HB3198

LRB10215006CPF20361b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB3198

Introduced 2/19/2021, by Rep. Deb Conroy

SYNOPSIS AS INTRODUCED:

See Index

Creates the Suicide Treatment Improvements Act. Provides that specified persons and entities shall require suicide prevention counselors on the person or entity's staff to perform specified suicide prevention services. Provides that the Department of Public Health shall require each suicide hotline and crisis hotline in the State to identify callers who are or may be suicidal. Provides for penalties for noncompliance with an order of the Department. Provides that services provided under the Act shall be covered by each group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the Act's effective date. Provides that each county and municipal law enforcement officer shall annually complete at least 2 hours of in-service training on the appropriate response to emergencies that involve a person who is or may be suicidal. Requires the governing body of each county to appoint a suicide prevention response coordinator to perform specified actions. Provides that suicide prevention counselors dispatched to an emergency scene shall have specified duties. Provides that PSAP call-takers shall evaluate and determine whether a request for emergency services involves a person who is or may be suicidal. Requires specified agencies to adopt rules to implement specified provisions of the Act. Contains other provisions. Amends the Department of State Police Law. Requires the Office of the Statewide 9-1-1 Administrator to develop comprehensive guidelines and adopt rules and standards for the handling of suicide or suicide calls by Public Safety Answering Point telecommunicators. Contains suicide training requirements for PSAP telecommunicators. Effective July 1, 2021.

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FISCAL NOTE ACT MAY APPLY

STATE MANDATES ACT MAY REQUIRE REIMBURSEMENT

A BILL FOR

AN ACT concerning health.

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

Section 1. Short title. This Act may be cited as the Suicide Treatment Improvements Act.

Section 5. Definitions. In this Act:

"At-risk patient" means a patient who has attempted suicide or who has suicidal ideations, behaviors, or tendencies, as indicated by a formal suicide risk assessment under this Act.

"Care transition" means the transfer or transition of a patient from one health care or behavioral health care provider to another.

"Department" means the Department of Public Health.

"Mental health screener" means a psychiatrist, psychologist, social worker, registered professional nurse, or other individual trained to do outreach only for the purposes of psychological assessment who is employed by a screening service and possesses the license, academic training, or experience required by rules adopted by the Department; except that a psychiatrist and a licensed clinical psychologist who meet the requirements for mental health screeners are not required to comply with any additional requirements adopted by

the Department.

"Outpatient treatment provider" means a community-based mental health facility or center, including, but not limited to, a suicide treatment center, that is licensed or funded by the Department of Public Health to provide outpatient mental health treatment services.

"Person who is or may be suicidal" or "person in crisis who is or may be suicidal" means a person who is experiencing a mental health crisis, is experiencing or expressing suicidal ideations or tendencies, or is undertaking or contemplating suicidal actions, but who has not yet been subject to a formal suicide risk assessment conducted pursuant to this Act.

"Psychiatric facility" means a State psychiatric hospital, a county psychiatric hospital, or the psychiatric unit of a county hospital, a short-term care facility, a special psychiatric hospital, or the psychiatric unit of a general hospital or other health care facility licensed by the Department of Public Health.

"Rapid referral" means the taking of appropriate steps by:

(1) a psychiatric facility, prior to an at-risk patient's discharge from inpatient care, to facilitate the at-risk patient's immediate access to an appropriate outpatient treatment appointment as soon as is practicable, and preferably within 48 hours, after discharge; or

(2) an outpatient treatment provider to facilitate an

at-risk patient's immediate access to an appointment with another outpatient treatment provider or an inpatient psychiatric facility as soon as is practicable, and preferably within 48 hours, after referral thereto.

"Screening service" means a public or private ambulatory care service designated by the Department that provides mental health services, including assessment, emergency, and referral services to persons with mental illness in a specified geographic area.

"Suicide prevention counselor" means a licensed psychiatrist, clinical psychologist, or other mental health professional, or a properly qualified paraprofessional crisis counselor, who has specialized certification or has completed specialized training in the standardized assessment of suicide risk and the provision of suicide prevention counseling to at-risk patients.

"Supportive contacts" means brief communications with a patient that occur during care transitions, or when a patient misses an outpatient appointment or unexpectedly drops out of outpatient treatment, and that show support for the patient and are designed to promote a patient's feeling of connection to treatment and willingness to collaboratively participate in treatment. "Supportive contacts" include the sending of postcards, letters, email messages, and text messages; the making of phone calls; or the undertaking of home visits either by the mental health care professional or suicide

prevention counselor who is providing care to the patient or by an outside organization, such as a local crisis center, with which the psychiatric facility or outpatient treatment provider has a contract or other agreement.

