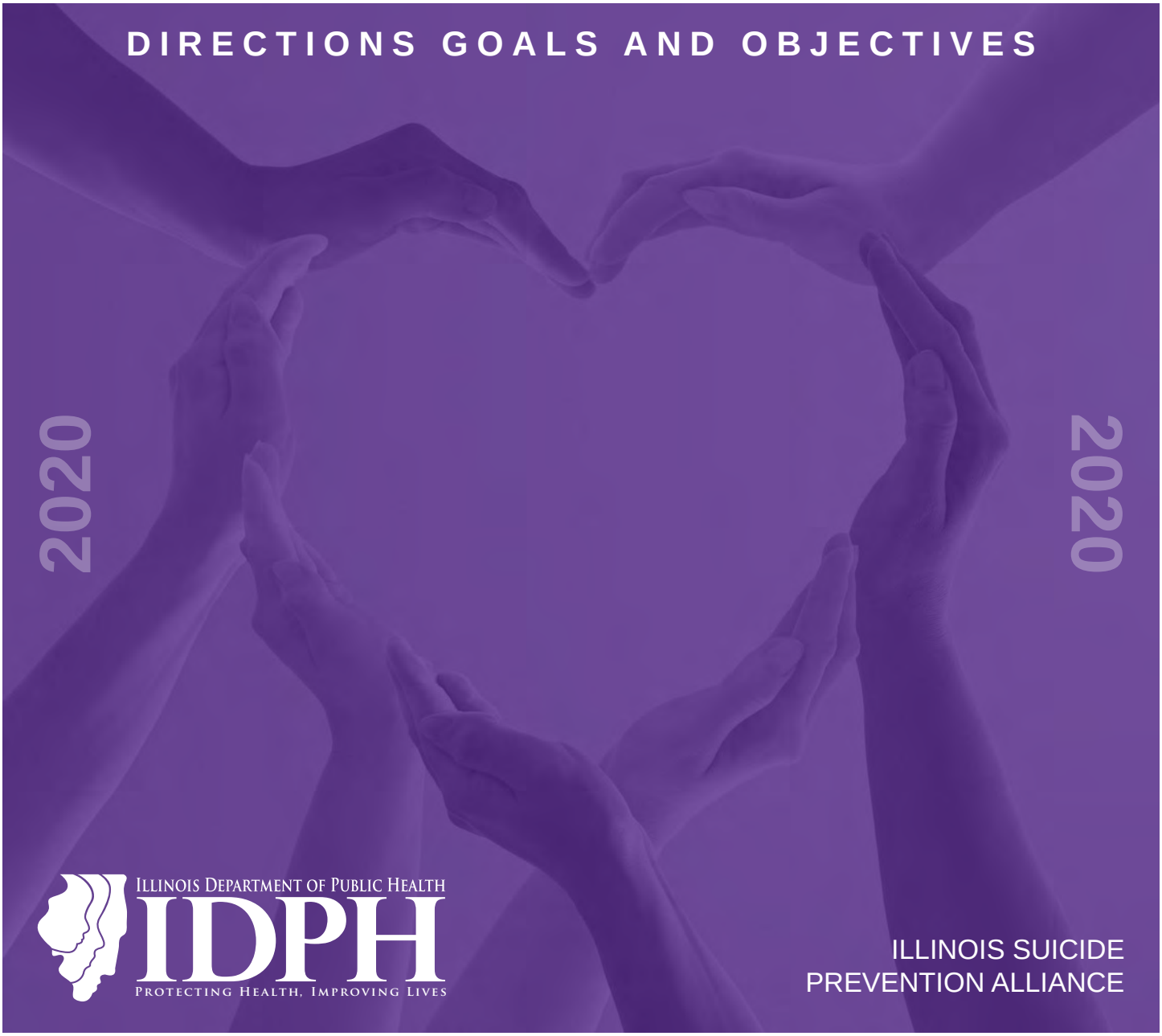
State of Illinois
Illinois Department of Public Health

ILLINOIS SUICIDE PREVENTION STRATEGIC PLAN

DIRECTIONS GOALS AND OBJECTIVES



ILLINOIS DEPARTMENT OF PUBLIC HEALTH
IDPH
PROTECTING HEALTH, IMPROVING LIVES

ILLINOIS SUICIDE
PREVENTION ALLIANCE

Gov. JB Pritzker and Members of the Illinois General Assembly:

This 2020 Illinois Suicide Prevention Strategic Plan is the second of a three-step process initiated last year to reverse the relentlessly increasing suicide rates in the State of Illinois. Public Act 101-0331, which became effective August 9, 2019, envisioned the establishment of an infrastructure for suicide prevention, the development of a comprehensive plan to prevent suicide, and funding to implement that plan. The law took the first step by giving the Illinois Department of Public Health responsibility for coordinating statewide suicide prevention, intervention, and postvention programs, services, and efforts. The filing of this plan completes the second step by providing a comprehensive, public health-based strategy to prevent suicide. The third step, which has yet to be taken, is to provide funding to implement the plan.

The plan suggests activities for a wide-range of governmental and non-governmental stakeholders. The only way to ensure that those activities are coordinated and effective will be for IDPH to receive funding to implement its responsibility under PA 1010-331.

You provided excellent direction with the enactment of Public Act 101-0331. With broad stakeholder participation, we have developed a plan with bold strategies and comprehensive activities for every element of Illinois society. Without funding, however, the plan will be ineffective and Illinois suicide rates will continue to rise.

We therefore passionately request the funding necessary to implement this 2020 Illinois Suicide Prevention Strategic Plan.

Respectfully,

Illinois Suicide Prevention Alliance

Illinois Suicide Prevention Alliance

Appointed and Pending (*) Members	
Member	Representing
Stan Lewy	Survivor of Suicide
Jenna Famer	Centerstone; Representative from a suicide prevention program serving rural communities
Michael McCarter	Blessing Health System; Representative from emergency medical services
Katie Jones	Representative for the lesbian, gay, bi-sexual, transgender, and questioning community
Hannah Jordan	Bob Michel Department of Veterans Affairs Outpatient Clinic; Representative from veteran service
Eric Davidson	Illinois Higher Education Center for Alcohol, Other Drug, and Violence Prevention; Representative from higher education
Chuck Johnson	Illinois Health and Hospital Association
Steve Moore*	American Foundation for Suicide Prevention
Kimberly Bryan*	Survivor of Suicide
Olivia Johnson*	Blue Wall Institute; Researcher in suicidology
Jessica (Angel) Hamilton*	Survivor of Suicide

Angela Thinnes*	Representing mental health consumers
Shirley Davis*	Representing mental health consumers
Stephanie Weber*	Suicide Prevention Services

Ex-officio members

Member	Representing
Dr. Teresa Glaze	Illinois Department of Human Services
Rebecca Doran	Illinois State Board of Education
Brian Kieninger	Illinois Department of Public Health (IDPH) Division of Emergency Medical Services and Highway Safety
Mike Berkes/Dana Wilkerson	Illinois Department on Aging
Lt. Col. Akil Smith	Illinois State Police
Brenda Henderson	Illinois Department of Children and Family Services
Mary Ratliff	Illinois Criminal Justice Information Authority
Dawn Whitcomb	Illinois Department of Veterans' Affair
Jennifer Martin	Illinois Department of Public Health

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SUMMARY OF RECOMMENDATIONS

The Illinois Suicide Prevention Strategy recommendations are based on the 2012 National Strategy for Suicide Prevention. Modifications reflect specific needs of Illinois and recent developments in suicide prevention.

Strategic Direction 1. Healthy and Empowered Individuals, Families, and Communities

Suicide prevention should follow a public health model that provides a role for all elements of our community.

- Goal 1. Integrate and coordinate suicide prevention activities.
- Goal 2. Utilize communications to change attitudes and behaviors toward suicide and behavioral health.
- Goal 3. Increase understanding of protective factors and how to promote wellness and recovery.
- Goal 4. Promote responsible media reporting of suicide.

Strategic Direction 2. Clinical and Community Preventive Services

Clinical providers and community preventative services should be provided tools to reduce suicide risk factors and to promote protective factors.

- Goal 5. Promote wellness and prevent suicide and related behaviors.
- Goal 6. Reduce access to lethal means of suicide.
- Goal 7. Provide training to community and clinical service providers.

Strategic Direction 3. Health Care Providers

Health care providers should adopt a comprehensive suicide prevention program with an aspirational goal of “zero suicide.”

- Goal 8. Implement a comprehensive suicide prevention program.
- Goal 9. Provide effective care transitions.
- Goal 10. Provide care and support to individuals affected by suicide deaths and attempts.

Strategic Direction 4. Surveillance, Research, and Evaluation

Illinois should promote comprehensive public health surveillance, research-based suicide prevention programs, and regular evaluation and improvement of programs.

- Goal 11. Improve the timeliness and usefulness of data and the ability to use that data.
- Goal 12. Promote and support suicide prevention research.
- Goal 13. Evaluate the impact and effectiveness of suicide prevention programs.

HOW TO USE THIS PLAN

Communities should use this plan as a guide to the development and implementation of their own local plans. Potential activities for different stakeholders are listed at the end of each of the 13 goals. Following the list of the strategic directions, goals, and objectives, on page 85, activities are reorganized so each stakeholder can view activities they can take to help meet the plan's goals. These stakeholders and their activities begin on the following pages:

Through strong community action, the overall goal of this plan is to reduce suicide and suicidal behaviors in all populations. Suicide is a huge, complex problem and Illinois' communities are too diverse in their members and needs for a single intervention to be adequate. Thus, a diverse array of interventions will be required to meet the local needs of the many unique communities in Illinois. This plan should be viewed as a compass shared by suicide prevention stakeholders that will give a unifying direction to their programs. The goals and objectives can only be met if pursued by all stakeholders. A combination of collaboration and individual initiative is essential if the activities outlined in this section are to be effective.

INTRODUCTION

In 2002 the U.S. Surgeon General issued the National Suicide Prevention Strategy, which encouraged states to create their own suicide prevention plans. In response, Illinois enacted the Suicide Prevention, Education, and Treatment Act (Public Act 093-0907), which required the Illinois Department of Public Health to establish a Suicide Prevention Strategic Planning Committee to develop the Illinois Suicide Prevention Strategic Plan. Public Act 095-0109 changed the name of the committee to the Illinois Suicide Prevention Alliance. The first Illinois Suicide Prevention Strategic Plan was submitted in 2007. The most recent update to that plan is the 2018-2021 Illinois Suicide Prevention Strategic Plan.

On August 9, 2019, Public Act 101-0331 became effective and gave new responsibilities to IDPH and the Alliance, including requiring the development of a new state plan to be submitted to the General Assembly and governor within one year. With guidance from public and private partners, IDPH and the Illinois Suicide Prevention Alliance devoted several meetings to revising the current plan. Members took steps to review the 2018-2021 strategic plan, reflect on accomplishments, modify the objectives, and identify recommended action steps. Where appropriate, this plan identifies potential strategies and potential audiences for individual objectives.

Like the 2018-2021 strategic plan, this plan is comprehensive, complex, and ambitious. This updated plan challenges communities, public health professionals, and health care providers to educate, inform, and motivate the public to maximize resources to reduce the burden of suicide. The goal is an improved environment and better outcomes for individuals with mental health conditions, and for those whose life situations have brought seemingly unbearable pain.

What is suicide?

Suicide occurs when a person ends their life. In 2018 in Illinois, there were 1,488 suicides, making it the state's 11th leading cause of death. For young adults 15 to 34 years of age, suicide is the state's third leading cause of death. Nationally, suicide is the 10th leading cause of death.

Suicide is a major public health problem in the United States. Despite the overwhelming numbers, however, the tragedy of suicide is hidden by stigma, myth, and shame. The stigma surrounding suicide often has an impact on prevention and intervention efforts. Additionally, many people have the mistaken notion that talking about suicide causes it to happen, but experts agree suicide is preventable.

Suicide affects all ages and is a problem throughout the life span. In Illinois, it is the second leading cause of death for people 10 to 34 years of age, the fourth leading cause among people 35 to 54 years of age, and the eighth leading cause among people 55 to 64 years of age.

Who is at risk?

Suicide does not discriminate based on race, gender, or age. Some groups are at higher risk than others, such as those with a mental health condition or suffering from substance use disorders. Suicide rates vary by race/ethnicity, age, and other population characteristics.

Other Americans disproportionately impacted by suicide include veterans, military personnel, and workers in certain occupational groups, including law enforcement, construction and the arts, design, entertainment, sports, and media. Sexual minority youth (i.e., those identifying as gay, lesbian, bisexual, or another non-heterosexual identity or reporting same-sex attraction or sexual partners) bear a large burden as well, and experience increased suicidal ideation and behavior compared to their non-sexual minority peers. LGBTQ+ youth with nonaccepting parents may also have an elevated risk of suicide.

In Illinois, men are 3 to 4 times more likely than women to die from suicide. More women than men report attempting suicide. In addition, suicide rates are higher among middle aged adults, whereas suicide attempt rates are higher among young people.

Why does anyone die by suicide?

Many people's first question about suicide is "Why?" There is no easy answer. Suicide research is a growing field, helping to increase our understanding and to recognize the effectiveness of traditional practices in our communities. The voices of suicide attempt survivors and those who have lost loved ones to suicide help explain how a person in crisis can turn toward suicide. Research is evolving and there is still much to learn. Many people feel negative or uncomfortable talking about suicide and those who have personal experience with it. This is called stigma and it limits our ability to prevent suicide. Discomfort talking about suicide stems from cultural and religious traditions, fear of worsening the problem by discussing it, and the shame, guilt, and isolation felt by many who have experienced suicide loss or suicide lived experience (suicide attempts or ideation). Some suicide risk factors, such as depression, cognitive disability, and substance use, also carry stigma (Keller, et.al., 2019).

How can we prevent suicide?

