AN ACT concerning health.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois is amended by adding Section 2310-455 as follows:

(20 ILCS 2310/2310-455 new)

Sec. 2310-455. Suicide prevention. Subject to appropriation, the Department shall implement activities associated with the Suicide Prevention, Education, and Treatment Act, including, but not limited to, the following:

(1) Coordinating suicide prevention, intervention, and postvention programs, services, and efforts statewide.

(2) Developing and submitting proposals for funding from federal agencies or other sources of funding to promote suicide prevention and coordinate activities.

(3) With input from the Illinois Suicide Prevention Alliance, preparing the Illinois Suicide Prevention Strategic Plan required under Section 15 of the Suicide Prevention, Education, and Treatment Act and coordinating the activities necessary to implement the recommendations in that Plan.

(4) With input from the Illinois Suicide Prevention

Alliance, providing to the Governor and General Assembly the annual report required under Section 13 of the Suicide Prevention, Education, and Treatment Act.

(5) Providing technical support for the activities of the Illinois Suicide Prevention Alliance.

Section 10. The Suicide Prevention, Education, and Treatment Act is amended by changing Sections 5, 13, 15, 20, and 30 as follows:

(410 ILCS 53/5)

Sec. 5. Legislative findings. The General Assembly makes the following findings:

(1) 1,474 Illinoisans lost their lives to suicide in 2017. During 2016, suicide was the eleventh leading cause of death in Illinois, causing more deaths than homicide, motor vehicle accidents, accidental falls, and numerous prevalent diseases, including liver disease, hypertension, influenza/pneumonia, Parkinson's disease, and HIV. Suicide was the third leading cause of death of ages 15 to 34 and the fourth leading cause of death of ages 35 to 54. Those living outside of urban areas are particularly at risk for suicide, with a rate that is 50% higher than those living in urban areas.

(2) For every person who dies by suicide, more than 30 others attempt suicide.

(3) Each suicide attempt and death impacts countless other individuals. Family members, friends, co-workers, and others in the community all suffer the long-lasting consequences of suicidal behaviors.

(4) Suicide attempts and deaths by suicide have an economic impact on Illinois. The National Center for Injury Prevention and Control estimates that in 2010 each suicide death in Illinois resulted in $1,181,549 in medical costs and work loss costs. It also estimated that each hospitalization for self-harm resulted in $31,019 in medical costs and work loss costs and each emergency room visit for self-harm resulted in $4,546 in medical costs and work loss costs.

(5) In 2004, the Illinois General Assembly passed the Suicide Prevention, Education, and Treatment Act (Public Act 93-907), which required the Illinois Department of Public Health to establish the Illinois Suicide Prevention Strategic Planning Committee to develop the Illinois Suicide Prevention Strategic Plan. That law required the use of the 2002 United States Surgeon General's National Suicide Prevention Strategy as a model for the Plan. Public Act 95-109 changed the name of the committee to the Illinois Suicide Prevention Alliance. The Illinois Suicide Prevention Strategic Plan was submitted in 2007 and updated in 2018.

(6) In 2004, there were 1,028 suicide deaths in

Illinois, which the Centers for Disease Control reports was an age-adjusted rate of 8.11 deaths per 100,000. The Centers for Disease Control reports that the 1,474 suicide deaths in 2017 result in an age-adjusted rate of 11.19 deaths per 100,000. Thus, since the enactment of Public Act 93-907, the rate of suicides in Illinois has risen by 38%.

(7) Since the enactment of Public Act 93-907, there have been numerous developments in suicide prevention, including the issuance of the 2012 National Strategy for Suicide Prevention by the United States Surgeon General and the National Action Alliance for Suicide Prevention containing new strategies and recommended activities for local governmental bodies.

(8) Despite the obvious impact of suicide on Illinois citizens, Illinois has devoted minimal resources to its prevention. There is no full-time coordinator or director of suicide prevention activities in the State. Moreover, the Suicide Prevention Strategic Plan is still modeled on the now obsolete 2002 National Suicide Prevention Strategy.

(9) It is necessary to revise the Suicide Prevention Strategic Plan to reflect the most current National Suicide Prevention Strategy as well as current research and experience into the prevention of suicide.

(10) One of the goals adopted in the 2012 National Strategy for Suicide Prevention is to promote suicide

prevention as a core component of health care services so there is an active engagement of health and social services, as well as the coordination of care across multiple settings, thereby ensuring continuity of care and promoting patient safety.

(11) Integrating suicide prevention into behavioral and physical health care services can save lives. National data indicate that: over 30% of individuals are receiving mental health care at the time of their deaths by suicide; 45% have seen their primary care physicians within one month of their deaths; and 25% of those who die of suicide visited an emergency department in the year prior to their deaths.

(12) The Zero Suicide model is a part of the National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention, and a project of the Suicide Prevention Resource Center that implements the goal of making suicide prevention a core component of health care services.

(13) The Zero Suicide model is built on the foundational belief and aspirational goal that suicide deaths of individuals who are under the care of our health care systems are preventable with the adoption of comprehensive training, patient engagement, transition, and quality improvement.