"Warm hand-off" means a safe care transition that connects a patient directly with a new health care provider or interim contact, such as a crisis center worker or peer specialist, before the patient's first appointment with the new health care provider, or that connects a patient directly with a screening service or mental health screener for the purposes of determining whether involuntary commitment to treatment is warranted pursuant to relevant law.

Section 10. Suicide prevention counselors; policies and protocols; suicide risk assessments; discharge.

(a) Each psychiatric facility in the State shall require suicide prevention counselors on the facility's staff to:

(1) assess each patient's level of suicide risk, as provided by subsections (h) and (i);

(2) immediately provide individualized, one-on-one suicide prevention counseling to each patient deemed at risk of suicide; and

(3) provide ongoing suicide prevention counseling to each at-risk patient at the psychiatric facility on a daily basis or more frequently as may be commensurate with the results of the patient's suicide risk assessment,

until the patient is discharged from inpatient care or is deemed to be no longer at risk of suicide, whichever is sooner.

(b) Each outpatient treatment provider in the State shall require suicide prevention counselors on the provider's staff to:

(1) assess each patient's level of suicide risk, as provided by subsections (h) and (i);

(2) immediately provide individualized, one-on-one suicide prevention counseling to each patient deemed to be an at-risk patient;

(3) in cases where inpatient treatment may be necessary to address an at-risk patient's suicidal ideations, behaviors, or tendencies, either effectuate the voluntary admission and warm hand-off of the at-risk patient to an inpatient psychiatric facility or, if the patient refuses voluntary inpatient admission, effectuate a warm hand-off of the patient to a screening service or mental health screener to determine whether involuntary commitment to treatment is warranted under applicable law; and

(4) reengage and provide individualized, one-on-one counseling to each at-risk patient remaining in outpatient care, commensurate with the results of the patient's suicide risk assessment, whenever the patient has a subsequent clinical encounter with the outpatient

provider.

(c) A psychiatric facility shall ensure that a sufficient number of suicide prevention counselors are available on-site, 24 hours a day, 7 days a week, and an outpatient treatment provider shall ensure that a sufficient number of suicide prevention counselors are available on-site, during all hours of operation, to perform the suicide risk assessments and provide the individualized counseling required by this Section.

(d) Each psychiatric facility and outpatient treatment provider shall establish policies and protocols to provide for the effective, compassionate, and responsible discharge of at-risk patients from care and the smooth transition of at-risk patients through the continuum of care using warm hand-offs, rapid referrals, and supportive contacts.

(e) Each outpatient treatment provider shall additionally adopt policies and protocols providing for the warm hand-off of an at-risk patient to an inpatient psychiatric facility or to a screening service or mental health screener, as appropriate and in accordance with paragraph (3) of subsection (b), in any case where the patient's suicide prevention counselor or attending clinician has reason to believe that the patient may require commitment to inpatient treatment to address the patient's suicidal ideations, behaviors, or tendencies or associated mental health issues.

(f) A psychiatric facility or outpatient treatment

provider may enter into contracts or memoranda of understanding with outside organizations, including local crisis centers and other psychiatric facilities and providers, to facilitate the smooth and effective care transition of at-risk patients as provided by subsections (d) and (e).

(g) In no case shall a staff member of a psychiatric facility or a staff member of an outpatient treatment provider:

(1) discharge an at-risk patient into a homeless situation; or

(2) have an at-risk patient arrested or incarcerated in a jail or prison, unless the at-risk patient poses an otherwise uncontrollable risk to others.

(h) A suicide risk assessment shall be conducted at the following times:

(1) immediately upon a patient's initial admission to a psychiatric facility or upon a patient's first clinical encounter with an outpatient treatment provider;

(2) whenever there is reason for attending staff at a psychiatric facility or outpatient treatment provider to believe that a patient is developing new suicidal ideations, behaviors, or tendencies while under the care of the facility or provider;

(3) within 3 days prior to the discharge of an apparently non-suicidal patient from inpatient care;

(4) whenever a suicide prevention counselor is called

to assess a patient in a hospital emergency department under Section 15; and

(5) whenever a suicide prevention counselor is dispatched pursuant to Section 45 to assess a person at an emergency scene.