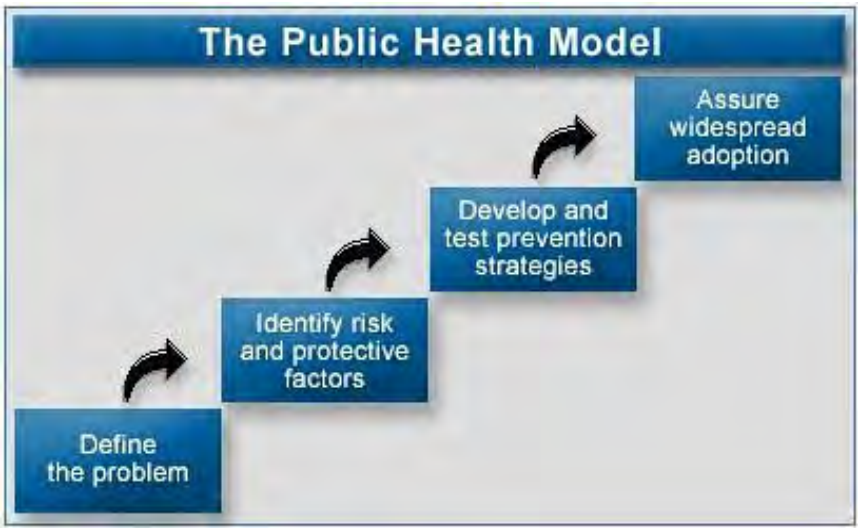
Suicide is a public health issue, so the most effective approach to its prevention is to adopt strategies based on the public health model. The 10 Essential Public Health Services developed by U.S. public health service agencies provide an interrelated set of activities:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and to solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html

Suicide, however, is a specific type of public health issue, falling under the category of "violence." The public health model for violence prevention is a more linear approach:

1. Gather data to identify the who, what, when, and why of a violent event.
2. Identify the factors that protect people or put them at risk for experiencing violence.
3. Develop and test evidence-based prevention strategies utilizing input from the community and stakeholders.
4. Promote widespread adoption include training, networking, technical assistance, and evaluation.



https://www.cdc.gov/violenceprevention/publichealthissue/publichealthapproach.html

This plan incorporates elements of both the basic public health model and the specific violence protection model. The overriding principle of this plan is that everyone can help prevent suicide. Knowing the warning signs, risk factors, and how to get help, can help save lives. While suicide is often thought of as an individual problem, it also impacts families, communities, and society in general. A public health approach can help address factors contributing to suicide. The long-term goal of public health is to reduce people's risk for suicidal behavior by addressing factors at the individual (e.g., substance abuse), family (e.g., poor quality parent-child relationships), community (e.g., lack of connectedness to people or institutions), and societal levels (e.g., social norms that support suicide as an acceptable solution to problems; inequalities in access to opportunities and services) of the social ecology.

References:

Centers for Disease Control and Prevention. Retrieved from: https://www.cdc.gov/violenceprevention/pdf/ASAP_Suicide_Issue2-a.pdf

Keller, S., McNeill, V., Honea, J., & Paulson Miller, L. (2019). A look at culture and stigma of suicide: textual analysis of community theatre performances. International journal of environmental research and public health, 16(3), 352.

National Center for Injury Prevention and Control, Division of Violence Prevention. (2020). Retrieved from https://www.cdc.gov/violenceprevention/suicide/fastfact.html

National Institute of Mental Health (NIMH). Retrieved from https://www.nimh.nih.gov/health/publications/suicide-faq/index.shtml

SUICIDE DATA

Suicide in the World, United States, and Illinois (2018)

Globally more than 800,000 people die by suicide every year, meaning someone dies by suicide every 40 seconds.

In the United States, suicide is the 10th leading cause of death, with 48,344 in 2018, which is more than from homicide, war, and natural disasters combined.

In Illinois, suicide is the 11th leading cause of death, resulting in 1,488 deaths (11.3 per 100,000 residents) in 2018.

In Illinois, suicide is the third leading cause of death for ages 15-34 and fourth leading cause of death for ages 35-44. However, suicide deaths are only part of the problem. More people survive suicide attempts than die. They are often seriously injured and need medical care.

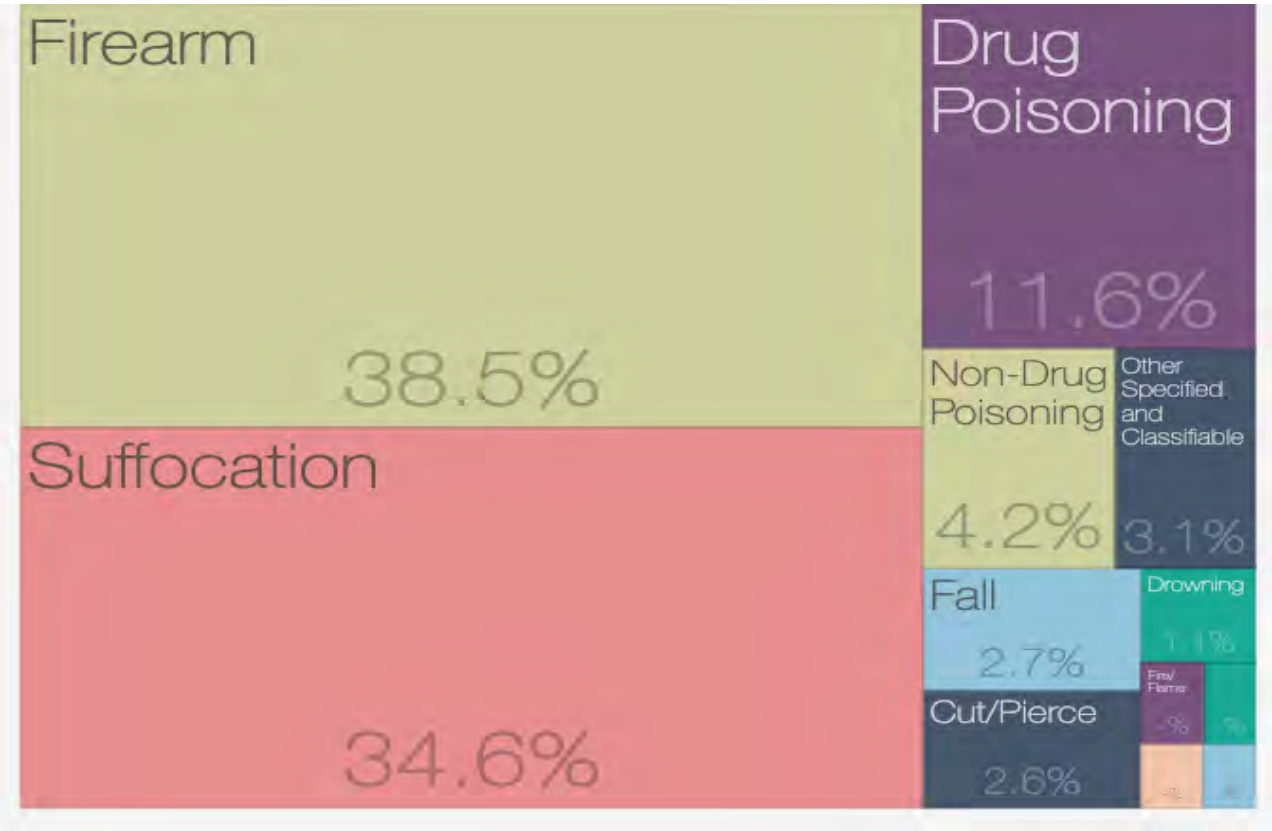
Suicide Methods

In Illinois, firearms are the most used method of suicide (38.5%), with suffocation being the second most used method (34.6%). Other reported methods of suicide include drug poisoning, fall, cut/pierce, drowning, and other specified and classified.

The most used method of suicide for men is use of firearms (43.2%).

The most used methods of suicide for women are suffocation (31.9%) and drug poisoning (30.4%).

Figure 1. Methods; Suicide Mortality, Illinois, (NCHS Vital Statistics System, 2018)



Suicide Circumstances

Typically, there is no single cause for suicide. Circumstances are often complex and may include a combination of some of the following: alienation, loss of connectedness, mental health conditions, interpersonal and/or life stressors, grief, illness, brain structure or function, serious or chronic pain, childhood abuse or trauma, previous suicide attempts, family history of suicide, and substance abuse.

The most common circumstances surrounding suicide are related to mental health, including being described as having a depressed mood or treatment for mental illness at the time of death. In fact, the risk of suicide is increased by more than 50% in individuals affected by depression. Roughly 90% of those who die by suicide have one or more mental disorders at the time of their death.

Populations with disproportionately high suicide rates include American Indians/Alaska Native and white adults, older adults, veterans, those living in rural areas, and LGBTQ adults and youth.

Mental Health Care in Illinois

Illinois proves to be unique in that the state contains a small portion of extremely metropolitan counties (i.e., Cook and the collar counties), many rural counties, and some counties with elements of both.

The uneven availability of behavioral health services in Illinois reflects population densities. Thus, Cook County and the collar counties have greater availability of behavioral health care than the less dense counties in other parts of the state.

Illinois ranks 20th in comparison to other states regarding access to mental health care. This includes access to insurance, access to treatment, quality and cost of insurance, access to special education, and workforce availability. Unfortunately, Illinois demonstrates significant shortages in mental health professionals in 97 of 102 counties.

Figure 2. Health Professional Shortage Areas: Mental Health, (HRSA, 2019)

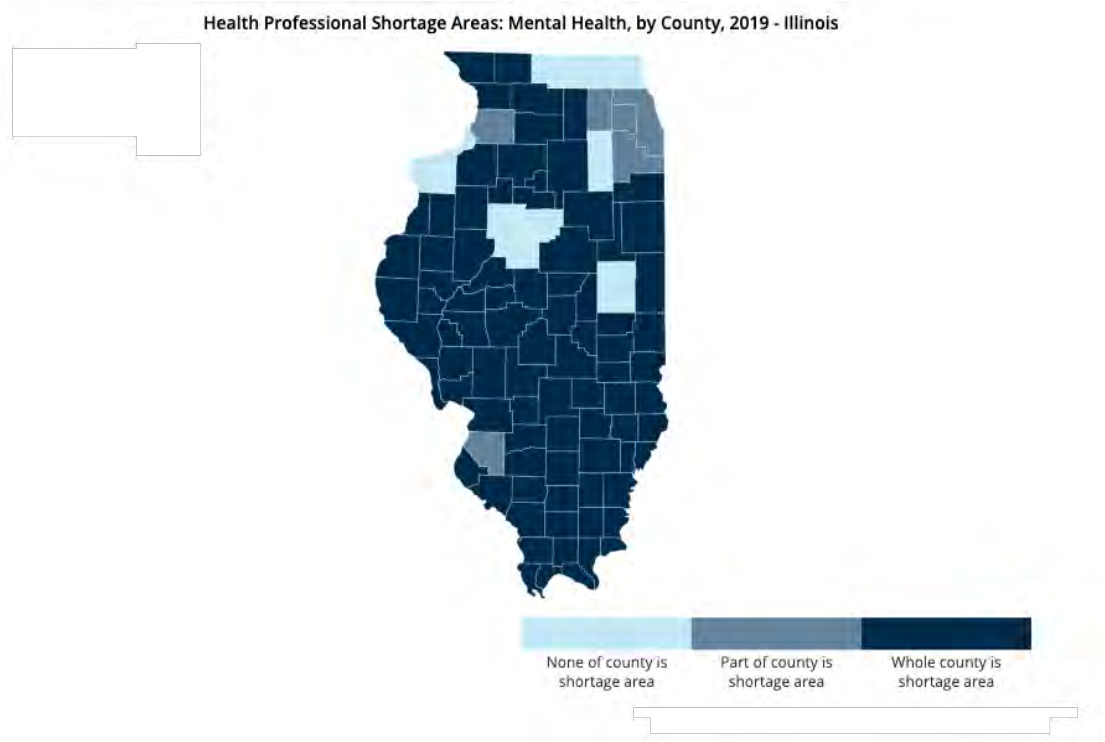
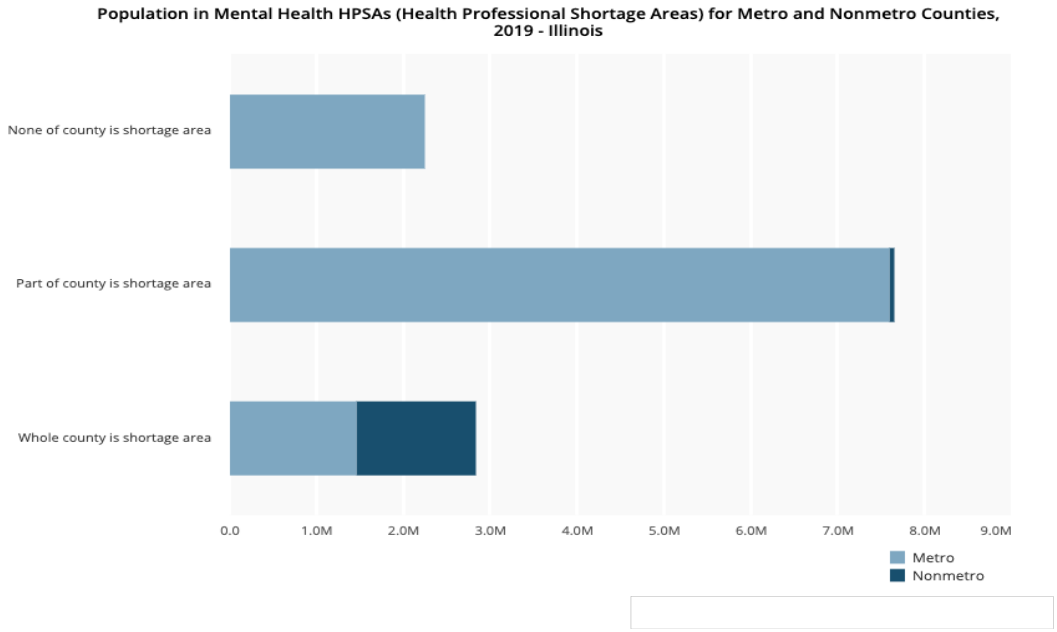


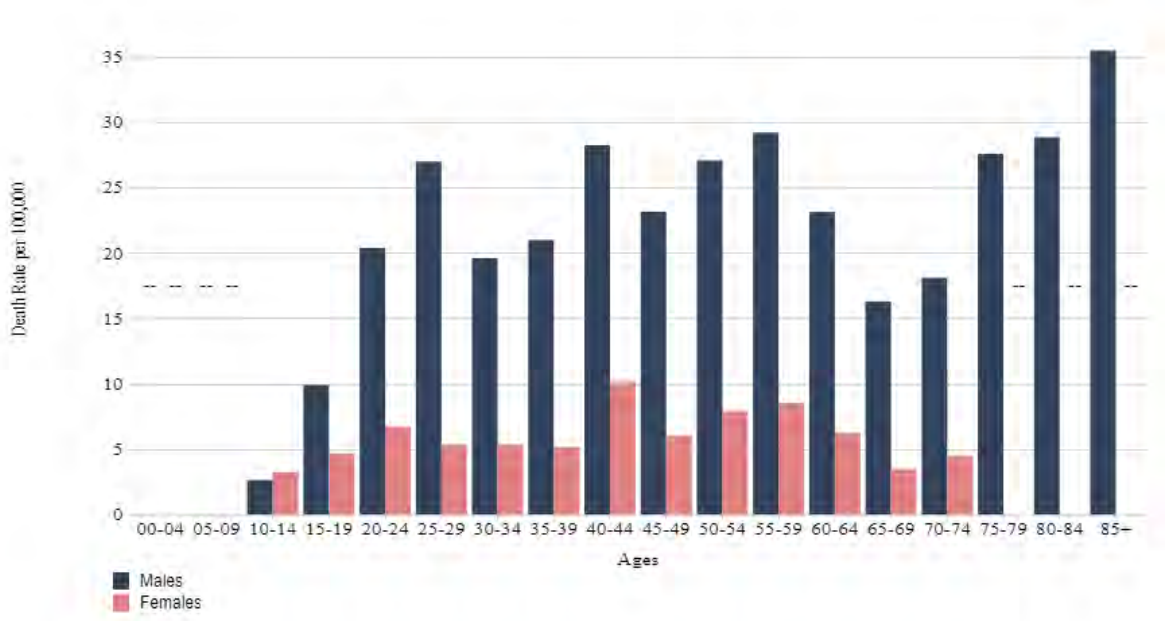
Figure 3. Population in Mental Health Professional Shortage Areas, (HRSA, 2019)



