.[5] Specifically, in a study of more than 2,600 individuals who died by suicide from 2000 to 2013, researchers found that nearly 30% of the decedents made some type of health care visit in the seven days before their death, 54.3% in the prior month, and more than 90% within the year.[6] This data suggests that providers in health care settings have the opportunity to identify individuals experiencing suicide risk and ensure that they are connected to evidence-based care.

Public policy can provide incentives for health care settings and providers to implement proven strategies to help prevent suicide. The World Health Organization endorses a policy approach to suicide prevention, saying suicide is a health issue that "needs to be prioritized on the global public health and public policy agendas."[7] At the state and local levels, policymakers should "build suicide prevention into the fabric of a community, … unlock opportunities, build partnerships," and foster safe and healthy communities to save lives.[8]

However, preventing suicide through policy can be a complex and difficult undertaking. In a 2018 survey of suicide prevention leaders from all 50 states, five U.S. territories, and 15 Indigenous tribes, 71% of respondents indicated a lack of state legislation or policy as a barrier to suicide prevention efforts in their jurisdictions. Such legislation helps to "stabilize, sustain, and spur growth in suicide prevention," according to a U.S. Centers for Disease Control and Prevention (CDC) survey on suicide prevention, and its absence can hinder progress and innovation.[9]

This brief by the American Foundation for Suicide Prevention, with support from The Pew Charitable Trusts, identifies three evidence-based state-level policies and strategies for comprehensive, effective suicide prevention in health care settings:

- Suicide prevention training for health care professionals.
- Mental health parity in insurance coverage, which requires reimbursement for mental health care on par with physical health care.
- Integration of suicide prevention in primary care settings.

These policies were also included in the 2024 National Strategy for Suicide Prevention (NSSP), published by the U.S. Department of Health and Human Services.[10] The brief will highlight how four states—Colorado, Montana, Oregon, and Vermont—have successfully implemented at least one of these policies, and the factors that facilitated or created barriers to implementation.

# Methodology

This research began with a literature review that encompassed both academic and gray literature published outside traditional academic channels, as well as legislative and programmatic documents. The goal of the literature review was to identify evidence-based policies and programs that advance effective suicide prevention and care in health care settings. Databases—including PubMed, APA PsycInfo, EBSCOhost, and Google Scholar—were queried for empirical studies, systematic reviews, case studies, and review pieces focused on the U.S. and the intersection of public policy and health care related to suicide prevention. Articles reviewed were primarily published after 2010, with foundational articles included regardless of publication date. The literature review identified three state legislative policies that provide promising evidence to effectively address suicide risk for patients in health care settings.

Along with conversations with policy experts in leading national organizations such as the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention, the review highlighted four states that have: (1) a history of some success in one or more of the three evidence-based policies identified in the literature review; (2) successful intergovernmental and community collaboration efforts; and/or (3) the presence of successful suicide prevention leaders in the form of state employees, evaluators, researchers, or volunteer advocates. These findings informed a qualitative research design involving expert interviews with state-level suicide prevention professionals who work for state agencies and universities, as well as nonprofit staff and volunteers, to understand how the specific policies and programs identified in the literature review were successfully implemented in Colorado, Montana, Oregon, and Vermont. Researchers conducted seven interviews with suicide prevention leaders across these four states.

# Evidence-based state policies

Three proven strategies that can help facilitate access to prevention and intervention services for patients at risk for suicide are suicide prevention training for health care providers, mental health parity, and the integration of suicide prevention strategies in primary care. These policies have the potential to change the way health care providers approach suicide, helping make suicide care a routine part of mainstream health care.

## Training for health care professionals

Despite frequent patient interactions, most mental health and primary care providers lack formal training in suicide assessment and intervention. Furthermore, while certain mental health conditions like depression are associated with risk for suicide, treatment for these conditions often lacks suicide-specific care.[11] This inadequate training impairs health providers' ability to identify risk and provide comprehensive, evidence-based suicide care, including screening and assessing at-risk patients and referring them to follow-up intervention and treatment services.