(i) A suicide risk assessment shall be performed using a standardized tool, methodology, or framework and shall be based on data obtained from the patient, as well as pertinent observations made by the attending clinician, assigned suicide prevention counselors, and other staff members having direct contact with the patient, and, to the extent practicable, any other information about the patient's history, the patient's past, recent, and present suicidal ideation and behavior, and the factors contributing thereto that is available from all other relevant sources, including outside treatment professionals, caseworkers, caregivers, family members, guardians, and any other persons who are significant in the patient's life. The suicide risk assessment shall include an evaluation of the patient's current living situation, housing status, existing support systems, and close relationships and shall indicate whether there is any evidence that the patient is being subjected to abuse, neglect, exploitation, or undue influence by family members, caregivers, or other persons.

(j) Counseling and treatment provided to address an at-risk patient's suicidal ideations, behaviors, or tendencies shall be supplemental to any other treatment that is received

by the patient for the patient's other mental health issues.

(k) The results of a patient's suicide risk assessment and notes regarding the progress of suicide prevention counseling provided to an at-risk patient shall be documented in the patient's health record.

Section 15. Emergency departments; suicide prevention counselors.

(a) Each physician in a hospital's emergency department who has reason to believe that a patient under the physician's care is or may be suicidal shall, as soon as is practicable after the patient is stabilized and conscious, ensure that the patient is met in the emergency room by a suicide prevention counselor from the hospital's psychiatric ward, who shall:

(1) perform an on-site suicide risk assessment, in accordance with subsections (h) and (i) of Section 10;

(2) immediately provide the patient with individualized, one-on-one suicide prevention counseling, commensurate with the results of the suicide risk assessment, prior to the patient's discharge from the emergency room; and

(3) immediately link the person who is or may be suicidal to appropriate treatment facilities, programs, and services, through the use of warm hand-offs and supportive contacts, as deemed by the suicide prevention counselor to be appropriate based on the results of the

on-site suicide risk assessment.

(b) If the suicide prevention counselor under subsection (a) concludes that inpatient psychiatric treatment may be necessary to address and mitigate the at-risk patient's suicide risk and tendencies, the suicide prevention counselor shall recommend, and the attending emergency room physician shall effectuate, the patient's voluntary admission and warm hand-off to the hospital's psychiatric ward immediately following the completion of the patient's emergency care. If the patient refuses to be admitted to the hospital's psychiatric ward, the attending emergency room physician shall effectuate the warm hand-off of the patient to a screening service or mental health screener to determine whether involuntary commitment to treatment is necessary to address the patient's suicidal ideations, behaviors, and tendencies or associated mental health issues.

Section 20. Suicide hotlines. The Department shall require each suicide hotline and crisis hotline in the State, including, but not limited to, each community-based suicide hotline, to identify callers to the hotline who are or may be suicidal, provide immediate suicide prevention counseling to each such caller, and ensure that a sufficient number of suicide prevention counselors are available on staff at all times during the hotline's operation to provide the counseling.

Section 25. Suicide prevention counselors; interacting with at-risk patients.

(a) Any suicide prevention counselor or other staff member employed by a psychiatric facility, outpatient treatment provider, or suicide or crisis hotline, and any other health care professional, when interacting with an at-risk patient, shall:

(1) treat the at-risk patient with the same dignity and respect that is shown to other patients;

(2) adopt a stance that reflects empathy, compassion, and an understanding of the ambivalence the at-risk patient may feel in relation to the patient's desire to die;

(3) treat the at-risk patient in an age-appropriate manner and use methods of communication that the patient can understand;

(4) attempt to engender confidence in the at-risk patient that there is an alternative to suicide, and encourage the patient to use all available services and resources to empower the patient to choose such an alternative;

(5) not engage in activities or communication methods that may result in the increased traumatization or retraumatization of the at-risk patient;

(6) with the exception of suicide assessments

performed pursuant to Section 10, not engage in the psychological testing of a patient who is in crisis or who has recently been lifted out of a crisis situation; and

(7) not engage in behavior that discriminates against or stigmatizes the patient.

(b) A psychiatric facility or outpatient treatment provider shall require and facilitate the biennial training of all staff on the following issues:

(1) the fundamentals of the facility's or provider's suicide prevention policies and protocols;

(2) the particular suicide care policies and protocols that are relevant to each staff member's role and responsibilities;

(3) the signs and symptoms that can be used by both clinical and nonclinical staff to identify existing patients who may be developing new suicidal ideations, behaviors, or tendencies;

(4) the importance of, and methods and principles to be used in, ensuring the safe and responsible discharge and care transition of at-risk patients; and

(5) the respectful treatment of, effective communication with, and destigmatization of at-risk patients.