Suicide by Age and Gender

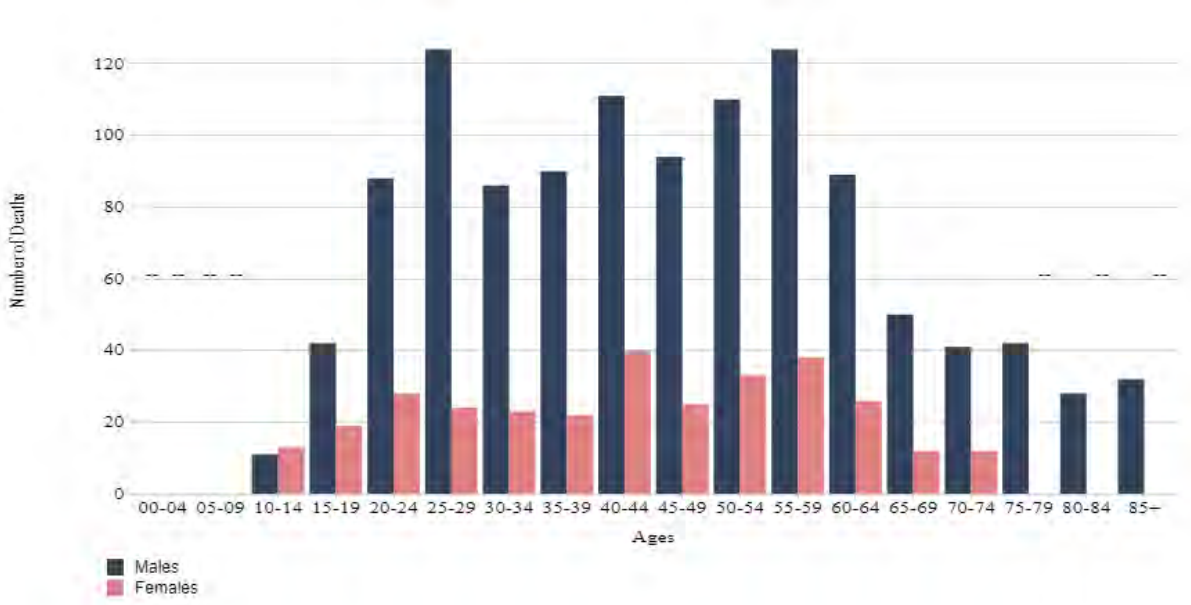
Differences in suicide exist by age and gender in Illinois. Across all ages, males have a higher rate of suicide than females; males are 3.6 times more likely to die by suicide than females. In 2018 males died by suicide at the rate of 18.07 per 100,000, whereas the female suicide rate was 4.98 per 100,000. Within each gender, there are distinct differences by age. The following chart shows the suicide rate broken down by age group.

Figure 4. Sex; Suicide Mortality Rate, Illinois, (NCHS Vital Statistics System, 2018)



The above chart shows the rate of suicide by gender. It is also useful to examine the number of deaths by gender and age group. Examining the rates of suicide helps identify groups most at risk for suicide. Examining the number of suicides helps identify the ways in which intervention could save the most lives.

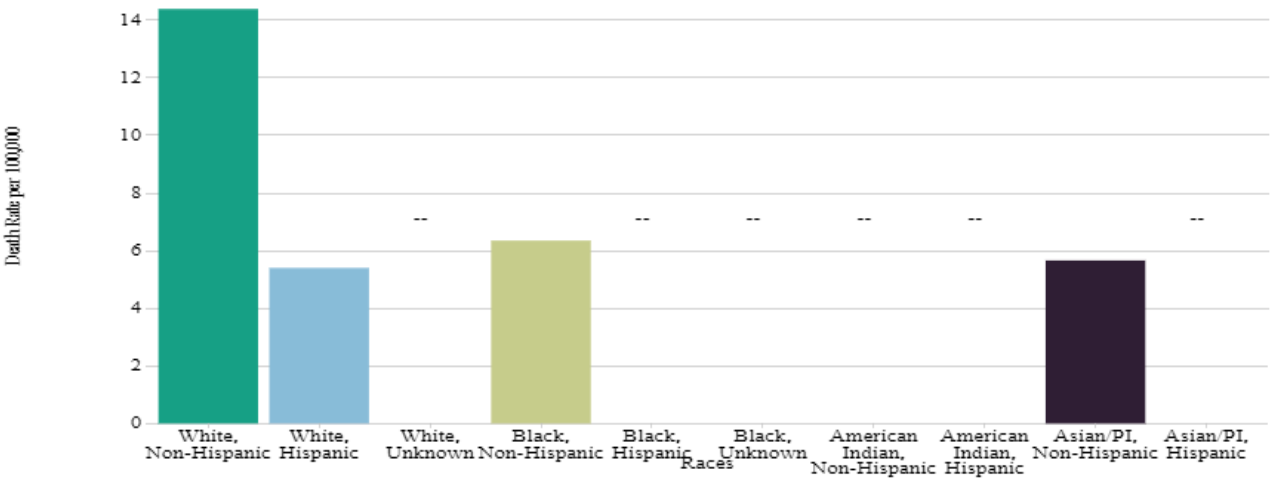
Figure 5. Age; Suicide Mortality Deaths, Illinois, (NCHS Vital Statistics System, 2018)



Suicide by Race/ Ethnicity

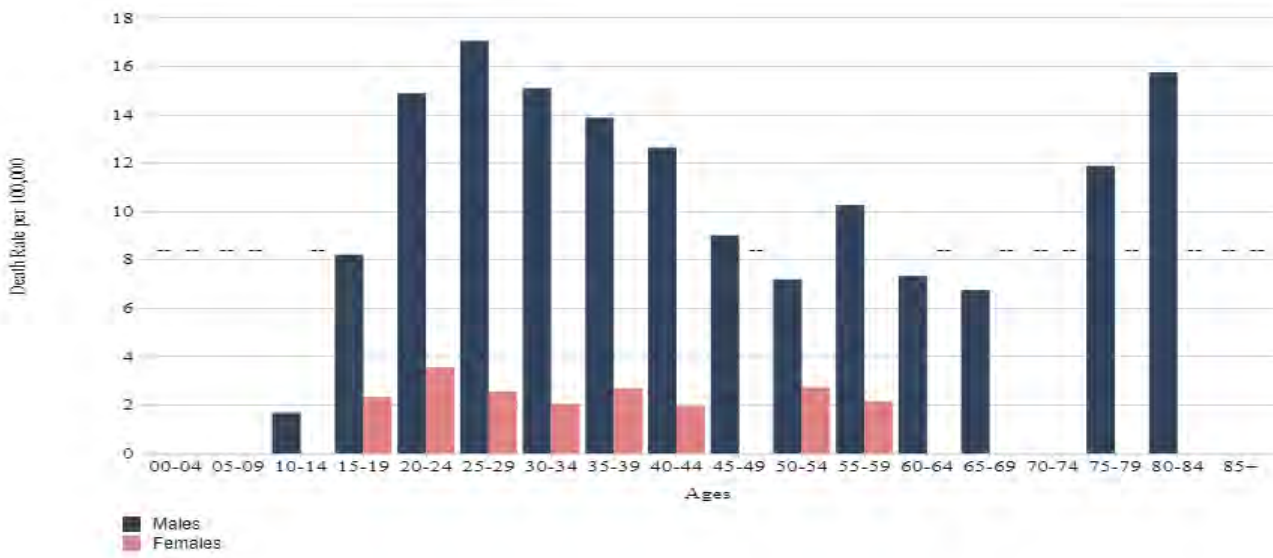
In Illinois, those who identify as White Non-Hispanic have the highest rate of suicide for all racial groups.

Figure 6. Race/ Ethnicity; suicide rate, Illinois, (NCHS Vital Statistics System, 2018)



Within racial groups, there can be significant differences by age and gender. For example, an examination of Black suicides for 2009-2018 reveals a high suicide rate for young males that declines as they age.

Figure 7. Black suicide rate, Illinois, (NCHS Vital Statistics System, 2009-2018)



Suicide by County in Illinois

The combination of rural and urban areas in Illinois presents a challenge for suicide prevention. Figures 8 and 9 show that while rural counties experienced the highest rates of suicide from 2008-2017, the largest number of suicides took place in the Chicago metropolitan region. Special attention needs to be given to areas with the highest rates of suicide without neglecting the fact that reducing the overall number of suicides in Illinois requires a focus on more densely populated areas.

This disparity is also demonstrated by 2018 suicide figures. The U.S. Department of Agriculture has developed the "Rural Urban Continuum Code," which is a classification scheme that distinguishes metropolitan counties and non-metropolitan counties, with further categorization based on degree of urbanization and adjacency to a metropolitan area. Of the 1,488 Illinois suicide deaths in 2018, 1,223 were in counties designated as metropolitan and 265 were in non-metropolitan counties. Yet the age-adjusted rate of death per 100,000 for the non-metropolitan counties (18.22 per 100,000) far exceeded the rate of metropolitan counties (10.47 per 100,000).

Difference in rates across counties may be due to multiple factors, including differences in risk and protective factors, socioeconomic characteristics, access to behavioral health care resources, and distance from emergency health care services. The best way to understand which factors contribute to this difference is to implement an effective public health surveillance model for suicide. Goal 11 of this plan discusses that model and recommends the acquisition of data providing the surrounding circumstances of each suicide in Illinois. Analysis of that data will enable the design of effective suicide prevention strategies for each area of Illinois as well as strategies that are appropriate for groups with a greater risk of suicide, such as the specific populations discussed in the next section.

References

Illinois Department of Public Health, Center for Health Statistics, Vital Records, 2008-2017

American Foundation for Suicide Prevention

CDC WISQARS™

Health Resources & Services Administration (HRSA)

Illinois Violent Death Reporting System (IVDRS)

Figure 8. Suicide Rates (per 100,000), 2008-2017 (IDPH)

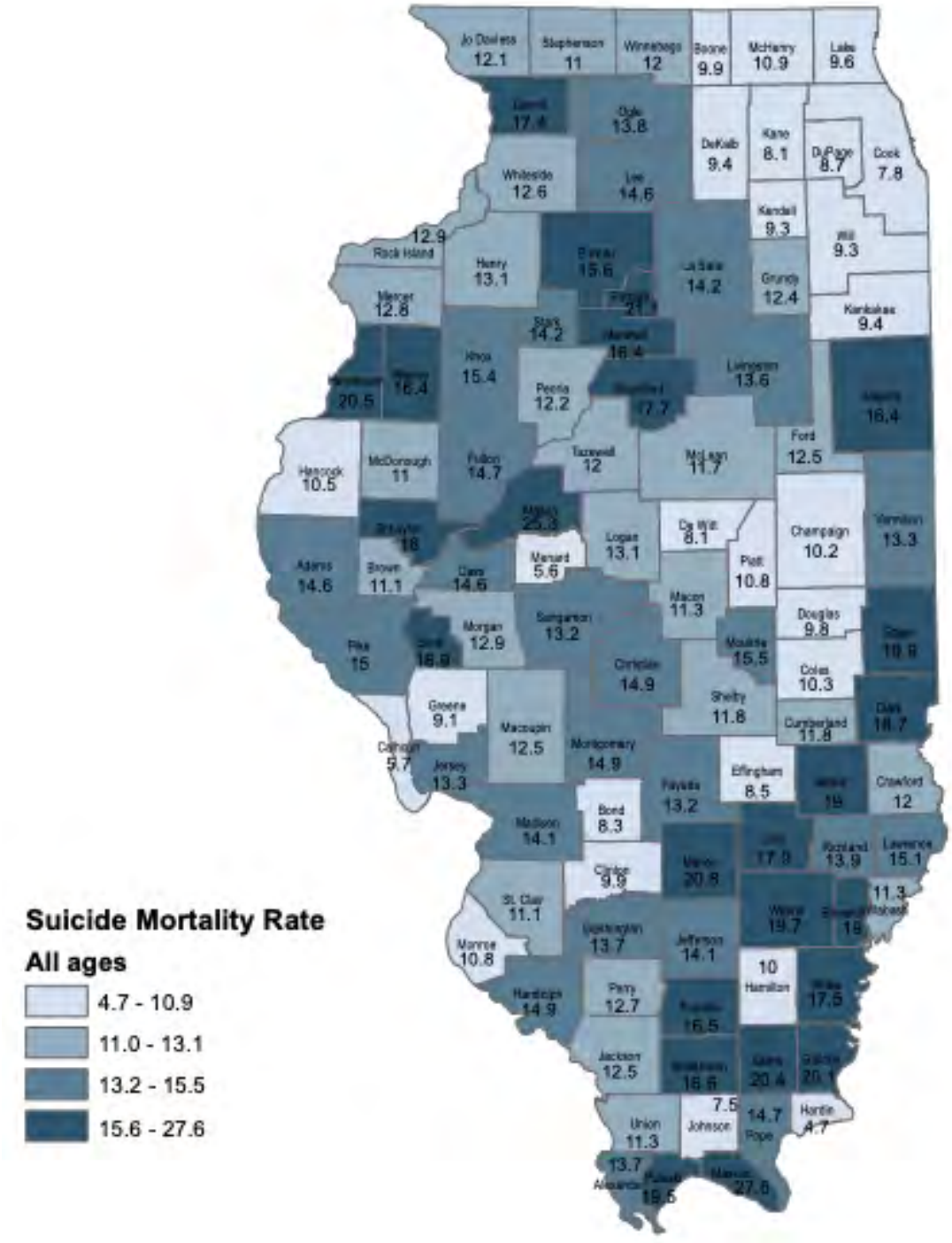
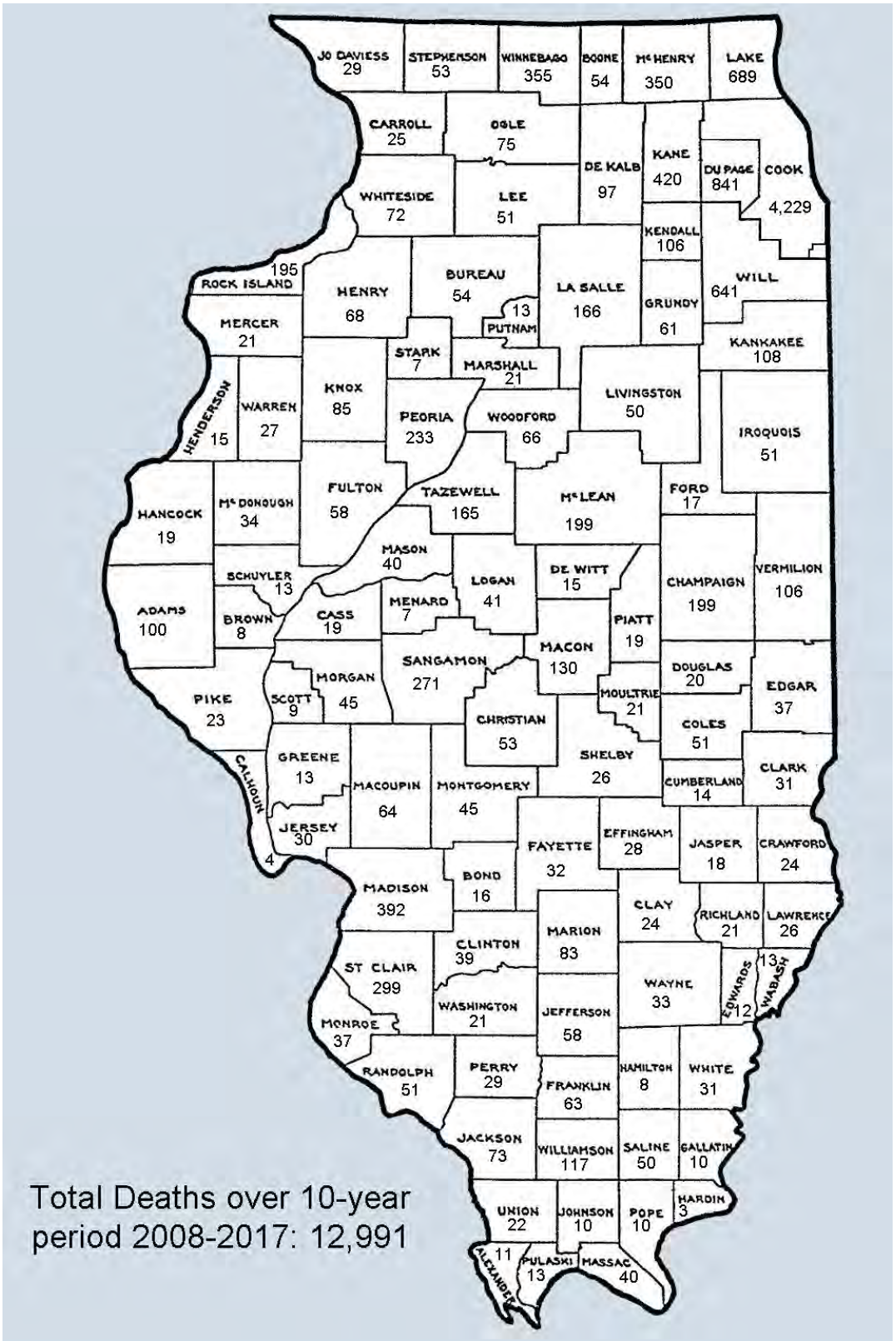