(14) Health care systems, including mental and

behavioral health systems and hospitals, that have implemented the Zero Suicide model have noted significant reductions in suicide deaths for patients within their care.

(15) The Suicide Prevention Resource Center facilitates adoption of the Zero Suicide model by providing comprehensive information, resources, and tools for its implementation.

~~(1) The Surgeon General of the United States has described suicide prevention as a serious public health priority and has called upon each state to develop a statewide comprehensive suicide prevention strategy using a public health approach. Suicide now ranks 10th among causes of death, nationally.~~

~~(2) In 1998, 1,064 Illinoisans lost their lives to suicide, an average of 3 Illinois residents per day. It is estimated that there are between 21,000 and 35,000 suicide attempts in Illinois every year. Three and one half percent of all suicides in the nation take place in Illinois.~~

~~(3) Among older adults, suicide rates are increasing, making suicide the leading fatal injury among the elderly population in Illinois. As the proportion of Illinois' population age 75 and older increases, the number of suicides among persons in this age group will also increase, unless an effective suicide prevention strategy is implemented.~~

~~(4) Adolescents are far more likely to attempt suicide than other age groups in Illinois. The data indicates that there are 100 attempts for every adolescent suicide completed. In 1998, 156 Illinois youths died by suicide, between the ages of 15 through 24. Using this estimate, there were likely more than 15,500 suicide attempts made by Illinois adolescents or approximately 50% of all estimated suicide attempts that occurred in Illinois were made by adolescents.~~

~~(5) Homicide and suicide rank as the second and third leading causes of death in Illinois for youth, respectively. Both are preventable. While the death rates for unintentional injuries decreased by more than 35% between 1979 and 1996, the death rates for homicide and suicide increased for youth. Evidence is growing in terms of the links between suicide and other forms of violence. This provides compelling reasons for broadening the State's scope in identifying risk factors for self harmful behavior. The number of estimated youth suicide attempts and the growing concerns of youth violence can best be addressed through the implementation of successful gatekeeper-training programs to identify and refer youth at risk for self-harmful behavior.~~

~~(6) The American Association of Suicidology conservatively estimates that the lives of at least 6 persons related to or connected to individuals who attempt~~

~~or complete suicide are impacted. Using these estimates, in 1998, more than 6,000 Illinoisans struggled to cope with the impact of suicide.~~

~~(7) Decreases in alcohol and other drug abuse, as well as decreases in access to lethal means, significantly reduce the number of suicides.~~

~~(8) Suicide attempts are expected to be higher than reported because attempts not requiring medical attention are not required to be reported. The underreporting of suicide completion is also likely because suicide classification involves conclusions regarding the intent of the deceased. The stigma associated with suicide is also likely to contribute to underreporting. Without interagency collaboration and support for proven, community-based, culturally-competent suicide prevention and intervention programs, suicides are likely to rise.~~

~~(9) Emerging data on rates of suicide based on gender, ethnicity, age, and geographic areas demand a new strategy that responds to the needs of a diverse population.~~

~~(10) According to Children's Safety Network Economics Insurance, the cost of youth suicide acts by persons in Illinois who are under 21 years of age totals $539,000,000, including medical costs, future earnings lost, and a measure of quality of life.~~

~~(11) Suicide is the second leading cause of death in Illinois for persons between the ages of 15 and 24.~~

~~(12) In 1998, there were 1,116 homicides in Illinois, which outnumbered suicides by only 52. Yet, so far, only homicide has received funding, programs, and media attention.~~

~~(13) According to the 1999 national report on statistics for suicide of the American Association of Suicidology, categories of unintentional injury, motor vehicle deaths, and all other deaths include many reported and unsubstantiated suicides that are not identified correctly because of poor investigatory techniques, unsophisticated inquest jurors, and stigmas that cause families to cover up evidence.~~

~~(14) Programs for HIV infectious diseases are very well funded even though, in Illinois, HIV deaths number 30% less than suicide deaths.~~

(Source: P.A. 93-907, eff. 8-11-04.)

(410 ILCS 53/13)

Sec. 13. Duration; report. The Department, in consultation with ~~All projects set forth in this Act must be at least 3 years in duration, and the Department and related contracts as well as~~ the Illinois Suicide Prevention Alliance, must submit an annual report ~~annually~~ to the Governor and General Assembly on the effectiveness of the ~~these~~ activities and programs undertaken under the Plan that includes any recommendations for modification to Illinois law to enhance the effectiveness of

the Plan.

(Source: P.A. 95-109, eff. 1-1-08.)

(410 ILCS 53/15)

Sec. 15. Suicide Prevention Alliance.

(a) The Alliance is created as the official grassroots creator, planner, monitor, and advocate for the Illinois Suicide Prevention Strategic Plan. No later than one year after the effective date of this amendatory Act of the 101st General Assembly ~~Act~~, the Alliance shall review, finalize, and submit to the Governor and the General Assembly the 2020 Illinois Suicide Prevention Strategic Plan and appropriate processes and outcome objectives for 10 overriding recommendations and a timeline for reaching these objectives.