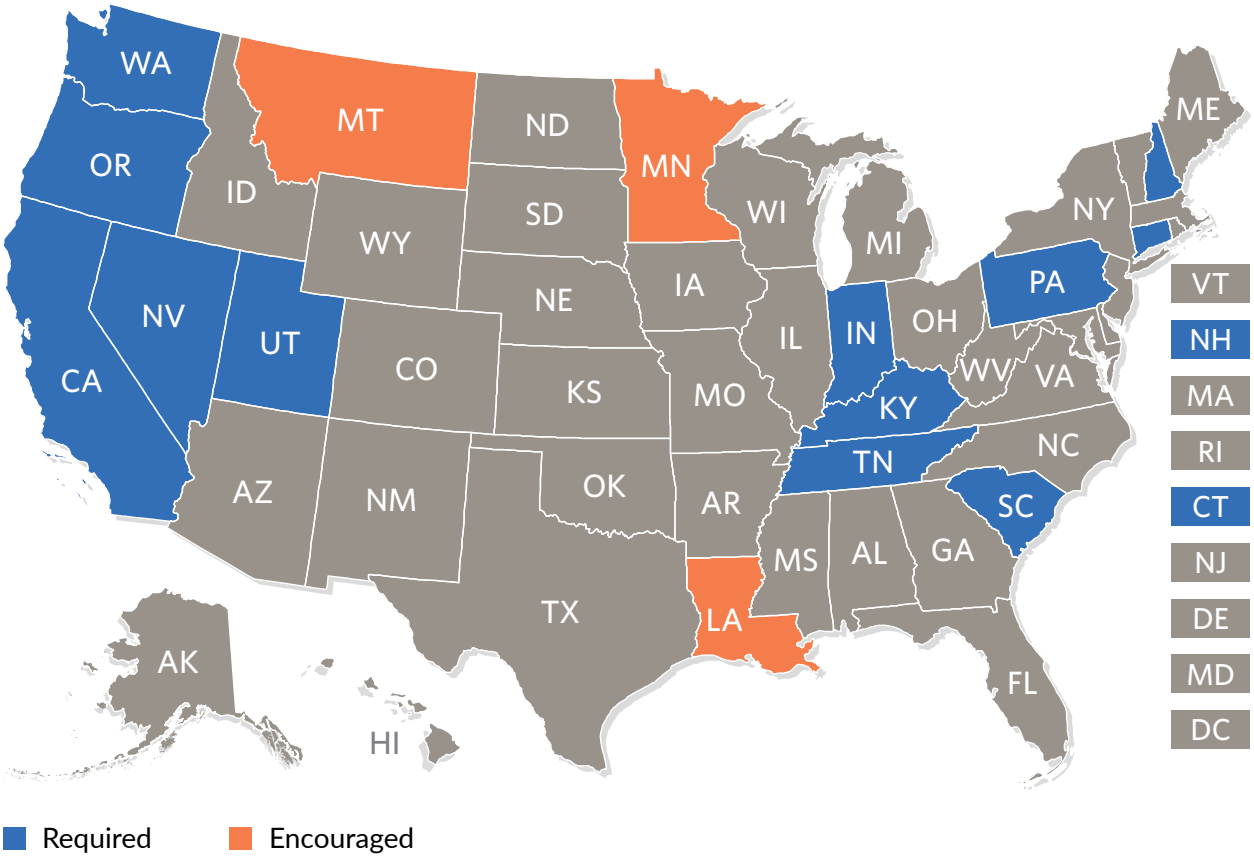
Research indicates that comprehensive approaches to suicide prevention in hospitals and large health maintenance organizations have demonstrated suicide rate reductions. These approaches often include training for health professionals as a critical component of their strategy.[12] Moreover, providers report greater confidence in assessment and treatment of suicidal patients and implement changes to suicide care practices and clinical policy after going through training.[13]

State policy can help fill this training and knowledge gap with laws mandating training as part of continuing education or licensure renewal to ensure that providers maintain the skills to address suicide risk. As of June 2024, 12 states require training in suicide prevention or assessment, treatment, and management for health professionals.[14] (See Figure 1.)

Within these 12 states, however, there is wide variation in the scope of this training and the professionals to whom such mandates apply.[15] For example, most state mandates require training for licensed mental health professionals such as psychologists, professional counselors, social workers, and marriage and family therapists, but they often do not extend this requirement to primary care providers or other medical/surgical providers and specialties. States that require training for these providers have diverse requirements, with some requiring only a one-time training. Individuals who die by suicide are more likely to have seen a primary care provider in the month before their death than any other type of health professional, making a strong case for extending regular training mandates to these providers.[16]

Figure 1

## 12 States Require and 3 Encourage Suicide Prevention Training for Health Care Professionals




Source: "Health Professional Training in Suicide Assessment, Treatment, and Management," American Foundation for Suicide Prevention, June 2024, https://afsp.org/training-health-professionals-in-suicide-assessment-treatment-and-management/.