Figure 9. Suicide Death, 2008-2017 (IDPH)



UNDERSTANDING SUICIDE

After a suicide death, grieving family and friends are often left wondering why, but answering that question can be difficult. Suicide is frequently attributed to a single cause, such as mental illness, bullying, or a job loss, but that is rarely the case. Suicide is complex and results from a combination of factors. Individual characteristics (e.g., personality traits or mental illness) play a role, but social experiences (e.g., relationships or exposure to violence) and the environment (e.g., social, political, cultural, economic conditions) are also important factors. Although suicide is typically thought of as a mental health problem, it is a complex social issue and a public health concern that requires multiple levels and types of interventions. Suicide prevention efforts should not be exclusively focused on the mental health service system and should be expanded to include family, friends, neighborhoods, community groups, religious organizations, businesses, schools, and all levels of government. Suicide prevention efforts should include many different partners working collaboratively and using diverse resources and tools. Everyone plays a role in suicide prevention.

Risk and Protective Factors

Risk factors are characteristics that make it more likely that a person will have thoughts of suicide or attempt suicide. Risk factors generally contribute to long-term risk, but situational stressors may also increase immediate suicide risk. Risk factors may be fixed and unchangeable, such as history of child abuse or exposure to suicide, or they may be modifiable or treatable, such as substance use or relationship problems. Protective factors are characteristics that make suicide less likely by promoting resiliency and providing support to vulnerable people. Risk and protective factors for suicide exist on many levels, from the individual to the societal. The goal of suicide prevention is to reduce risk factors and to increase protective factors for individuals and in families, communities, and society as a whole.

Risk Factors

- Previous suicide attempt
- Exposure to suicide through family, peers, or celebrities
- Impulsive or aggressive tendencies

- Feelings of hopelessness
- Mental illness, particularly depression, bipolar disorder, borderline personality disorder
- Eating disorders
- Substance use disorder
- Isolation or feeling disconnected from other people
- Bullying or public humiliation
- Exposure to violence in the family or community
- Sexual assault or abuse
- Relationship problems
- Family separation
- Employment or financial problems
- Experiencing a significant loss
- Health problems, including chronic pain
- Bullying or public humiliation
- Incarceration
- Access to lethal means, particularly firearms
- Lack of access to mental/behavioral health care
- Multiple military trauma involved deployments and survival grief
- Workplace exposure to trauma (first responders, health care workers)

Protective Factors

- Coping skills, conflict resolution skills, and problem-solving skills
- Sense of purpose or reasons for living
- Supportive and affirming families
- Safe schools and neighborhoods
- Feeling connected to family, peers, and the community
- Access to care for physical, mental/behavioral, and substance abuse disorders
- Economic stability and social welfare
- Cultural and religious beliefs that discourage suicide
- Restrictions on access to lethal means, particularly firearm safety

Warning Signs

Risk factors help to identify people who may be more likely to experience suicidal thoughts or behaviors, but many people have risk factors and do not have thoughts of suicide or attempt suicide. Warning signs help to identify those who might be experiencing suicidal thoughts and behaviors and are at immediate risk. In other words, risk factors indicate that someone could possibly be suicidal at some point, while warning signs indicate that someone may be suicidal right now.

Indirect warning signs indicate that someone may be experiencing emotional distress and may be having thoughts of suicide. Direct warning signs indicate that someone may be at imminent risk and may be planning a suicide attempt. People showing direct warning signs should not be left alone and need immediate suicide intervention.

Indirect Warning Signs

- Feeling empty, hopeless, or having no reason to live
- Feeling trapped or having no solutions to problems
- Guilt or shame
- Anxiety, agitation, or irritability
- Anger or rage
- Emotional crisis or unbearable emotional pain
- Extreme mood swings
- Increased alcohol or drug use
- Withdrawing from family, friends, or activities
- Changes in eating or sleeping habits
- Engaging in risky and dangerous behaviors

Direct Warning signs

- Talking of being a burden to others
- Talking about death or wanting to die
- Giving away important possessions
- Saying goodbye to family and friends
- Making a will or getting affairs in order, including arranging for care of family members or pets
- Planning for suicide and preparing means, such as acquiring a firearm or stockpiling pills

Understanding Suicide in Specific Populations

Some populations experience shared risk factors that can increase the possibility of suicide for people who identify with that group. Importantly, people in these groups are not inherently more suicidal than others, but their increased risk lies in experiences that happen to them because of their group identity. Suicide prevention efforts must recognize and respond accordingly to these unique needs. It is important to note that data are difficult to obtain for many of these populations and their subgroups due to relatively small numbers. Thus, our understanding of suicide risk for small groups is imperfect. One solution is the discussion in Goal 11 to develop better systems for recording, reporting, and analyzing suicide attempt data, which is always more robust than suicide completion data. Nevertheless, there is sufficient data to support the following discussion.

LGBTQ+

The diverse LGBTQ+ (lesbian, gay, bisexual, transgender, and queer or questioning) community is made up of people who are not heterosexual or cisgender (having a gender identity that matches one's sex at birth), including those who identify as lesbian, gay, bisexual, transgender, queer, asexual, pansexual, demisexual, polysexual, aromantic, intersex, non-binary, two-spirit, agender, bigender, polygender, genderfluid, genderqueer, and other sexual orientations and gender identities. Research on suicide in the LGBTQ+ community has generally been limited to people who identify as lesbian, gay, bisexual, and transgender, although these data may include people who have other identities but are limited to reporting only these options. Depending on identity, 25-50% of people in the LGBTQ+ community attempt suicide, with the highest risk among transgender people.

LGBTQ+ people frequently receive messages in society (through interpersonal interactions, in the news, media, politics, and religion) that they are not accepted, should be excluded from social life, and do not deserve the same rights as others. They may experience family rejection, some to the extent of being disowned by their family, which can lead to homelessness for youth. They are more likely to experience discrimination, harassment, and bullying due to their identity, and are more likely to experience violence and sexual assault. LGBTQ+ people may also go through conversion therapy, a discredited practice that attempts to change their sexual orientation or gender identity through techniques using shame, emotional trauma, and physical

abuse. These experiences can lead to higher rates of mental illness, such as depression, post-traumatic stress disorder (PTSD), and substance use, which also increase risk for suicide.

Affirming the identity of LGBTQ+ people is an important protective factor. This can happen in interpersonal interactions, such as calling trans people by their chosen name and using inclusive language to refer to romantic partners, and policies, practices, and laws, such as creating norms of stating pronouns and anti-discrimination laws. Support from family and friends, access to safe and affirming social spaces, and access to culturally aware health and mental health providers are also protective.

Service Members, Veterans, and Their Families

Veteran suicides are 13.5% of all U.S. adult suicide deaths, but veterans only make up 7.9% of the nation's adult population. Veteran suicide includes data on people currently serving (active duty) and those who served in the National Guard and Reserves without being federally activated.

Suicide risk for veterans is highest for those who served in the Vietnam War era and the post-9/11 Gulf War era. Veterans who serve in combat can experience trauma that increases their risk for PTSD, other mental illnesses, such as depression or anxiety and substance use disorders. They may also experience moral injury, which refers to the extreme feelings of guilt, shame, betrayal, or moral disorientation that can occur when someone does, witnesses, or experiences things that violate their moral beliefs. While suicide risk in veterans is often attributed to combat experiences, veterans who serve during peace time and veterans who do not have combat experience also experience higher rates of suicide due to general stressors related to military service. Active duty personnel can experience family separation related to deployments and stress in personal relationships due to their duties that can lead to feelings of inadequacy in their familial roles as spouses or parents. Veterans may have difficulty readjusting to civilian life, which can be exacerbated by experiences of trauma or moral injury, and may experience relationship issues, difficulty in employment, financial issues, and homelessness. Additional risk factors include military sexual trauma, duration of conflict and, as veterans age, life stage changes, retirement, and the loss of friends.

While veterans have available many benefits and services, not all veterans are eligible for these services. There are about 20 million veterans, but only 9 million are eligible for health care services due to a service-connected disability. Similarly, of the 620,000 Illinois veterans, only 180,000 are eligible for U.S. Department of Veterans Affairs (VA) health care services. Further, due to bad experience, ignorance of the services available, and the complexity of eligibility, many veterans do not seek VA help. Thus, on average, 14 of the 20 veterans who die by suicide in Illinois were not receiving services from the Veterans Health Administration.

Because of the special issues faced by veterans, and the fact that many do not use VA services or require services beyond those provided by the VA, it is important that service providers inquire whether a patient or client has served in the military. Providers should also be trained to understand and to be sensitive to the unique experience of military service and the needs of veterans.

A public health approach recognizes that veterans can benefit from wide-ranging social supports to prevent isolation, unemployment, poverty, and homelessness. Also important are quality health care for physical injuries and pain, treatment for substance use disorders, and mental health care to address the effects of trauma and moral injury. Communities can also help veterans re-integrate by creating affirming spaces and recognizing the benefits of the skills and experiences veterans can bring to jobs and community activities.

Veterans are more likely than most people to attempt suicide using firearms, which contributes to the high rate of suicide deaths due to their lethality. Forty-five percent of suicides in the general public are by firearm, but 67% of veterans' suicides are by firearm. Consequently, firearm safety strategies are particularly important for preventing veterans' suicides.

First Responders

First responders include police officers, firefighters, emergency medical service providers, emergency dispatchers, and doctors, nurses, and other medical personnel. About 1 in 4 police officers report thoughts of suicide, and more officers die of suicide than die in the line of duty. Compared to the general population, emergency medical technicians (EMTs) are about 10 times more likely to report suicidal thoughts and firefighters are about three times

more likely to attempt suicide, with firefighters who are also EMTs being six times more likely to attempt suicide than those who just have firefighting duties. Compared to people working in non-medical professions, doctors are two times as likely and nurses are four times as likely to die of suicide.

First responders face unique stressors in their jobs, particularly related to experiences of trauma. In their jobs, they often see the worst of what can happen to people and the worst of what humans can do to each other. These traumas increase their risk for PTSD, other mental illnesses such as depression or anxiety, and substance use disorders. First responders often report feeling unable to talk about these traumatic experiences or to seek emotional support from loved ones out of fear of traumatizing them by sharing what they see on the job. Furthermore, it is difficult for them to seek support from their employers or coworkers out of fear of having people think they are not capable of doing their job and concern they may lose their job. This can lead to feelings of isolation, increased substance use, and issues in personal relationships. First responders are also at risk for moral injury. For example, doctors and nurses may experience extreme guilt when they feel they have a responsibility to save people but then are unable to do so, often for reasons out of their control, such as a lack of available resources, financial constraints, or lack of insurance coverage for patients.

Since the suicide risk in first responders is related to job stress (although risk is increased in those with other non-job-related risk factors), employers play an integral role in building protective factors. Workplaces should have procedures to address job stress and trauma and to prevent burnout, such as accommodating time off policies, employee assistance programs, mentoring, or coaching programs, and procedures to identify and intervene with employees who may be at risk for suicide. Workplaces can build cultures that foster communication and respect, promote emotional and physical wellness, and decrease the stigma and potential discrimination first responders may feel about seeking support. First responders can also benefit from legal protections that prevent their job loss due to suicidal thoughts and behaviors, mental/emotional health issues, or substance use issues.