Section 30. Noncompliance; Department of Public Health; disciplinary action.

(a) If the Department has reason to believe that a facility or provider under its jurisdiction, or any staff member employed thereby, is failing to comply with the provisions of this Act or any of the internal suicide care policies or protocols adopted pursuant to this Act, the Department shall order the facility or provider, as appropriate, to undertake corrective action within a reasonable time frame, as may be deemed by the Department to be necessary to ensure future compliance with this Act or the suicide prevention policies and protocols adopted pursuant to this Act, as the case may be. If the facility or provider denies that a violation exists or has occurred, it shall have the right to apply to the Department for a hearing and the hearing shall be held, and a decision rendered, within 48 hours after receipt of the request.

(b) Any psychiatric facility or outpatient treatment provider that fails to comply with an order of the Department that is issued pursuant to subsection (a) shall be liable to a civil penalty of not more than $2,500 for a first offense and not more than $5,000 for a second or subsequent offense.

(c) Any staff member of a psychiatric facility or outpatient treatment provider who violates the provisions of subsection (g) of Section 10, and any staff member of a psychiatric facility, an outpatient treatment provider, a suicide or crisis hotline, or other health care professional who violates the provisions of subsection (a) of Section 25,

shall be subject to a civil penalty of not more than $500 for a first offense, not more than $1,000 for a second offense, and not more than $2,500 for a third or subsequent offense. The person shall also be subject to:

(1) potential criminal liability and civil lawsuits, including lawsuits for punitive damages, for any injury that is proximately caused by the person;

(2) the suspension or revocation of the person's professional license or certification;

(3) the revocation of the person's mental health accreditation; and

(4) the termination of the person's employment.

Section 35. Coverage; insurance or managed care plans. Services provided under this Act shall be covered by each group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this Act.

Section 40. Law enforcement officers.

(a) Each county and municipal law enforcement officer in the State shall annually complete at least 2 hours of in-service training on the appropriate response to emergencies that involve a person who is or may be suicidal.

(b) The in-service training course required pursuant to this Section shall, at a minimum:

(1) include instruction on:

(A) the importance of, and need for, law enforcement officers to engage in calm, gentle, and respectful interactions with a person who is or may be suicidal;

(B) the importance of, and need for, law enforcement officers, to the greatest extent practicable, to avoid the use of unnecessary force and to instead use verbal methods of communication and other nonviolent means to de-escalate an emergency situation involving a person who is or may be suicidal; and

(C) specific techniques, means, and methods, consistent with the principles identified under this subsection, that are to be employed by law enforcement officers when approaching, communicating with, engaging in physical contact or the use of force with, and de-escalating a situation involving, a person who is or may be suicidal; and

(2) require training program participants to engage in various simulated role-playing scenarios to demonstrate their ability to effectively interact with and de-escalate emergency situations involving a person who is or may be suicidal.

(c) Each instructor who is assigned to teach the in-service courses required by this Section shall have

received at least 40 hours of training in mental health crisis intervention from a nationally recognized organization that educates law enforcement officers in the use of appropriate emergency response methods.

Section 45. Suicide prevention response coordinators; emergency scenes.

(a) The governing body of each county shall appoint a suicide prevention response coordinator to facilitate and coordinate the deployment of qualified suicide prevention counselors to emergency scenes involving persons who are or may be suicidal.

(b) A local suicide prevention response coordinator appointed pursuant to subsection (a) shall compile and maintain an up-to-date list of qualified suicide prevention counselors in the county. To the extent practicable, whenever a law enforcement officer is dispatched to an emergency scene involving a person who is or may be suicidal, as determined by the emergency call-taker pursuant to Section 50, the suicide prevention response coordinator shall coordinate the contemporaneous dispatch of a suicide prevention counselor to the emergency scene.

(c) A suicide prevention counselor dispatched to an emergency scene pursuant to this Section shall:

(1) provide assistance to the law enforcement officer at the emergency scene, as may be necessary to facilitate

the nonviolent de-escalation of the emergency situation;

(2) perform an on-site suicide risk assessment of the person who is or may be suicidal, in accordance with the provisions of subsections (h) and (i) of Section 15; and

(3) immediately link the person who is or may be suicidal to appropriate treatment facilities, programs, and services, through the use of warm hand-offs and supportive contacts, as deemed by the suicide prevention counselor to be appropriate based on the results of the on-site suicide risk assessment. If the suicide prevention counselor concludes that inpatient psychiatric treatment may be necessary to address and mitigate the person's suicidal risk and tendencies, the suicide prevention counselor, in cooperation with the on-site law enforcement officer, as appropriate, shall effectuate the person's voluntary admission and warm hand-off to a psychiatric facility as soon as is practicable after the immediate crisis is resolved. If the person refuses to be admitted to a psychiatric facility, the suicide prevention counselor, in cooperation with the on-site law enforcement officer, as appropriate, shall effectuate the warm hand-off of the person to a screening service or mental health screener to determine whether involuntary commitment to treatment is necessary to address the person's suicidal ideations, behaviors, and tendencies or associated mental health issues.