## Suicide prevention integration in primary care

The integration of mental health and suicide prevention services into primary care settings can help improve patient access to these services, coordinate care between mental health providers and primary care physicians, and address patients' health needs in a holistic manner. Primary care providers can use key suicide prevention interventions, such as safety planning and lethal means counseling—helping patients at risk to identify steps to take during a suicidal crisis and ensuring that they are separated from means they can use to harm themselves—that have shown positive results for patients, including a reduced risk of suicide attempts.[17] Although research has not established a causal link between mental health integration and lower state suicide rates, some studies have found reductions in suicidal ideation (a range of contemplations, wishes, and preoccupations with death and suicide) among patients utilizing integrated physical and mental health care.[18] And integrated care models can also reduce time and location burdens related to follow-up for patients, and allow for more holistic care coordination and attention to social determinants of health—the environmental, social, and economic factors that can shape health and well-being.[19]

Several federal legislative advancements have encouraged integrated care, such as the Mental Health Parity Act of 1996, the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, and the Affordable Care Act of 2010, which also provided funding for such initiatives.[20] However, federal legislation has broadly focused on the integration of mental and behavioral health services rather than suicide prevention specifically.

Various approaches to mental health care integration have been shown to increase access to suicide prevention and intervention services. This brief highlights three examples:[21]

- Quality improvement initiatives, or programs and strategies designed to monitor, analyze, and improve the quality of mental health services and patient outcomes (such as the Zero Suicide framework, intended to integrate evidence-based interventions into health care settings and systems).
- Telehealth expansion, or policies that make it easier for patients to receive remote mental health services and monitoring from their own homes.
- Coordinated care organizations, or local networks of physicians, counselors, and dentists who work together to integrate care, maintain costs, and measure outcomes.

One barrier to the adoption of integrated care models has been a lack of reimbursement for preventive services from public and private health insurers, though the U.S. Centers for Medicare & Medicaid Services and other insurers have started to address this obstacle by covering at least some services.[22]

## State enforcement of mental health parity

Many people face challenges finding affordable care because there are often disparities in insurance coverage for behavioral and physical health conditions. Mental health parity refers to insurance coverage for mental health and substance use disorder treatment being no more restrictive than coverage for strictly physical health conditions.

Research indicates that state mental health parity laws are associated with higher use of mental health services, improved mental health outcomes, and reduced state suicide rates.[23] One study observed that states saw an increase in self-reported use of mental health care services one year after implementing these laws.[24] Another study found that mental health parity laws were associated with an estimated 5% reduction in suicide rates across the 29 states examined.[25]

Over the last nearly 30 years, the federal government has passed several pieces of legislation aimed at addressing disparities in insurance coverage. The Mental Health Parity Act, MHPAEA, the Affordable Care Act, and the fiscal years 2021 and 2023 Consolidated Appropriations Acts (CAAs) established, enhanced, and provided enforcement mechanisms for mental health parity. Yet, although these laws allowed for great advancements in mental health parity, suicide prevention was not specifically mentioned until the 2021 CAA.

Recent regulations have strengthened enforcement of these policies by requiring additional compliance oversight; mandating health plans and issuers to develop and implement a data analysis plan to demonstrate access to mental health and substance use disorder care; and taking corrective action to address existing disparities in coverage practices.