Youth

The suicide rate in youth (including children and adolescents under age 20) is consistently lower than in adults. Nevertheless, while the suicide rate is increasing in all ages, it is increasing faster in youth than adults. Youth may

be less likely than adults to die of suicide, but they are more likely to report thoughts of suicide and attempt suicide. This is demonstrated by the responses of Illinois high school students to the 2019 Centers for Disease Control and Prevention Youth Risk Behavior Survey.

(Percent)	Total	Male	Female
During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?	36.3	26.8	46.0
During the past 12 months, did you ever seriously consider attempting suicide?	19.0	13.9	23.7
During the past 12 months, did you make a plan about how you would attempt suicide?	15.6	12.1	19.0
If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?	3.1	3.2	2.8

Youth suicide risk is related to their developmental stage and abilities, discrimination by adults, and the unique generational experiences they have due to the time in which they are growing up. Young people have less well-developed problem-solving and coping skills, leading to difficulty in managing stress, crisis, and trauma that can leave them feeling overwhelmed and unable to see solutions to their problems. Young people are also heavily influenced by peer relationships, such that their identities are affected by how they feel their peers see them. Youth are more likely to internalize the ways in which they think others identify or define them, such as popular, weird, a nerd, smart, good or not good at particular things, or liked or not liked by others, although their perceptions may not match reality. Youth can feel great distress about the way they think others view them, they can feel pressure to live up to these perceptions, or they can feel inadequacy in their ability to meet them, all of which can increase feelings that they are not good enough, don't fit in, or that others would be better off without them.

Suicide intervention for youth can be hindered by adultism, discrimination by adults based on the belief that adults know more than youth and have the right to act on them without their consent. Youth often report they do not feel adults understand them and they do not trust adults. As such, youth are more

likely to seek help from peers rather than adults, and those peers are also unlikely to seek support or intervention from adults. When adults do become aware of suicidal thoughts and behaviors in youth, rather than being supportive and understanding, they may impose restrictive interventions, such as forced counseling or hospitalization, that further deter youth from seeking help. Adults can have difficulty understanding the experiences of youth due to the difference between the experiences they had when they were young and what youth experience today. Young people report stress due to increased academic pressure to attend college, increased competition in academics and the job market, and fears of personal safety due to mass shootings or police brutality. Although many adults attribute the increase in youth suicide to increases in social media and smartphone usage, youth themselves do not report these as significant issues and the research on the relationship does not conclusively support this claim.

Protective factors for youth include supportive relationships with adults, stable familial relationships with good communication, affirming and inclusive social spaces, access to groups and activities in which they can feel successful and connected, opportunities to participate in and contribute to school or community projects, programs that build problem-solving skills and conflict resolution skills, and access to quality emotional, behavioral, and medical health care.

All youth should have restricted access to drugs, alcohol, and firearms. More than half of youth suicides are by firearms and two-thirds of the guns belonged to a family member, usually their parents. Given that many parents are unaware of their child's suicidal thoughts, safe storage of firearms in all homes with youth is important for preventing youth suicide.

It is also important to recognize the long-term impact that adverse childhood experiences may have on risk of suicide after a youth reaches adulthood. Adverse childhood experiences, or ACEs, are potentially traumatic events that occur in childhood (0-17 years). These include:

- Experiencing violence, abuse, or neglect.
- Witnessing violence in the home or community.
- Having a family member attempt or die by suicide.

Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with:

- Substance misuse
- Mental health problems
- Instability due to parental separation or household members being in jail or prison

ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood. ACEs can also negatively impact education and job opportunities. Many of these long-term impacts may increase the risk of suicide.

Exposure to ACEs occurs disproportionately among racial/ethnic minority youth, which likely contributes to existing health disparities. Intervention and prevention programs focused on improving child health and reducing racial/ethnic disparities must be informed by knowledge of the additional barriers faced by racial/ethnic minority youth. In line with these priorities, all intervention and prevention efforts should be community-partnered, grounded in cultural competence and humility, and aligned with community values and priorities.

The Elderly

In general, people are at greatest risk for suicide in middle age (age 25-64). However, when considering age and gender, elderly men have the highest suicide rate of any demographic group. While the risk of suicide for woman increases into middle age and then decreases, the risk of suicide for men continues to increase throughout the lifespan.

Major depression is the strongest risk factor for suicide in the elderly. While depression in the elderly is related to life course changes that come with aging, depression is not an inevitable outcome of aging. It is a common misconception that depression is a natural or normal part of the aging process, and suicide in the elderly is not considered as shocking or tragic as suicide in youth or middle-aged adults. These ageist discriminatory beliefs prevent outreach efforts to provide support for life changes in the elderly to prevent depression and to identify and treat mental illness. While the ability to cope with and manage stressors increases with age, the elderly face new stressors and a cumulation of stressors that may overwhelm their typical coping

abilities. Risk factors for depression and suicide in the elderly include social isolation, physical disability and pain, cognitive decline, loss of independence, and the deaths of friends and loved ones. These changes may lead to feelings of disconnection, inadequacy, burdensomeness, a loss of identity, and a loss of purpose in life. Elderly men are particularly susceptible to these effects. Elderly men may become more socially isolated than women because men are not socialized to value and to cultivate strong personal relationships. They may lack deep connections with friends and family, and as they lose friends and family through death, they may have difficulty establishing new relationships. Men are also socialized to define themselves and to create their identity based on their job and their ability to be a provider. As they lose their physical or cognitive abilities and their connections to work through retirement or disability, they can suffer serious shocks to their identity and have difficulty recognizing their worth and purpose. Men in general are also less likely than women to seek support and to receive treatment for mental illness.

Societal norms and values that respect the elderly and recognize their worth are important protective factors. Also, respect for and acceptance of the aging process and changes that come with aging can be protective against suicide. The elderly can also benefit from funding for services and supports, including health care, mental health care, social services, and those that provide opportunities for community engagement and participation. Because the elderly face physical health issues with increasing frequency and severity, the integration of physical and mental health services can minimize comorbidity of physical illness with depression and anxiety. Maintaining social connections and an active lifestyle are beneficial for the elderly, and community programs should work on creative ways to overcome barriers and support the elderly in staying engaged in life. Elderly people are more likely to use lethal means for suicide, including firearms, suffocation, and drowning, so means safety is important for suicide prevention.

People of Color

White people account for the majority of suicide deaths, but suicide is by no means an issue only affecting White people. The suicide rate is highest in Native Americans, and lowest in Blacks, Latinx, and Asians, although there is also variation between ethnic communities within each of these groups. Variations in suicide rates for racial groups reflect differences in cultural norms

and values and unique social experiences based on racial identities, including discrimination, racial trauma, and oppression.

The suicide rate is increasing in all racial groups, but the rate for Native Americans and Alaskan natives is increasing more substantially than others. Much of this is driven by the dramatic increase in n youth suicides. In other racial groups, the suicide rate is highest in middle-aged adults, but the suicide rate in natives is highest in youth and young adults. Suicide clusters are common as native youth are affected by the culmination of multiple suicide deaths in their community. Historical trauma from genocide and continued racism lead to experiences of violence and poor social and health outcomes. Native people tend to live in isolated rural areas that lack resources, including mental health care.

Myths about Black people not dying of suicide lead to underreporting and undercounting of suicide in the Black community. Strong cultural and religious norms against suicide, while protecting Black people from suicide, also prevent Black communities from acknowledging and accepting suicide deaths. Black people experience significant institutional and individual racism leading to poor health and social outcomes, including poverty and unemployment. Additionally, Black people are disproportionately subjected to state violence through police brutality and incarceration. Black people consistently receive messages from society that they are to be under suspicion for being violent criminals and that their bodies have no value and can be subjected to violence and violation at any time. These racist messages can lead to negative self-perceptions and doubts about their value and place in the world, especially in young Black boys. Since 2003, the suicide rate in Black boys age 5-11 has doubled, and Black boys are more likely than other youth to show depressive symptoms after seeing videos and reports about police brutality against Black people. Historical and current discrimination in medical and mental health care causes Black people to be denied appropriate and adequate treatment and leads to distrust that prevents them from using formal service systems.

Latinx is an all-encompassing term that includes many different Spanish-speaking cultural and ethnic groups from Mexico, Central and South America, and the Caribbean. Latinx people in the U.S. are assumed to be immigrants, but some have been in the country for generations, becoming Americans as the U.S. took over land in the Southwest. However, our understanding of suicide in Latinx people is primarily related to those who are more recent

immigrants. Latinx people report the highest levels of hopelessness of any racial group. Latinx people are subjected to institutional and individual racism, and both documented and undocumented people consistently receive messages from society that they are not Americans and do not belong in American society. Latinx people can experience feelings of cultural alienation as they are disconnected from their native culture and family in their home country. Stress from generational differences in levels of acculturation into U.S. society can lead to family conflict. Language and cultural inhibitions or barriers can prevent Latinx people from being able to access services and supports, finding safe and secure employment, and generally engaging in community life. Latinx people can also experience fear about being deported or having family members deported and may experience traumatic family separations due to immigration enforcement activities.

Asians are an ethnically and culturally diverse group that includes people from Asia, Native Hawaiians, and Pacific Islanders. Like Latinxs, Asians have both been in the U.S. for generations and are recent immigrants. Asians experience significant social exclusion and are treated as foreigners who are not able to integrate into U.S. society. Asians who come to the U.S. as refugees have high rates of depression and PTSD. Recent immigrants can experience acculturative stress and family conflict between generations within a family. Americans hold a general stereotype of Asians as being well-educated and wealthy (the model minority myth), but Asians are more likely to experience poverty. Financial barriers, in addition to cultural and language barriers, prevent Asians from seeking and receiving mental health care.

Cultural affiliation and pride in racial or ethnic identity is important for protecting against suicide in people of color. Institutions can implement practices and encourage social norms that respect and affirm different cultural identities to encourage cultural pride. Policies protecting people of color from discrimination and practices that promote social inclusion are also important. They not only support positive identity development, but also reduce suicide risk factors, including poverty, unemployment, homelessness, substance use, and mental illness. Familism, or strong feelings of commitment and loyalty to the extended family, also protects against suicide in some ethnic communities because it encourages strong communication and family support. Communities of color often have strong moral and religious beliefs against suicide. While this protects against deaths, people of color still experience emotional distress and suicidal thoughts. Suicide intervention programs

should be culturally aware and developed to meet the needs of unique racial/ethnic groups.

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COVID-19 and Suicide

In response to the COVID-19 pandemic, local and state governments instituted strong measures to stop the spread of the coronavirus by limiting physical contact between people. Stay-at-home orders in Illinois placed limits on the number of people who could gather in a space, and included the closure

of schools and religious institutions, non-essential businesses, restaurants and bars, personal care services, entertainment venues, and parks and recreational facilities. In public spaces, people were required to wear masks and maintain 6 feet of distance from others. The pandemic and the response created risk factors that can lead to an increase in suicides, both immediately and over time. Lives were unexpectedly disrupted leading to feeling a loss of control and fear and anxiety about the future. As we learned more about the damage the virus can do, fear of infection and death increased. Doctors, nurses, and medical staff suffered trauma, burnout, and moral injury from experiencing so much illness and death. Business owners feared losing their livelihood. Unemployment increased dramatically and many families faced financial strain. People were unable to meet their basic needs, including food, housing, utilities, and non-emergent health care. Communities feared increases in drug and alcohol use, domestic violence, and child abuse as people were forced to stay in unhealthy environments at home. People suffered the detrimental effects of social isolation, including increases in depressive symptoms and emotional crisis. Established coping methods were cut off as public spaces like religious institutions, gyms, and parks closed, and counselors and therapists ended in-person services. Firearm sales increased meaning more people had easy access to lethal means for suicide. There was substantial fear of a secondary mental health pandemic leading to dramatic increases in deaths from suicide, drug overdoses, and alcohol use.

The concern of an increase in suicides due to the pandemic has some historical support. Suicides did increase after the 1918 flu pandemic[1] and the 2003 SARS outbreak.[2] Suicide has also increased during economic downturns,

[1] Wasserman, I.M. (1992), The Impact of Epidemic, War, Prohibition and Media on Suicide: United States, 1910–1920. Suicide and Life-Threatening Behavior, 22: 240-254. doi:10.1111/j.1943-278X.1992.tb00231.x

[2] Cheung, Y.T., Chau, P.H. and Yip, P.S.F. (2008), A revisit on older adult suicides and Severe Acute Respiratory Syndrome (SARS) epidemic in Hong Kong. Int. J. Geriat. Psychiatry, 23: 1231-1238. doi:10.1002/gps.2056

including the Great Depression [3] and the 2008 recession. [4] Given the widespread experience of risk factors due to the pandemic, an increase in the suicide rate seems probable. However, while suicide has increased during some disease outbreaks, it has not increased during others. The "pulling together effect," [5] in which people tend to feel more connected during collective experiences, may protect against suicide. During times of national crisis, such as after the assassination of President John F. Kennedy[6] and the 9/11 terrorist attacks,[7,8] the suicide rate decreased as people felt greater social connection due to strengthened national identity. In response to the COVID-19 pandemic, government leaders encouraged this collective identity to achieve compliance with public safety measures, including Gov. JB Pritzker's "All In Illinois" campaign. While the goal was to protect from disease, the efforts can also protect against suicide by increasing social connectedness. "We're all in this together" is a powerful belief.

Increased suicide deaths from COVID-19 are not inevitable, because, while risk factors for suicide have increased, protective factors can increase as well. Communities came together and governments took steps to prevent social isolation, financial distress, and emotional crisis. People found creative ways to promote the sentiment that we are still connected even though we must be apart, including sharing music from balconies, cheering on medical workers together, and writing chalk messages on sidewalks. Donations and funding to provide food to children and families, eviction freezes and rental assistance,

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[3] Luo, F., Florence, C. S., Quispe-Agnoli, M., Ouyang, L., & Crosby, A. E. (2011). Impact of business cycles on US suicide rates, 1928-2007. American journal of public health, 101(6), 1139–1146. https://doi.org/10.2105/AJPH.2010.300010

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[8] Salib E. (2003). Effect of 11 September 2001 on suicide and homicide in England and Wales. The British journal of psychiatry: the journal of mental science, 183, 207–212. https://doi.org/10.1192/bjp.183.3.207

utility assistance programs, increased unemployment benefits, and federal stimulus payments provided a reprieve from financial strain. Families used the time spent home together to reconnect and strengthen their relationships. Crisis services increased capacity to meet demand and mental health service providers quickly implemented virtual services, including telehealth and online support groups. Experience with treatments such as telehealth may have long-term positive impacts, such as demonstrating ways to increase services to areas with shortages of behavioral health personnel. These efforts are certainly not end-all solutions, but they do illustrate what communities can do with determination and support. These are just the beginning of what we can accomplish.

