AN ACT concerning public 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 Prevention, Education, and Treatment Act.

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

(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.

Section 10. Definitions. For the purpose of this Act, unless the context otherwise requires:

"Committee" means the Illinois Suicide Prevention Strategic Planning Committee.

"Department" means the Department of Public Health.

"Plan" means the Illinois Suicide Prevention Strategic Plan set forth in Section 15.

Section 13. Duration; report. 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 Suicide

Prevention Strategic Planning Committee must report annually to the Governor and General Assembly on the effectiveness of these activities and programs.

Section 15. Suicide Prevention Strategic Planning Committee.

(a) The Committee 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 Act, the Committee shall review, finalize, and submit to the Governor and the General Assembly the Illinois Suicide Prevention Strategic Plan and appropriate processes and outcome objectives for 10 overriding recommendations and a timeline for reaching these objectives.

(b) The Committee shall use the United States Surgeon General's National Suicide Prevention Strategy as a model for the Plan. The Committee 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 Committee shall prepare a report of that review, including its recommendations, and shall submit the report to the Governor and the General Assembly by December 31, 2004.

(c) The Director of Public Health shall appoint the members of the Committee. The membership of the Committee 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 committee 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 committee 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 Committee, a steering committee, and core members of the full committee shall monitor and guide the definition and direction of the goals of the full Committee, shall review and approve productions of the plan, and shall meet before the full Committee meetings.

Section 20. General awareness and screening program.

(a) The Department shall provide technical assistance for the work of the Committee 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) 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.

Section 25. Additional duties of the Committee. The Committee shall:

(1) Act as an advisor and lead consultant on the design, implementation, and evaluation of all programs outlined in this Act.

(2) Establish interagency policy and procedures among appropriate agencies for the collaboration and coordination needed to implement the programs outlined in this Act.

(3) Design, review, select, and monitor proposals for the implementation of these activities in agencies throughout the State.

Section 30. Suicide prevention pilot programs.

(a) The Department shall establish, when funds are appropriated, 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.

(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 Committee 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.

Section 99. Effective date. This Act takes effect July 1, 2004.