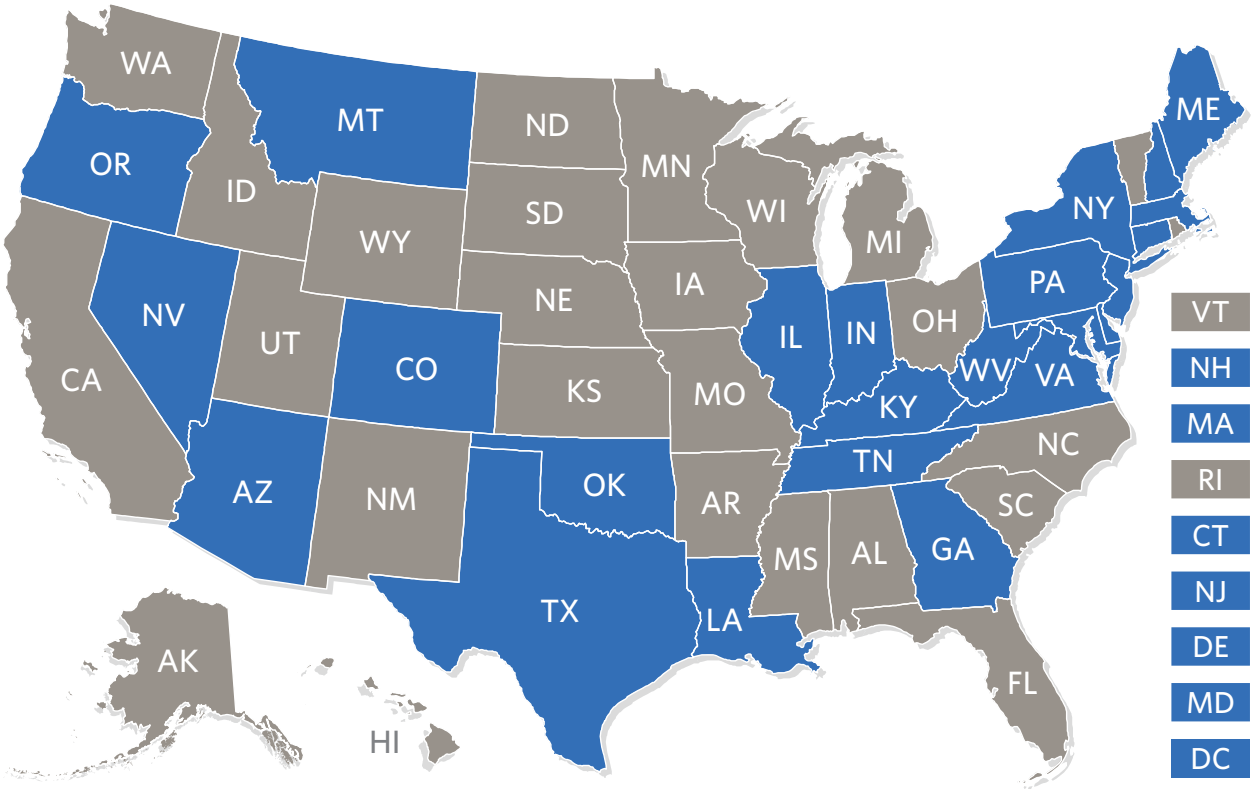
Yet oversight of enforcement for parity policies has fallen largely to states, resulting in most states passing laws requiring some level of parity and compliance with the federal law. Specifically, state parity reporting laws are essential to ensuring consistent implementation of the federal law. Such mandates require insurers and health plans to submit annual parity compliance analyses to state regulatory agencies and require state regulators to implement and report on enforcement activities. Compliance analyses are critically important to enforcing state and federal parity requirements: Without regular, accurate, and comprehensive reports on the coverage offered by insurance plans, state and federal agencies will be unaware of ongoing violations and unable to address them.

Currently, 24 states and the District of Columbia have parity reporting laws. (See Figure 2.) For states without reporting requirements, the 2021 CAA allows state insurance commissioners to request analyses from insurance payers to ensure parity law compliance.

Figure 2

## States With Mental Health Parity Reporting Laws

24 states and D.C. require violations to be reported




Source: "Mental Health Parity," American Foundation for Suicide Prevention, Jan. 9, 2023, https://afsp.org/mental-health-parity/.



## State policy implementation

Colorado, Montana, Oregon, and Vermont—four states diverse in geography, politics, and population—have all implemented the three state policies discussed above to varying degrees. (See Appendix.) The legislative, political, and economic landscape within each state, as well as a multitude of other factors, affects whether and how suicide prevention policies are enacted, scaled, and evaluated. This section highlights factors that promote success or create challenges for state policy adoption, implementation, and evaluation.

# Factors that promote successful state implementation of suicide prevention policy in health care settings

Across the four states, researchers identified three major factors that facilitated suicide prevention policy implementation supported by the literature review: leadership buy-in, collaboration and cross-sector support between those leaders and other health system professionals, and sustained funding. In combination, these factors have the potential to produce the most effective and sustained health care suicide prevention efforts. These findings reinforce similar conclusions identified in the literature review and expert interviews.

## Effective leadership buy-in

Effective leadership—at the individual, community, organizational, and state levels—is essential to the successful implementation of suicide prevention strategies in health care settings. Leaders must buy into and support the chosen strategy.[26] In particular, researchers identify leadership as a key aspect of readiness for change; leaders provide the motivation, guidance, and support necessary not only for implementation, but also for convincing others that reform is needed.[27]

## Collaboration and cross-sector support

Incorporating suicide prevention successfully into a state's health care system requires support from and collaboration among three key groups of stakeholders: community members, including users of health care services; officials and staff members in relevant state departments; and both the executive and legislative branches of government. Public health reform researchers refer to these three groups as an "iron triangle" of support that is pivotal for success.[28] Ideally, the iron triangle includes collaboration among departments and coalitions, federal and state governments, and communities affected by suicide, all of which help to overcome divides and encourage collaboration, combining research, policy, public health, and lived experience perspectives to design and enact change.[29]

## Sustained funding

Sustained funding that allows states to test and implement reform strategies over long periods of time is also key to ensuring innovation and success. In particular, funding mechanisms that allow for flexibility to develop and test novel approaches, and for evaluation over long periods of time, can help build an evidence base for chosen strategies and sustain their implementation for the long term.[30]