While it will be several years (suicide data is not available for analysis for two years) before we know whether these efforts were enough to prevent an immediate increase in suicides, this experience has provided the opportunity for progress that will hopefully prevent many more suicides in the future. The predicted mental health pandemic does not have to result in deaths. We may not be able to prevent the stressors a pandemic brings, but, if we act now, we can prevent those stressors from resulting in death. The pandemic has highlighted gaps and failures in our service systems and forced creative and innovative solutions and a re-imagining of how we provide suicide intervention services. With support and funding, we can make these systems stronger and more effective. The pandemic has also highlighted the need for upstream prevention and strengthened calls to improve the general social, financial, emotional, and physical wellness of society as a whole. Suicide is complex and is not caused by any one factor, including a pandemic or economic recession. Those that die of suicide during these times of great distress are often people who have other risk factors or experience other life stresses. For too long, the voices of suicide prevention activists calling for change to reduce these risks by creating a world worth living in, one that is equitable and just and provides for everyone’s needs, have been silenced and ignored. COVID-19 has provided an opportunity for them to be heard.

STRATEGIC DIRECTIONS, GOALS, AND OBJECTIVES

While this Illinois strategic plan follows the outline of the 2012 National Strategy for Suicide Prevention, it contains modifications to that plan that reflect the needs of Illinois. Most significantly, this plan emphasizes the public health approach to suicide prevention, provides resources for programs relevant to each stakeholder, and provides those stakeholders with specific recommended actions they can take to prevent suicide.

An important part of this plan is the section that follows each of the 13 goals setting forth specific activities that can be taken by various elements of our community to further that goal. This is not an exhaustive list, but merely suggestions that send the message that all of us have a role. After the discussion of the 13 goals, these activities are listed a second time sorted under each of the organizations so every part of our community can see the range of activities they can take to prevent suicide.

STRATEGIC DIRECTION 1.

Healthy and Empowered Individuals, Families, and Communities

Suicide is caused by a combination of risk factors that offset the protective factors in our lives. Individuals, families, and communities can all take steps that minimize these risk factors and promote these protective factors. Therefore, suicide should be treated as a public health issue that is addressed with a comprehensive approach that provides a role for all of us.

Goal 1. Integrate and coordinate suicide prevention activities.

Suicide shares risk and protective factors with mental health conditions and substance use disorders as well as many types of trauma. (The term "behavioral health" is used in this strategy when referencing mental health conditions and substance use disorders together). Thus, individuals and organizations working in those areas can integrate suicide prevention into their work. Similarly, gatekeepers in a position to recognize the signs of a person who is at risk for suicide, or able to minimize risk factors and promote protective factors, can integrate suicide prevention into their activities. Governmental bodies, workplaces, schools, law enforcement and criminal justice settings, health care providers, community-based agencies, and faith-based organizations all have a role to play. Coordination of those activities will ensure suicide prevention is effective and provided efficiently.

Objective 1.1: Integrate suicide prevention into the values, culture, leadership, and work of governmental and non-governmental organizations.

Most organizations engage in activities that can minimize suicide risk factors or promote protective factors. They can participate in the public health approach to suicide by integrating its prevention into their programs, services, and activities. This requires more than simply adding a few programs or training a few people within the organization. Rather, it requires an integration of suicide prevention into the entire mission of the organization.

Making suicide prevention part of an organization's mission is particularly important for those that are temporarily or permanently housing members of the community. Goal 8 of this plan addresses comprehensive suicide prevention programs for health care organizations, but persons at risk for suicide may reside in a wide-range of governmental and nongovernmental facilities that are not considered health care facilities. These include state and local correctional facilities, long-term care facilities, assisted living establishments, nursing homes, homeless shelters, youth facilities, and veteran's homes. There is a wide array of suicide prevention resources that the organizations responsible for these institutions can rely upon to establish comprehensive suicide prevention programs. For example, officials responsible for state prisons and county or municipal jails can find suicide prevention resources for correctional facilities at the National Institute of Corrections, the National Commission on Correctional Health Care, and the Suicide Prevention Resource Center.

Objective 1.2: Collaborate suicide prevention programming by all levels of government.

Each of the state's levels of government have a role to play in suicide prevention. Those roles will be most effective if coordinated in a manner that recognizes the legal authority, strengths, and weaknesses of each and the needs of the communities they serve. Structures should be established that provide ways for state, county, and local government, as well as the agencies, departments, bureaus, and offices within those levels of government, to collaborate on suicide prevention.

Objective 1.3: Develop and sustain public-private partnerships to advance suicide prevention.

A public health approach to suicide requires effective partnerships between private and public bodies and organizations. Public bodies can provide coordination and support to private organizations that may be closer to the community, have passion for their cause, and able to offer innovation and efficiency.

Objective 1.4: Integrate suicide prevention into health care reform efforts.

Our health care system can play several roles in suicide prevention. First, mental health conditions and substance use disorders are among the most important suicide risk factors. An effective suicide prevention strategy is to ensure that laws and policies give health care systems incentives to provide access to care for mental and substance use disorders. Second, primary care providers are in a position to identify those at risk for suicide and provide intervention and treatment. Thus, an effective suicide prevention strategy is to incorporate suicide prevention activities into clinical settings and integration of physical and behavioral health services.

None of this is possible however, if behavioral health care does not exist in a person's community or if persons with behavioral health conditions are unable to pay for that care. Nor is it likely that absent insurance reimbursement, primary care providers will provide non-medical services such as effective intervention, transition of care, and follow-up services. Therefore, health care reform efforts must address the financing of behavioral health care and non-medical services provided to those at risk for suicide. The different mechanisms used in this country to pay for health care and the different state and federal agencies regulating those mechanisms makes this a challenging task. These payment mechanisms include Medicaid, Medicare and commercial insurance obtained through employer plans, the Affordable Care Act's Marketplace, or through other private insurance providers. Individuals who are serving or who have served in the military and their family members may receive health care through TRICARE. These payment mechanisms have distinct rules and regulations that may restrict payment for behavioral health care or suicide prevention services, either by limiting the services that are covered or by establishing reimbursement rates that discourage behavioral health providers from joining health care networks. When these mechanisms are not available, then a patient is left with self-pay, or assistance from public or private organizations.

In summary, reducing the risk factor of behavioral health conditions and providing treatment for suicidal behavioral requires addressing the issue

of financing our health care system. Goal 5 of this plan addresses compliance with existing laws that require insurance carriers to provide behavioral health care insurance that is comparable to insurance for physical or surgical care ("parity"). Goal 1 addresses a more ambitious goal of ensuring that reimbursement rates for behavioral health care and options for payment of that care are sufficient to ensure that necessary services are available to all persons who need them, regardless of where they live in Illinois.

GOAL 1 ACTIVITIES

Businesses and Employers

- Designate a member of the organizations' leadership team as a champion for suicide prevention and the promotion of mental health.
- Promote suicide prevention through professional associations and funding behavioral health, suicide awareness, and prevention efforts.
- Promote social connectedness among employees by offering opportunities to engage in community service work or recreational activities as teams.

Health Care Systems, Insurers, and Clinicians

- In their role as employers of the health care workforce, take every action recommended for "Businesses and Employers" in this plan.
- Collaborate with behavioral health providers to develop and to provide local information, resources, and professional development/training opportunities.
- Collaborate with, and where necessary, advocate with, insurance carriers and relevant state agencies, such as the Illinois Department of Insurance and the Illinois Department of Healthcare and Family Services, to ensure that reimbursement rates for behavioral health care are sufficient and that reimbursement can be provided for all services required under a comprehensive suicide prevention program.

Individuals and Families

- Participate in grassroots community organizations promoting behavioral health and preventing suicide.

Nonprofit, Community, and Faith-Based Organizations

- In their role as employers, nonprofit, community and faith-based organizations should take all the actions recommended for "Businesses and Employers" in this plan.
- Faith-based organizations: utilize the Suicide Prevention Resource Center support of the faith community resources https://www.sprc.org/settings/faith-communities.
- Participate in local coalitions of stakeholders to promote and implement comprehensive suicide prevention efforts at the community level.
- Sponsor, support, and/or promote training programs for behavioral health, suicide awareness, and prevention.
- Advocate for and support increased opportunities and funding initiatives that promote behavioral health and prevent suicide.
- Collaborate with governmental and non-governmental behavioral health and suicide prevention stakeholders to share knowledge and resources.
- Advocate for effective oversight of the providers of private insurance and Medicaid to ensure that coverage for behavioral health services is comparable to coverage for physical illness services.
- Advocate for constituents with their insurance providers to ensure coverage for behavioral health services.

Schools, Colleges, and Universities

- In their roles as employers of the educational workforce, every educational institution should take the actions recommended for "Businesses and Employers" in this plan.
- Create a working partnership with local behavioral health providers serving their area.

- Identify and disseminate information about behavioral health and suicide prevention resources available within the community to students and staff.

State and Local Government

- Advocate for and support increased opportunities and funding initiatives for suicide prevention activities by state and local government and private entities.
- Collaborate with other suicide prevention stakeholders to share knowledge and resources for suicide prevention among citizens with mental and substance use disorders.
- Promote the objectives, goals, and strategies of this 2020 Illinois Suicide Prevention Strategic Plan within government and to the public.
- Provide resources for the delivery of Mental Health First Aid.
- In their roles as employers of the state and local governmental workforce, all levels of government should take every action recommended for "Businesses and Employers" in this plan.
- State agencies and local government participate in the Illinois Suicide Prevention Alliance.
- State: ensure compliance with laws directing educational systems to prevent suicide and bullying.
- State: Provide resources to IDPH necessary for it to comply with the provisions of 20 ILCS 2310/2310-455 that require it to implement activities associated with the *Suicide Prevention, Education, and Treatment Act*.
- Collaborate with insurance carriers and health care providers to ensure reimbursement rates for behavioral health care are sufficient and reimbursement can be provided for all services required under a comprehensive suicide prevention program.
- Increase reimbursement rates for behavioral health services under Medicare and Medicaid to a level sufficient to encourage providers to participate in those programs.

Goal 2. Utilize communications to change attitudes and behaviors toward suicide and behavioral health.

Research-based communication campaigns that use media and messaging that are appropriate for a targeted population can play an important role in suicide prevention. Effective communications can dispel common myths about suicide and behavioral health conditions, reduce stigma, foster open conversations, and inform the public of the ways they can help themselves and others. Messaging should be positive and promote hope, connectedness, social support, resiliency, and help seeking. A good resource for messaging is "The Framework for Successful Messaging" developed by the National Action Alliance for Suicide Prevention. http://suicidepreventionmessaging.org/

Objective 2.1: Communicate effectively with defined segments of the population.

While there are suicide risk and protective factors that are common throughout the community, the relative importance of those factors varies within different segments of the population. Moreover, different segments of the population are best reached by different communications media. Thus, effective communications should reflect messaging and media that is most appropriate for a targeted segment of the population, such as anti-bullying messaging on social media platforms used by youth.

Objective 2.2: Communicate effectively with policymakers.

Policymakers understand their role in promoting public health through initiatives, policies, and programs that are within the scope of their authority. Communications efforts designed to educate policymakers should demonstrate that suicide is a public health issue affecting their constituents and stakeholders and there are concrete steps they can take to minimize risk factors and promote protective factors.

Objective 2.3: Communicate effectively on-line.

On-line communications should promote positive messages and support safe crisis intervention strategies by encouraging help seeking and providing support to individuals with suicide risk. Websites, interactive educational, virtual worlds, gaming and social networking websites, and mobile apps, can all enable effective communications with and among those at risk for suicide. Social media can provide crisis resources, opportunities for friends to intervene, and peer support. Online communications can be particularly important for persons who may be socially isolated or otherwise difficult to reach.

GOAL 2 ACTIVITIES

Businesses and Employers

- Provide written materials and hold workshops promoting employee behavioral health.

Health Care Systems, Insurers, and Clinicians

- Provide the local community with information about behavioral health and local resources.

Individuals and Families

- Share your story with policymakers during behavioral health and suicide prevention advocacy.

Nonprofit, Community, and Faith-Based Organizations

- Develop suicide and behavioral health awareness written and online communications that are culturally, linguistically, geographically, and age-appropriate.
- Work with educational authorities to develop and/or provide age-appropriate behavioral health and suicide prevention curriculum for K-12 students.
- Conduct or host forums, health fairs, safety events addressing behavioral health, and suicide prevention.
- Provide policymakers with geographically and culturally specific data relevant to their constituency.

Schools, Colleges, and Universities

- Develop written and online communication messages for teachers, administration, students, and parents about resources available for behavioral health and suicide prevention.
- Conduct or host forums, health fairs, safety events on suicide, and behavioral health awareness.
- Support wellness promotion activities during times of stress and transition.
- Colleges and universities: Increase the visibility of behavioral health and suicide prevention services provided by student health plans and create a culture that removes the stigma of their use.

State and Local Government

- Each agency, department, bureau, office, or other organization of government should provide suicide and behavioral health awareness communications to their constituency / client population that are culturally, linguistically, geographically, and age-appropriate.

Goal 3. Increase understanding of protective factors and how to promote wellness and recovery.

Just as all of us should have knowledge of the warning signs of suicide, we should also have knowledge of the ways to promote wellness and resilience. Educational efforts should reduce the stigma of mental health conditions and substance use disorders and encourage people to take steps to promote their own wellness and that of others.

Objective 3.1: Promote effective programs and practices that increase protection from suicide risk.

Promoting physical, mental, emotional, and spiritual wellness is crucial to increase protection from the risk of suicide. Better sleep and nutrition, exercise, use of relaxation techniques, and more outdoor activities can improve all these indicators of wellness. Programs and activities that

begin at a young age that incorporate problem-solving skills and social support can help individuals cope with emotional distress throughout their lives. Policies and programs that foster social connectedness and peer support can also help promote mental and physical health and recovery.

Objective 3.2: Reduce the stigma associated with suicide, mental health conditions, and substance use disorders.

Bias, prejudice, and discrimination discourage many people who have experienced trauma or who have suicidal thoughts, mental health conditions or substance use disorders, from seeking help. Stigma associated with their particular social, cultural, or religious community may present additional barriers to seeking help. Effective communications that understands and respects those communities can reduce that stigma.

Objective 3.3: Promote a message of hope.