(b) The Plan shall include: ~~The Alliance shall use the United States Surgeon General's National Suicide Prevention Strategy as a model for the Plan.~~

(1) recommendations from the most current National Suicide Prevention Strategy;

(2) current research and experience into the prevention of suicide;

(3) measures to encourage and assist health care systems and primary care providers to include suicide prevention as a core component of their services, including, but not limited to, implementing the Zero Suicide model; and

(4) additional elements as determined appropriate by the Alliance.

The Alliance shall review the statutorily prescribed missions of major State mental health, health, aging, and school mental health programs and recommend, as necessary and appropriate, statutory changes to include suicide prevention in the missions and procedures of those programs. The Alliance shall prepare a report of that review, including its recommendations, and shall submit the report to the Department for inclusion in its annual report to the Governor and the General Assembly ~~by December 31, 2004~~.

(c) The Director of Public Health shall appoint the members of the Alliance. The membership of the Alliance shall include, without limitation, representatives of statewide organizations and other agencies that focus on the prevention of suicide and the improvement of mental health treatment or that provide suicide prevention or survivor support services. Other disciplines that shall be considered for membership on the Alliance include law enforcement, first responders, faith-based community leaders, universities, and survivors of suicide (families and friends who have lost persons to suicide) as well as consumers of services of these agencies and organizations.

(d) The Alliance shall meet at least 4 times a year, and more as deemed necessary, in various sites statewide in order to foster as much participation as possible. The Alliance, a

steering committee, and core members of the full committee shall monitor and guide the definition and direction of the goals of the full Alliance, shall review and approve productions of the plan, and shall meet before the full Alliance meetings.

(Source: P.A. 95-109, eff. 1-1-08.)

(410 ILCS 53/20)

Sec. 20. General awareness and screening program.

(a) The Department shall provide technical assistance for the work of the Alliance and the production of the Plan and shall distribute general information and screening tools for suicide prevention to the general public through local public health departments throughout the State. These materials shall be distributed to agencies, schools, hospitals, churches, places of employment, and all related professional caregivers to educate all citizens about warning signs and interventions that all persons can do to stop the suicidal cycle.

(b) This program shall include, without limitation, all of the following:

(1) Educational programs about warning signs and how to help suicidal individuals.

(2) Educational presentations about suicide risk and how to help at-risk people in special populations and with bilingual support to special cultures.

(3) The designation of an annual suicide awareness week

or month to include a public awareness campaign on suicide.

(4) An annual ~~A~~ statewide suicide prevention conference ~~before November of 2004~~.

(5) An Illinois Suicide Prevention Speaker's Bureau.

(6) A program to educate the media regarding the guidelines developed by the American Association for Suicidology for coverage of suicides and to encourage media cooperation in adopting these guidelines in reporting suicides.

(7) Increased training opportunities for volunteers, professionals, and other caregivers to develop specific skills for assessing suicide risk and intervening to prevent suicide.

(Source: P.A. 95-109, eff. 1-1-08.)

(410 ILCS 53/30)

Sec. 30. Suicide prevention pilot programs.

(a) The Department shall establish, when funds are appropriated, programs, including, but not limited to, pilot and demonstration programs, that are consistent with the Plan. ~~up to 5 pilot programs that provide training and direct service programs relating to youth, elderly, special populations, high-risk populations, and professional caregivers. The purpose of these pilot programs is to demonstrate and evaluate the effectiveness of the projects set forth in this Act in the communities in which they are offered. The pilot programs shall~~

~~be operational for at least 2 years of the 3-year requirement set forth in Section 13.~~

~~(b) The Director of Public Health is encouraged to ensure that the pilot programs include the following prevention strategies:~~

~~(1) school gatekeeper and faculty training;~~

~~(2) community gatekeeper training;~~

~~(3) general community suicide prevention education;~~

~~(4) health providers and physician training and consultation about high risk cases;~~

~~(5) depression, anxiety, and suicide screening programs;~~

~~(6) peer support youth and older adult programs;~~

~~(7) the enhancement of 24-hour crisis centers, hotlines, and person-to-person calling trees;~~

~~(8) means restriction advocacy and collaboration; and~~

~~(9) intervening and supporting after a suicide.~~

(b) ~~(c)~~ The funds appropriated for purposes of this Section shall be allocated by the Department on a competitive, grant-submission basis, which shall include consideration of different rates of risk of suicide based on age, ethnicity, gender, prevalence of mental health disorders, different rates of suicide based on geographic areas in Illinois, and the services and curriculum offered to fit these needs by the applying agency.

~~(d) The Department and Alliance shall prepare a report as~~

~~to the effectiveness of the demonstration projects established pursuant to this Section and submit that report no later than 6 months after the projects are completed to the Governor and General Assembly.~~

(Source: P.A. 95-109, eff. 1-1-08.)

Section 99. Effective date. This Act takes effect upon becoming law.