# Examples of state policy implementation

## Colorado

In Colorado, leadership, collaboration, cross-sector support, and funding led to the passage of S.B. 16-147, which supports the adoption and implementation of the Zero Suicide framework in health settings.[31] This legislation established a Colorado suicide prevention plan to be developed based on the framework and coordinated through the Office of Suicide Prevention (OSP). The legislation urges the OSP—working with the Suicide Prevention Commission and other stakeholders including health care and behavioral health systems, criminal justice systems, and educational institutions—to develop a state suicide prevention model incorporating components of Zero Suicide. The bill encouraged the development of improved training plans for providers, including risk screening and assessment and emergency procedures for 72-hour holds. The Colorado-National Collaborative, a public-private partnership, has also played a key role in bolstering the awareness and adoption of Zero Suicide

by coordinating with local departments of public health, collaborating with the Colorado Behavioral Health Administration on care integration initiatives, and promoting best practices related to lethal means safety and follow-up care for suicide loss survivors.[32]

With leadership and partnerships in place, Colorado was then able to seek federal funding from the Substance Abuse and Mental Health Services Administration to broaden and deepen the implementation of Zero Suicide. As one Colorado expert said, "Having a mandate to pursue suicide prevention in the health care center from that state level really entrenches this [framework]—institutionalizes it in a way that we can then apply for funding." Colorado's Department of Health Care Policy and Financing also provides incentives for health systems to adopt Zero Suicide through its Hospital Quality Incentive Payment (HQIP) program. The HQIP subcommittee identifies measures for health care settings to implement, which health systems then report on in order to qualify for financial incentives. Beginning in 2021, Zero Suicide was incorporated under the HQIP program's patient safety measures and includes practices such as establishing a Zero Suicide implementation team in health settings, conducting an organizational self-survey on current practices, and training providers in evidence-based suicide prevention practices.[33]

Combined with effective leadership and collaboration, these incentives have increased the use of Zero Suicide in health care settings across the state. Colorado's OSP hosts monthly Zero Suicide learning collaboratives with health systems, collaborates with the national Zero Suicide Institute at the Education Development Center, provides technical assistance to sites implementing Zero Suicide, and manages implementation reporting in the state. "I think one strength of Colorado's work is that coordination between health systems … to really tie the ribbon on care transitions and make sure that we are following up with someone after they are seen," one expert said.

## Montana

In rural states like Montana, finding a primary care provider—let alone one with training in suicide prevention—can be challenging. To expand access to health care services in the state and address barriers to care, communities and nonprofit organizations collaborated on their advocacy efforts, which led to the expansion of telehealth services with the passage of H.B. 43. This legislation aimed to address the geographic and financial limitations that make it difficult for individuals to access medical services, including mental health services, and other resources by permanently lifting certain restrictions on telehealth services that were paused during the pandemic.

Now, providers can render certain types of services without an established patient-provider relationship. The bill also removes restrictions on geographic proximity and location of patients and allows for additional types of technology to be used for telehealth services, such as audio-only calls. The expansion of telehealth has particularly affected and accommodated the most rural and remote communities around the state, and it has also increased access to care for the elderly, veterans, and others who may experience financial or transportation barriers to traditional care. "We're seeing an increase in access to health care that wasn't there because of the innovation with telehealth and the understanding of the vastness of our state," said one Montana expert.

## Oregon

In Oregon, collaboration and cross-sector support has helped enact suicide prevention policies addressing mental health parity and training for providers. In particular, the Oregon Alliance to Prevent Suicide (OAPS)—a state coalition supported by the Oregon Health Authority (OHA)—brings together subject matter experts, state agencies, representatives from multiple sectors (e.g., health care, schools, nonprofits, legislators),

community members, and those with lived experience to develop public policy recommendations for suicide prevention. Since it was established in 2016, the OAPS has supported 18 pieces of suicide prevention-related legislation.[34] The leadership and coordination provided by the OAPS have helped to advance meaningful legislation informed by lived experience. According to an Oregon expert, "The alliance has done a really amazing job bringing in the voices of lived experience. [OAPS] kind of led the charge with that."

Two pieces of legislation highlight the importance of such collaboration. In 2021, Oregon passed mental health parity legislation with H.B. 3046 directing Medicaid and private health insurance plans to cover behavioral health services, establishing standards for reporting to ensure compliance with parity rules, and requiring an annual comprehensive report to the Oregon Legislature. The most recent Health Services Advisory Group report from the OHA to the Oregon Legislature found that the administration of mental health and substance use disorder benefits were largely compliant with parity laws.[35]

Oregon also passed H.B. 2315 in 2021, requiring professionals licensed by a state board or regulated by the OHA to receive training in suicide risk assessment, treatment, and management as part of continuing education requirements. These mandates have made a difference for both patients and providers. As one Oregon expert explained, training has helped to ensure that providers are more comfortable asking their patients about their suicide risk: "It's making it so they know how to ask that question. They know what to do if [patients] say 'yes.' It makes it a little bit less hard to ask that question."