All of us should understand that mental health conditions and substance use disorders are treatable. This positive message of hope for recovery and attainment of a meaningful life will encourage people to seek help for themselves and others. This positive message will also encourage family members, friends, employers, and the others in our lives, to provide support during that recovery. It is important to engage persons with lived experience (suicide attempt survivors, those that have struggled with suicidal thoughts, or those with a history of mental health conditions or substance use disorder) in promoting this message of hope. They can serve as positive role models of hope, particularly with persons in their community (e.g., age group, geographic area, race, culture, or ethnic group). They can also provide insights that aid in prevention planning, treatment, and education.

GOAL 3 ACTIVITIES

Businesses and Employers

- Implement organizational changes (e.g., work schedules, leave time, duties, and responsibilities) to promote employees' mental health.
- Implement employee physical, mental, emotional, and spiritual wellness programs.
- Increase the visibility of behavioral health and suicide prevention services provided by employee health plans and create a culture that removes the stigma of their use.
- Promote awareness and education during May, Mental Health Awareness Month.

Health Care Systems, Insurers, and Clinicians

- Participate in community awareness campaigns to promote wellness and reduce the stigma of behavioral health conditions and suicide.
- Communicate messages of resilience, hope, and recovery to patients with mental health conditions and substance use disorders.

Individuals and Families

- Build strong, positive relationships with family and friends.
- Become involved in their community (e.g., mentor or tutor youth, join a faith or spiritual community, reach out to older adults in the community).
- Volunteer to help in forums, health fairs, and safety events addressing behavioral health, suicide awareness and prevention.
- Encourage open conversation and dialogue about suicide among family, friends, and other social networks.
- Volunteer to speak as a person who has lost a loved one to suicide, has struggled against suicide, or has lived with a mental health condition or substance use disorder.
- Support or participate in peer networks that promote behavioral health, prevent suicide, or support suicide loss survivors.

Nonprofit, Community, and Faith-Based Organizations

- Provide opportunities for social participation and inclusion for those who may be isolated or at risk.
- Sponsor, provide, support, and/or promote peer-based support groups for substance use disorder, mental health, suicide prevention, and suicide loss survivors.
- Recruit persons with lived experience who are willing to serve as speakers, provide them support and opportunities to share their experiences.

Schools, Colleges, and Universities

- Implement programs and policies to prevent abuse, bullying, violence, and social exclusion.
- Implement programs and policies to build social connectedness and promote positive mental and emotional health.
- Sponsor and support groups/clubs to promote a setting of togetherness and mental wellness for students and/or engaging in suicide prevention efforts.
- Provide and support student activities for mental health awareness during May, Mental Health Awareness Month.
- K-12: Implement an anti-bullying policy required by 105 ILCS 5/27-23.7 and regularly review its effectiveness and make appropriate changes.
- K-12: Promote resiliency and protective factors in health curriculum.
- Provide opportunities for those with lived experience to share their story.

State and Local Government

- Promote and share resources listing evidence-based programs and practices for suicide prevention

Goal 4. Promote responsible media reporting of suicide.

News and entertainment media can play a positive role in suicide prevention by treating it as a complex public health problem that is preventable. First, responsible media treatment of suicide must be accurate and not promote myths that suicide is not preventable, is an individual or family failing, or happens suddenly with no visible cause. Second, media should treat suicide as it would any other public health issue and provide resources for individuals in crisis. Finally, stories addressing mental illness, substance abuse, and/or suicidal behaviors can promote hope, resiliency, and recovery when focusing on individuals who struggled, found help and appropriate treatment, and recovered.

Objective 4.1: News organizations should provide safe and responsible reporting of suicide and other related behaviors.

Exposure to suicide or suicidal behaviors through media reports of suicide can result in an increase in suicide and suicidal behaviors. This effect, called “suicide contagion,” can be minimized through responsible, culturally competent coverage of suicide, mental health conditions, and substance use disorders. Moreover, by treating suicide as a public health issue, responsible reporting can increase awareness of sources for help when in a crisis. Recommendations for media reporting of suicide developed by news organizations and suicide prevention organizations are at www.reportingonsuicide.org.

Objective 4.2: The entertainment industry should provide accurate and responsible portrayals of suicide and other related behaviors.

Accurate and responsible depictions of suicide, mental health conditions, and substance use disorders can help dispel the myths of those conditions and encourage people to seek help. Recommendations for treatment of suicide in entertainment programing are at https://theactionalliance.org/messaging/entertainment-messaging/national-recommendations.

Objective 4.3: Journalism and mass communication schools should teach responsible reporting and portrayal of suicide and related behaviors in their curricula.

Schools of journalism, film, and other disciplines in the communications field should include in their curriculum the standards discussed above for the news and entertainment industry.

GOAL 4 ACTIVITIES

Health Care Systems, Insurers, and Clinicians

- Health care professionals should discuss the public health aspect of suicide, the complexity of its causes, and provide a message of hope and recovery when interviewed on the subject.
- Identify content experts who can speak with media on issues related to suicide prevention, including best practices for media reporting on suicide events.

Nonprofit, Community, and Faith-Based Organizations

- Use timely and widely-covered news events to engage the media in targeted discussion about suicide prevention.
- Engage reporters, columnists, and news directors after suicide stories, informing them of positive and negative aspects of their reporting.
- Disseminate Recommendations for Reporting on Suicide to news organizations.
- Participate in efforts to educate entertainment media of appropriate depiction of suicide, mental health conditions, and substance use disorders.

Schools, Colleges, and Universities

- Colleges and universities: Integrate information about the responsible depiction of suicide and suicide-related behaviors into the curricula of schools of journalism, film, and other communications disciplines.
- Identify content experts who can speak with media on issues related to suicide prevention, particularly regarding youth suicide.

STRATEGIC DIRECTION 2.

Clinical and Community Preventive Services

Clinical and community-based organizations providing services that promote wellness are a significant component of the state's effort to prevent suicide. Many of the services they provide can reduce suicide risk factors and promote protective factors. Identification of those at risk for suicide can ensure they received services that are appropriate for their needs.

Primary care and other health care providers can provide clinical preventive services that can assess suicide risk and connect individuals at risk for suicide to available clinical services and other sources of care. Community-based organizations, such as schools, workplaces, and faith-based organizations can develop competence to incorporate suicide prevention as part of their mission and ensure those at risk for suicide are provided services that reduce that risk.

Goal 5. Promote wellness and prevent suicide and related behaviors.

Clinical and community-based organizations should develop programs that reduce risk factors, increase protective factors, and link individuals in crisis with appropriate services and supports.

Objective 5.1: Coordinate state and local suicide prevention programming.

Suicide prevention must focus on risk and protective factors at individual, family, community, and societal levels. Thus, efforts should involve collaboration by all levels of public and private sectors. That collaboration will allow efficient allocation of resources, the ability to reach a wide-range of individuals with culturally and geographically appropriate services, and the sharing of information and resources. An example of a current project to coordinate suicide prevention activities for a specific community is Illinois participation in the *Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and*

their Families sponsored by the Substance Abuse and Mental Health Services Administration and the Veterans Administration.

Objective 5.2: Include suicide prevention in community-based organization programs.

Many community-based organizations provide services and programs that indirectly or directly reduce risk factors and increase protective factors. These organizations should be encouraged to include as part of their services, suicide prevention education and wellness programs that can prevent suicide.

Objective 5.3: Intervene to reduce suicidal thoughts and behaviors in populations with suicide risk.

Personnel in clinical and community-based organizations should have suicide prevention as part of their responsibility. Risk and protective factors, as well as effective interventions, can vary across geographic and cultural communities, so it is important that they receive education specific to the unique needs of their constituent population. “Cultural community” in this context should be read broadly to include more than race or ethnicity. Cultural communities also include gender, age group, religion, employment, sexual orientation, gender identity, or any segment of the population that may have distinct risk factors or protective factors or that need distinct intervention techniques or treatment. For example, active military service personnel, veterans, and law enforcement personnel, as well as their families, face special challenges that may increase risk factors while having unique protective factors that need to be encouraged. Practitioners need to have cultural competency to be familiar with those risk and protective factors and appropriate intervention and treatment methods. Additionally, it is important that resources are concentrated on communities that have an elevated risk for suicide.

Objective 5.4: Increase access to programs and services for mental health conditions and substance use disorders.

Because mental health conditions and substance use disorders are among the most significant risk factors for suicide, it is important that

behavioral health care be available to those who need it. That availability can be constrained by both cost and geographic distribution of the behavioral health care workforce and behavioral health programs.

Enforcement of Illinois' behavioral health insurance parity law (215 ILCS 5/370c and 370c.1) can help address the issue of cost. The Illinois Department of Insurance (IDOI) and Illinois Department of Healthcare and Family Services (HFS) are required to implement annual commercial and Medicaid health plan oversight provisions, with input from the Parity Data Workgroup mandated by Public Act (PA) 100-1024. After the workgroup provides recommendations to the General Assembly on health plan data reporting requirements (e.g., administrative denial rates, denials for medical necessity), the General Assembly should implement these recommendations. Further, IDOI and HFS should quickly implement the annual treatment limitation reporting format for use by commercial and Medicaid health plans to demonstrate compliance with state and federal parity law.

Steps should also be taken to increase the state's behavioral health workforce and funding for community behavioral health services. Innovative techniques, such as telehealth, should be used to provide behavioral health care to underserved populations. Health care systems should be encouraged to integrate behavioral and physical health care in their services so that even a primary care level, there is an ability to recognize and respond to mental health conditions and substance use disorders.

Objective 5.5: Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care.

A person who is at risk for suicide will often exhibit warning signs to family members, friends, teachers, coaches, coworkers, and others with whom they come into contact. All of us should be able to recognize those warning signs indicating that someone is in crisis, know when and how to intervene, and be able to connect them with sources of help. Objective 7.1 of this plan provides a list of training programs that are appropriate for a wide-range of organizations.

Objective 5.6: Support availability of crisis hotline service.

In 2018, there were 88,615 calls from Illinois residents to the National Suicide Prevention Lifeline (1-800-273-8255). Due to inadequate staffing, limited hours, and geographic restrictions, only 29% of those calls were answered by one of the eight Illinois call centers. The remainder were answered by call centers outside Illinois and resulted in longer hold times and a limited ability to provide information about local resources. These figures are indicative of inadequate crisis intervention resources in Illinois. Recent federal legislation and action by the Federal Communications Commission may implement a three-digit lifeline phone number by 2022. By that time Illinois should implement a coordinated strategy to expand call center capacity.

GOAL 5 ACTIVITIES

Businesses and Employers

- Provide employees with behavioral health and suicide prevention awareness education.
- Ensure that employee health insurance provides coverage for behavioral health that is comparable to physical and surgical coverage.
- Promote suicide awareness and prevention during September National Suicide Prevention and Awareness Month.
- Provide employees with an online depression screening and referral program providing anonymity and confidentiality.

Health Care Systems, Insurers, and Clinicians

- Implement behavioral health services that increase availability to underserved communities.

- Advocate for insurance reimbursement for all elements of a comprehensive suicide prevention program.
- Participate in community suicide prevention awareness activities during September, National Suicide Prevention and Awareness Month.
- Implement crisis services, including 24 hour mobile crisis units, crisis contact, and crisis respite.

Individuals and Families

- Participate in local organizations influencing school curriculum and policies, such as advisory council, PTA, or school board and ensure compliance with suicide prevention and anti-bullying laws.
- Participate in behavioral health, suicide awareness and prevention trainings.
- Learn the signs and symptoms of suicide and suicidal behaviors and how to reach out to those who may be at risk.
- Advocate for the promotion of behavioral health and suicide prevention at the federal, state, and local governmental level.

Nonprofit, Community, and Faith-Based Organizations

- Implement suicide prevention programs that address the needs of groups at risk for suicide and that are geographically, culturally, linguistically, and age-appropriate.
- Provide suicide crisis hotline and text numbers in written materials and advocate their publication in media contacts.
- Organize or join coalitions advocating for laws and policies at the federal, state, and local level that promote behavioral health, suicide awareness and prevention.
- Develop suicide prevention written and on-line materials providing suicide risk factors, warning signs, and ways to help.
- Organize suicide prevention awareness activities during September, National Suicide Prevention and Awareness Month.

Schools, Colleges, and Universities

- Colleges and universities: All colleges and universities (not just public colleges and universities) provide the mental health awareness and suicide prevention measures required by Public Act 101-0251, *Mental Health Early Action on Campus Act.*
- Collaborate with behavioral health providers on local information, resources, and professional development/training opportunities.

- Incorporate suicide prevention and awareness into freshman orientation.
- Provide and support student activities during September, National Suicide Prevention and Awareness Month.
- Colleges and universities: Ensure that student health insurance provides coverage for behavioral health that is comparable to physical and surgical coverage.
- K-12: Implement suicide awareness and prevention policy required by 105 ILCS 5/2-3.166, regularly review its effectiveness, and make appropriate changes.
- K-12: Host and support training on behavioral health awareness and suicide prevention for parents.

State and Local Government

- Identify the needs of groups at risk for suicide and coordinate the provision of culturally, linguistically, and age-appropriate programs with local government and community-based organizations.
- Coordinate sharing of information, strategies and resources of government and community-based organizations providing suicide prevention programs.
- Offer suicide prevention and awareness trainings to agencies working in the community (e.g., school systems, senior centers, home health agencies).
- Make available to the public local resources and referrals for suicide prevention.
- Develop suicide prevention written and on-line materials providing risk factors, warning signs, and ways to help.
- Coordinate activities in furtherance of the recommendations developed by the 2020 Illinois participation in the Veterans Administration's Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families.
- State: Illinois State Board of Education (ISBE) should monitor and enforce compliance with suicide prevention and anti-bullying laws directed at primary and higher education institutions.
- Support crisis hot-line, text services, and peer support programs.
- State: IDOI/HFS strictly enforce compliance with Illinois' parity law (215 ILCS 5/370c and 370c.1), including implementation of the annual

treatment limitation reporting format for use by commercial and Medicaid health plans mandated by Public Act (PA) 100-1024.
- State: Adopt programs and incentives to increase the behavioral health workforce.
- State: Encourage expansion of telehealth and other forms of virtual behavioral health care to rural areas.
- Support "train the trainer" suicide awareness training to maximize the number of persons that can be reached.

Goal 6. Reduce access to lethal means of suicide.

Lethal means of suicide are those which, once taken, leave little or no opportunity for a person to change their mind or for others to intervene and save their life. For example, suicide attempts with a firearm are almost always fatal, while those with other methods more often result in survival. This is important because 9 out of 10 people who survive a suicide attempt do not go on to die by suicide later. Reducing access to lethal means during periods of crisis can make it more likely that the person will delay or survive a suicide attempt. Reducing access to lethal means is particularly important in preventing suicide by those experiencing a short-term crisis. Time and/or subsequent care and treatment may reduce or eliminate suicidal intent.