(d) The Attorney General, in consultation with the Department, shall:

(1) establish the necessary qualifications for a person to be appointed as a county suicide prevention response coordinator pursuant to this Section; and

(2) establish guidelines and protocols to be used by each county suicide prevention response coordinator in:

(A) establishing a list of qualified and locally available suicide prevention counselors pursuant to this Section; and

(B) facilitating the coordinated and contemporaneous dispatch of at least one suicide prevention counselor to each emergency scene involving a person in crisis who is or may be suicidal, as provided by this Section, whenever a law enforcement officer is dispatched to the emergency scene.

Section 50. PSAP call-takers; evaluation and determination.

(a) In this Section, "public safety answering point" or "PSAP" is a set of call-takers authorized by a governing body and operating under common management that receive 9-1-1 calls and asynchronous event notifications for a defined geographic area and processes those calls and events according to a specified operational policy.

(b) In addition to any other requirements that have been

established by law, rule, or regulation for PSAP call-takers, the PSAP call-taker of each 9-1-1 call shall evaluate whether a request for emergency services involves a person who is or may be suicidal.

(c) Whenever a PSAP call-taker determines that a request for emergency services involves a person who is or may be suicidal, the call-taker shall:

(1) if the PSAP serves as the dispatch point for the emergency call, directly notify the local suicide prevention response coordinator, appointed pursuant to subsection (a) of Section 45, that the call involves a person who is or may be suicidal; or

(2) if the PSAP does not serve as the dispatch point for the emergency call, directly notify the dispatching entity, upon transfer of the call thereto, that the request for emergency services involves a person who is or may be suicidal.

Any dispatching entity notified pursuant to this subsection shall directly notify the county suicide prevention response coordinator appointed pursuant to subsection (a) of Section 45 that the call involves a person who is or may be suicidal.

(d) Any notice that is provided to a local suicide prevention response coordinator, pursuant to subsection (c), shall be provided either contemporaneously upon or immediately prior to the dispatch of law enforcement to the emergency

scene.

Section 55. Rules.

(a) The Department shall adopt rules applicable to the facilities or providers under the Department's jurisdiction, pursuant to the Illinois Administrative Procedure Act, as may be necessary to implement the provisions of Sections 10, 15, 20, 25, and 30.

(b) The Department of Insurance shall adopt rules and regulations, pursuant to the Illinois Administrative Procedure Act, as may be necessary to implement the provisions of Section 35.

(c) The Attorney General, in consultation with the Department, shall adopt rules and regulations, pursuant to the Illinois Administrative Procedure Act, as may be necessary to implement the provisions of Sections 40 and 45.

(d) The Illinois State Police, in consultation with the Department, shall adopt rules and regulations, pursuant to the Illinois Administrative Procedure Act, as may be necessary to implement the provisions of Section 50.

Section 90. The Department of State Police Law of the Civil Administrative Code of Illinois is amended by adding Section 2605-53.5 as follows:

(20 ILCS 2605/2605-53.5 new)

Sec. 2605-53.5. 9-1-1 system; suicide.

(a) The Office of the Statewide 9-1-1 Administrator, in consultation with the Office of the Attorney General and the Illinois Law Enforcement Training Standards Board, shall:

(1) develop comprehensive guidelines for evidence-based, trauma-informed, victim-centered suicide or handling of suicide calls by Public Safety Answering Point ("PSAP") telecommunicators; and

(2) adopt rules and minimum standards for an evidence-based, trauma-informed, victim-centered training curriculum for suicide or handling of suicide calls for Public Safety Answering Point telecommunicators.

(b) Training requirements:

(1) Newly hired PSAP telecommunicators must complete the suicide training curriculum established in subsection (a) of this Section prior to handling emergency calls.

(2) All existing PSAP telecommunicators shall complete the suicide training curriculum established in subsection (a) of this Section within 2 years of the effective date of this amendatory Act of the 102nd General Assembly.

Section 99. Effective date. This Act takes effect July 1, 2021.

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Statutes amended in order of appearance