## Vermont

Through federal and state funding, cross-sector support, and effective leadership, Vermont has successfully implemented programs to improve the integration of suicide prevention and primary care. Key to this leadership are the Vermont Suicide Prevention Center (VTSPC), a public-private partnership that works with professionals across sectors to advance best practices for suicide prevention, and the Vermont Suicide Prevention Coalition, which includes cross-sector support from members representing public, private, and nonprofit entities. With VTSPC support, the coalition works with state government officials to coordinate statewide suicide prevention efforts.[36] One Vermont expert affirmed this collaboration: "The coalition has been very effective and does a lot of education and advocacy."

Quality improvement (QI) initiatives have been key in driving suicide prevention integration in Vermont. The state is one of 24 recipients of funding from the CDC's Comprehensive Suicide Prevention Program (CSP).[37] The grants the Vermont Department of Health received from 2020 to 2023 were used to create the Vermont Emergency Department Suicide Prevention Quality Improvement Initiative, which focused on improving the quality of care for patients in the state's 14 emergency departments who may be at risk for suicide.[38] The Vermont Program for Quality in Health Care (VPQHC) led this initiative, which focused on screening, assessment, safety planning, and follow-up care. "The drivers of increased activities, I think, are the grants," a Vermont expert said. "The CSP grant is getting toward the end of its fourth year and has been a catalyst for some of that activation." The initiative resulted in more than 300 hospital staff members completing this training. Building on this success, in response to the passage of H. 481 (Act 56) in Vermont in 2023, the initiative was submitted to the state's General Assembly as model protocol for suicide prevention and postvention (actions that lower risk and foster healing after a suicide death) services in health care facilities across the state.[39]

With a combination of federal (CSP) and state funding, Vermont also launched a QI initiative called Suicide Safer Pathways to Care program, which provides incentives to primary care practices to partner with community mental health agencies (CMHAs) with support from the VTSPC. The program provides mini-grants of $5,000 to primary care practices to collaborate with CMHAs to improve quality of care by establishing a clinical care pathway—or structured care plan—to guide suicide risk screening, assessment, safety planning, and follow-up

care for primary care patients.[40] CMHAs and primary care practices then meet regularly to discuss and improve these collaborative processes. Evaluations of the Suicide Safer Pathways to Care program have found that the program results in increased referrals and increased provider training, with 570 primary care and CMHA staff members trained in just the first six months of implementation.[41]

# Challenges to health care suicide prevention policy

Despite the successes in the four states, these promising policy approaches are complicated to adopt as state law, implement in practice, or evaluate in terms of effectiveness. Interviews with suicide prevention leaders identified three challenges that can create barriers to adopting and implementing suicide prevention policy: competing priorities, access to care and provider shortages, and difficulty linking prevention efforts to data showing lower suicide rates.

## Competing priorities

Providers, health care systems, and states alike have multiple priorities to consider and balance. These entities are called upon to address public health issues as well as social determinants of health. Often, these priorities require capacity and resources that limit teams' ability to focus on suicide prevention efforts. These competing priorities can also make it challenging to convince leaders and providers that policy changes are worth implementing. For example, because of existing institutional and organizational demands, one Vermont expert said that "getting [leaders and providers] to actually focus on a topic like developing and implementing a suicide prevention care pathway is a huge lift, and it's taken longer than it needed to take."

## Access to care and provider shortages

Geographic and financial limitations make it difficult for individuals to access medical services and other resources. Experts in all four states mentioned finding primary care providers with training in suicide prevention as a challenge, particularly in rural areas. As one Vermont expert said, "We have lots of barriers to reaching those far corners of the state that are harder to access, and we know the people can still be suffering and struggling."

Geography can also make scaling suicide prevention efforts difficult. As a Montana expert put it, "Scalability becomes an issue [determining] where we can work and provide a community with what [steps to take]. The next community over, though—it's hard to get them to do it. Taking things to scale across the state is really hard." And even if an individual can locate a primary care or mental health provider, financial burdens, including poor or nonexistent insurance coverage, often prevent people from engaging in care. This problem can be particularly challenging in the 10 states that have not expanded Medicaid coverage.[42]

Many states also find it difficult to attract new practitioners, even as existing providers struggle with burnout. "It's really the lack of providers and the cost that people have to take on—being overworked and having that constant burnout," an Oregon expert stated. "So, until that piece is changed, there is not going to be long-term sustainability." These challenges can make it difficult to attract new talent. "We constantly struggle with staffing. It's hard to hire physicians to come to [our state]," a Vermont expert said.

## Inadequate data infrastructure

Measuring the effect of state-level suicide prevention efforts is extremely difficult, because myriad factors influence the suicide rate. In addition, a state's data infrastructure can affect officials' ability to record and share information, and varying reporting timelines can lead to delays in gathering accurate figures. Adequate data infrastructure is necessary to accurately collect, analyze, use, and report on data related to suicide deaths in a

state, and to identify populations at risk, select appropriate prevention strategies, and evaluate the impact of interventions and programs. This challenge emerged in both the literature review for this brief and in the expert interviews. For example, after Vermont had experienced a slight dip in the suicide rate, one expert said, "I don't know how much of that can actually be attributed to what the state is doing." So, although many states are working hard to advance suicide prevention efforts in health care settings, assessing the effectiveness of these efforts remains challenging.

## Implications for research and practice

These findings have multiple implications for the future of research and practice in health care suicide prevention. First, the importance of robust research over an extended period on the impact of state-level health care policy on suicide rates cannot be overstated. Both the literature review and expert interviews conducted for this brief emphasize this need. At the state level, linking suicide prevention efforts to changes in the suicide rate is hampered by insufficient or inconsistent funding, short grant timelines, and challenges in data collection and reporting timelines. More broadly, there is scant published research in either the suicide or policy literature examining the effectiveness of policy efforts in saving lives. Increased research funding in this area and improved data infrastructure within and across U.S. states are necessary to fully understand if and how policy efforts affect suicide rates. This need also aligns with the NSSP, which prioritizes modernizing data infrastructure and staff capacity in these areas.[43]

Another key implication for practice is the need to implement and test novel prevention strategies. States, legislation, and funding mechanisms must allow for innovation and flexibility to develop, implement, and evaluate suicide prevention efforts in health care systems. The federal action plan that accompanies the 2024 NSSP outlines specific actions the federal government will prioritize to advance the goals and objectives of the NSSP.[44] In practice, however, novel approaches are often limited by grant timelines and administrative burdens, which may in turn curtail innovative thinking and solutions.[45] Strategies such as microgrants for primary care practices working with CMHAs and the expansion of telehealth access and insurance coverage are made possible through innovative thinking that is aligned with funding. Such funding should be sustained long enough to evaluate the short- and long-term impacts of those innovations.

Finally, both the literature and expert interviews emphasize the importance of collaboration in the effort to reduce suicides. Federal, state, and private funders have made great strides in this area. For example, the CSP grants, the American Foundation for Suicide Prevention's research grants program, and others emphasize the importance of partnerships and collaboration in research and practice. These advances should be maintained and expanded to encourage innovative collaborations within and across states.

## Conclusion

Effective state-level suicide prevention policy is challenging to implement and measure. In addition to the factors that promote prevention efforts and the challenges mentioned here, there are numerous considerations in the coordination of statewide prevention efforts. The Suicide Prevention Resource Center—a federally supported organization dedicated to advancing implementation of the NSSP—provides a valuable framework in its state suicide prevention infrastructure recommendations for addressing these considerations and moving toward more comprehensive suicide prevention efforts in the United States, many of which have been implemented by the states featured in this brief.[46]

A broad cross section of the U.S. population interacts with health care settings, and these visits offer a key intervention point where providers can identify people experiencing suicide risk and connect them to potentially life-saving care. Although evidence for a causal link between health care-related suicide prevention policies and state suicide rates is limited, there is clearly a need for systems change within health care to better support those at risk for suicide. Such changes require supporting patients as they search for entry points to care and support.[47] Many states—including the four featured in this brief—are seeing promising results. Particularly in states with effective leadership, cross-sector collaboration, and sustained funding, these changes can be implemented and scaled to benefit more people.

Both the existing literature and the expert interviews conducted for this brief suggest that those positive forces—leadership, collaboration, and funding—have the greatest impact when applied within a comprehensive, evidence-based suicide prevention framework such as Zero Suicide.[48] States can foster the development and implementation of innovative suicide prevention efforts through legislation and policy. To that end, the findings provide valuable insights into the combination of policies and constructive forces that may improve suicide prevention in health care settings, as well as the challenges to anticipate along the way.

# Limitations

This brief is subject to limitations. First, as mentioned, the literature relating to health policy evaluation and suicide prevention is relatively young, particularly as it pertains to suicide prevention in health care settings. There is little research assessing the causal relationship between suicide prevention policy and suicide rate reduction at the state or national level, making it difficult to identify evidence-based policies for suicide prevention in health care settings. Additional policy evaluation research is needed.

Second, the brief includes a small sample of expert interviews from four states, limiting the generalizability of findings to other states.

Finally, this brief is not intended to provide a comprehensive overview of state-level public policy related to suicide prevention in health care settings. Rather, it identifies promising policy solutions, highlights four states working toward prevention, and discusses the facilitating factors and challenges to enacting these solutions within these states. Still, the examples presented in this report provide valuable guidance for states hoping to save lives.

# Appendix

## State-Level Policy Solutions for Suicide Prevention in Health Care Settings Across Case-Study States

| State | Health (medical) professional training | Parity reporting | Example mental health integration models used* |
|---|---|---|---|
| **Colorado** | No laws | Required for public and private health plans<br>• C.R.S. § 10-16-147 requires the insurance commissioner to submit annual reports to the legislature about parity law compliance; requires insurance carriers to submit to the insurance commissioner and make available to the public annual reports about parity law compliance; requires the insurance commissioner to examine parity violation complaints from the office of the ombudsman for behavioral health access and report any actions taken to the office in a timely manner. | Zero Suicide (through the Hospital Quality Incentive Payment [HQIP] program)<br>• C.R.S. § 25-1.5-112 establishes the Colorado suicide prevention plan to be developed and implemented within the Office of Suicide Prevention (OSP) based on a comprehensive suicide prevention framework. |
| **Montana** | Encouraged<br>• MCA § 53-21-1101 requires the state suicide prevention officer to direct a statewide program that includes training for medical professionals and social service providers (among others) on recognizing the early warning signs of suicidality, depression, and other mental illnesses, and actions to take during and after a crisis. | Required for public health plans<br>• MCA § 33-22-707 requires health insurers that provide mental health or substance use disorder benefits to submit a report to the insurance commissioner upon request each year that complies with federal parity law. | Zero Suicide<br>Telehealth expansion<br>• MCA § 2-18-704, 20-25-1303, 20-25-1403, 33-22-138, 37-3-102, 37-11-101, 37-11-105, and 50-46-302 prohibits certain contract provisions that impose site restrictions on telehealth; provides that a previously established patient-health care provider relationship is not required to receive services by telehealth; revises the definition of telemedicine; extends the coverage requirement to public employee benefit plans and self-insured student health plans. |

| State | Health (medical) professional training | Parity reporting | Example mental health integration models used* |
|---|---|---|---|
| **Oregon** | Required<br>• ORS § 676.860 requires boards that license certain physical health care providers (e.g., occupational therapists, clinical nurse specialists, nurse practitioners, physicians, physician assistants, physical therapists) to, in collaboration with the Oregon Health Authority, adopt rules to require their licensees to report completion of any continuing education regarding suicide assessment, treatment, and management. | Required for public and private health plans<br>• ORS § 743B.427 requires insurers that provide behavioral health benefits to annually report parity compliance analyses to the Department of Consumer and Business Services; the department must then report these findings to the legislature. | Quality improvement initiatives<br>• Zero Suicide<br>• Behavioral Health Quality and Performance Improvement Plan<br>• Performance improvement projects<br>Coordinated care organizations<br>• S.B. 1580 provided legislative approval of OHA's proposals for a coordinated care organization model of health care delivery. |
| **Vermont** | No laws | No laws | Quality improvement initiatives<br>• Zero Suicide<br>• Vermont Program for Quality in Health Care<br>• Suicide Safer Pathways to Care Program |

*Note: These mental health integration models are those that emerged as most promising from the literature review and expert interviews and do not necessarily capture all mental health integration efforts within a given state.

# Endnotes


1 "Mortality 1999-2020," Centers for Disease Control and Prevention, WONDER online database, https://wonder.cdc.gov/.

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American Foundation for Suicide Prevention

**Contact:** Nicole Silverman, communications officer
**Email:** nsilverman@pewtrusts.org
**Project website:** pewtrusts.org/en/projects/suicide-risk-reduction-project

Founded in 1948, **The Pew Charitable Trusts** uses data to make a difference. Pew addresses the challenges of a changing world by illuminating issues, creating common ground, and advancing ambitious projects that lead to tangible progress.

Founded in 1987, the **American Foundation for Suicide Prevention** (AFSP) is dedicated to saving lives and bringing hope to those affected by suicide, including those who have experienced a loss. AFSP creates a culture that's smart about mental health through public education and community programs, develops suicide prevention through research and advocacy, and provides support for those affected by suicide.