Individuals experiencing significant distress or who have a recent history of suicidal behavior should not have easy access to means that may be used in a suicide attempt, including firearms, other weapons, medications, illicit drugs, chemicals used in the household, other poisons, or materials used for hanging or suffocation. Community efforts can include installing bridge or rail barriers and restricting access to popular jump sites.

Objective 6.1: Providers who interact with individuals at risk for suicide should provide lethal means counseling.

Health care providers, social service workers, clergy, first responders, school personnel, professionals working in the criminal justice system, and others who may interact with individuals in crisis should ask about the presence of lethal means and work with these individuals and their support networks to reduce that access. While voluntary steps to reduce access to firearms are preferable, family members and their support

network should be made aware of the Illinois Firearm Restraining Order Act (430 ILCS 67/1). That law authorizes a civil court to enter an order that temporarily prohibits a person who is a risk to themselves or others from possessing or buying firearms.

Certain at-risk groups are more likely to have access to a certain lethal means of suicide. For example, veterans and law enforcement personnel are more likely to own firearms, those working on farms have access to pesticides, and health care workers have access to lethal drugs. Therefore, it is important to ask whether a person or family member has served in the military and inquire about their employment. Lethal means counseling can include education about safe firearm storage and access, as well as the appropriate storage of alcoholic beverages, prescription drugs, over-the-counter medications, and poisons that may be available in the household. Organizations providing resources for lethal means counseling include:

- Suicide Prevention Resource Center https://training.sprc.org/enrol/index.php?id=20
- Veterans Administration https://www.mirecc.va.gov/lethalmeanssafety/
- Harvard University https://www.hsph.harvard.edu/means-matter/

Objective 6.2: Partner with firearm dealers and gun owner groups.

Among persons who attempt suicide, those who use firearms are more likely to die than those who use other means. Firearm dealers, shooting clubs, hunting organizations, and others in the firearm owning community can promote suicide prevention awareness as a component of firearm safety. Resources such as the *Safe Firearm Storage Toolkit*, developed by the Veterans Administration, the American Foundation for Suicide Prevention, and the National Shooting Sports Foundation can assist a community to raise awareness about safe storage practices.

Objective 6.3: Implement safety technologies to reduce access to lethal means.

Safety technologies can help prevent suicide by reducing access to lethal means of self-injury. Examples that can be implemented in Illinois include incorporating architecturally unobtrusive barriers into the original or retrofitted design of bridges, railroad platforms, or other popular jump sites.

GOAL 6 ACTIVITIES

Businesses and Employers

- Employee assistance counselors provide lethal means counseling where appropriate.

Health Care Systems, Insurers and Clinicians

- Incorporate lethal means counseling in all suicide prevention activities.

Individuals and Families

- Store household firearms locked and unloaded with ammunition locked separately and take additional measures if a household member is at high risk for suicide.
- Dispose of unwanted medications, particularly those that are toxic or abuse-prone, and take additional measures (e.g., a medication lock box) if a member of the household is at high risk for suicide).

Nonprofit, Community, and Faith-Based Organizations

- Educate clergy, parent groups, schools, juvenile justice personnel, rehabilitation centers, defense and divorce attorneys, and others about the importance of promoting efforts to reduce access to lethal means among individuals at risk for suicide.
- Initiate partnerships with firearm advocacy groups (e.g., retailers, shooting clubs, manufacturers, firearm retail insurers) to increase suicide awareness.
- Promote the use of the Firearms Restraining Order Act.
- Use the VA/AFSP/NSSF Safe Firearm Storage Toolkit to form a community effort to promote safe firearm storage. https://www.mentalhealth.va.gov/suicide_prevention/docs/Toolkit_Safe_Firearm_Storage_CLEARED_508_2-24-20.pdf

Schools, Colleges, and Universities

- Student health service and behavioral health counselors provide lethal means counseling where appropriate.

State and Local Government

- Sponsor trainings and disseminate information on means restriction, including the Firearms Restraining Order Act, to behavioral health providers, professional associations, and patients and their families.
- Sponsor medications take-back days and ongoing methods for the disposal of unwanted medications (e.g., secure collection kiosks at police departments or pharmacies).
- Promote education of suicide awareness and prevention among the firearms owning community. Examples include the Illinois State Police in its role overseeing Firearm Owner Identification licenses or the Illinois Department of Veterans Affairs and Illinois Department of Aging providing information to the populations they serve.
- Support measures designed to reduce suicide at hot spots (e.g., bridges, train platforms, atriums).

Goal 7. Provide training to community and clinical service providers.

Many professionals and members of the community are in a position to recognize those at risk for suicide. Training that is appropriate for their role should provide them with the knowledge to identify those at risk for suicide and how to address suicidal thoughts and behaviors. Training should allow the delivery of suicide prevention services in a culturally competent manner that recognizes linguistic, racial/ethnic, sexual, and gender differences.

Objective 7.1: Provide suicide prevention training to government and community organization personnel.

Numerous individuals working with or volunteering with governmental bodies and community-based organizations are “gatekeepers” who are regularly in contact with persons who could be at risk for suicide. A non-

exclusive list includes first responders, law enforcement professionals, juvenile justice personnel, corrections personnel, crisis line volunteers, clergy, school personnel, social service and human service providers, nursing homes, and human resource professionals. Additionally, any of us could find ourselves faced with a family member or friend experiencing suicidal thoughts.

When choosing a training program, it is important to understand the difference between screening for suicide and suicide risk assessment. Screening for suicide is the process of determining if a person may be at risk for suicide. Persons and organizations that could encounter a person at risk of suicide, which is all of us, should become familiar with suicide screening tools. Suicide risk assessment is the formal process, generally conducted by a behavioral health professional, that assesses the degree of risk of suicide to determine the type of intervention needed and to establish a treatment plan.

The Joint Commission on Accreditation of Healthcare Organizations compiled the following lists of validated evidence-based screening tools and validated evidence-based assessment tools for the institutions it accredits, but that are available for anyone.
https://www.jointcommission.org/resources/patient-safety-topics/suicide-prevention/

Evidence-Based Suicide Screening Tools

- Ask Suicide-Screening Questions (ASQ) Toolkit by National Institute of Mental Health
- Columbia-Suicide Severity Rating Scale (C-SSRS) triage version
- Patient Health Questionnaire-9 (PHQ-9) Depression Scale
- Suicide Behavior Questionnaire-Revised (SBQ-R, Osman et al., 2001).

Evidence-Based Suicide Risk Assessment Tools

- Columbia-Suicide Severity Rating Scale (C-SSRS) risk assessment version
- SAMHSA SAFE-T Protocol with C-SSRS
- Scale for Suicide Ideation – Worst (SSI-W; Beck et al., 1997)
- Beck Scale for Suicide Ideation (BSI; Beck & Steer, 1991).

In addition to these suicide risk assessment tools, the Suicide Prevention Resource Center provides comprehensive training for behavioral health professionals that includes screening and assessment: *Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals* (AMSR).

Screening and Intervention

There are several programs that provide basic gatekeeper training, which includes suicide screening and intervention techniques. These include

- Question Persuade Refer (QPR)
- Mental Health First Aid
- safeTALK
- Applied Suicide Intervention Skills Training (ASIST)
- Talk Saves Lives (American Foundation for Suicide Prevention).

Screening for suicide risk and basic intervention techniques should be an integral part of the services provided by community organizations and clinical service providers. Strategies for screening for suicide should be tailored to the individual and context. Any person identified as being at risk for suicide should be formally assessed for suicidal thoughts, plans, intent, access to lethal means, a history of previous attempts, and the presence of acute risk factors. Persons identified as being at risk for suicide should be provided immediate intervention and access to needed clinical care and support.

Training should be provided to organizations and individuals that is appropriate for the needs of different at-risk populations and the role of the community-based organization or individual. The Suicide Prevention Resource Center has published a guide for communities seeking to select and implement gatekeeper training.

http://www.sprc.org/sites/default/files/Selecting%20and%20Implementing%20a%20Gatekeeper%20Training.pdf

Objective 7.2: Provide suicide prevention training to health care personnel.

Primary care providers, emergency departments, hospitals, and behavioral health providers all play a role in suicide prevention. Within each system, personnel should be trained in the screening, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk.

Training should be appropriate for the role of everyone in a health care system. For example, all personnel who will interact with patients should receive training in screening for suicide risk. Behavioral health professionals should be trained to assess the risk of suicide for those screened to be at risk and provide immediate intervention services.

Psychiatrists and psychologists should be trained in suicide prevention therapy for patients determined to be at a severe risk for suicide, particularly patients who have just survived a suicide attempt. While treatment for behavioral conditions is an important component of suicide prevention, it is important to understand that suicidal ideation and attempts are not one end of the continuum of the severity of those conditions. Rather, behavioral health is only one of the risk factors that can result in a suicide. Therefore, persons who are at a severe risk of suicide should be provided evidence-based suicide specific therapy, such as dialectical behavior therapy (DBT), brief cognitive behavioral therapy (BCBT), cognitive behavior therapy for suicide prevention (CBT-SP), and collaborative assessment and management of suicidality (CAMS).

Health care systems adopting a comprehensive suicide prevention program will need to train all levels of personnel in these and additional areas such as billing, effective transition services, and follow-up services. This training is a key component of the comprehensive “zero suicide” program recommended in Strategic Direction 3 of this Strategic Plan.

Objective 7.3: Include suicide prevention as a core component of graduate and continuing education programs for health professions.

Few health professionals have received education specifically designed to help prevent suicide. All education and training programs for health professionals, including graduate and continuing education programs for these professions, should adopt core education and training guidelines addressing the prevention of suicide and related behaviors that are appropriate for their respective discipline. All degree-granting undergraduate and graduate programs in relevant professions should include these guidelines as a part of their curricula.

Objective 7.4: Include suicide prevention as a core education component required by credentialing and accreditation bodies.

The inclusion of core education training in recertification or licensing programs can help ensure professionals who have completed training acquire competence in addressing suicidal behaviors and remain competent over time. Such professionals include physicians, psychologists, social workers, nurses, and other health professionals subject to licensing and recertification.

Objective 7.5: Ensure that suicide prevention training addresses the unique issues of the groups at greater risk of suicide.

While thoughts of suicide can reach any member of the community, certain groups are especially at risk due to a variety of factors that are unique to that group. It is important that community and clinical service providers receive training that allows them to understand the special risk factors and protective factors for these groups so they can recognize those at risk and provide effective intervention. These groups include:

- Certain age groups (youth, middle-age men, elderly)
- Service members, veterans, and their families
- Groups facing discrimination for any reason (racial, ethnic, or religious minorities; disabled persons)
- Persons with chronic disease or chronic pain
- Persons with mental health conditions or substance use disorders
- Survivors of a suicide attempt
- Survivors of the loss of a loved one to suicide
- Victims of recent trauma

- LGBTQ+
- Persons with a history of child or adolescent trauma

Training should be designed to enable providers to offer culturally competent prevention and treatment practices that are consistent with the needs of the groups they will encounter.

GOAL 7 ACTIVITIES

Businesses and Employers

- Provide suicide prevention education and training to supervisors and staff.
- Ensure that counselors in an employee assistance program are trained to assess and manage suicide risk.

Health Care Systems, Insurers, and Clinicians

- Host and promote evidence-based behavioral health, suicide awareness, and screening and prevention programs for the community.
- Provide training to all personnel necessary for implementation of a comprehensive suicide prevention program targeted to their role (screening, assessment, intervention, treatment, follow-up, recordkeeping, billing).
- Support training mental health professionals to provide evidence-based suicide prevention therapy (DBT, BCBT, CBT-SP, CAMS).
- Include behavioral health, suicide awareness and prevention training in medical school curriculum.
- Credentialing and accreditation bodies: Include suicide prevention as a core educational requirement for health care systems and professionals.

Nonprofit, Community, and Faith-Based Organizations

- Train staff and volunteers in suicide awareness and prevention, ensuring that the training is appropriate for the needs of the at-risk populations faced by the organization.

Schools, Colleges, and Universities

- Colleges and universities: All colleges and universities (not just public colleges and universities) provide training for school personnel required by Public Act 101-0251, *Mental Health Early Action on Campus Act.*
- K-12: Provide mental health awareness and suicide prevention training to staff required by state law (105 ILCS 5/34-18.7 and 105 ILCS 5/10-22.39).

State and Local Government

- Incorporate suicide prevention training into professions that have exposure to traumatic events (e.g., law enforcement, EMS, fire and rescue, emergency department staff).
- Support and promote crisis intervention team (CIT) training for law enforcement officers.
- Provide financial and logistical support for suicide screening and suicide risk assessment to the public and health care personnel.
- Provide suicide prevention training to staff at state or county run facilities, including corrections, behavioral health, senior care, and veterans' facilities.
- Provide schools and colleges with training and resources to assist in compliance with laws requiring suicide prevention training and education.
- State: Include suicide prevention as a core educational requirement for the licensing of medical and behavioral health systems and professionals.

STRATEGIC DIRECTION 3.

Health Care Providers

Health care providers play a critical role in suicide prevention because people at risk of suicide are often seen in health care settings for reasons other than mental health conditions. Screening of all patients, regardless of the reason for being seen by a health care professional, can lead to a determination of suicide risk. Those persons who are determined to be at risk for suicide can then be provided appropriate intervention services and treatment.

The U.S. Surgeon General's National Suicide Prevention Plan recommends that health care providers make "zero suicide" an aspirational goal. Illinois law makes zero suicide for health care providers a priority by requiring that this strategic plan include "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"[410 ILCS 53/15(b)(3)]. The purpose of the zero suicide model is not merely to prevent suicides taking place in a hospital or health care setting, but rather, to develop comprehensive systems that provide the opportunity for patients to overcome their suicidal urges after receiving care.

The research supporting the goal of zero suicide in health care settings is compelling. Approximately 75% of individuals who die by suicide are in contact with a primary care physician in the year before their death, and 45% do so within one month of their death (Luoma JB, Martin CE, Pearson JL. *Contact with mental health and primary care providers before suicide: a review of the evidence*. Am J Psychiatry. 2002;159(6):909-916.). The correlation between emergency department visits and suicide is even stronger. A study released in 2019 found that people who presented to California emergency departments with deliberate self-harm had a suicide rate in the year after their visit 56.8 times higher than those of demographically similar Californians (Goldman-Mellor, S., Olfson, M., Lidon-Moyano, C., & Schoenbaum, M. (2019). *Association of suicide and other mortality with emergency department presentation.* JAMA Network Open.).

The relationship between substance use disorder and suicide is demonstrated in a study released in 2020, which found that patients who visited the emergency department for an opioid overdose are 18 times more likely to die

by suicide than the general population in the year after being discharged. Similarly, in the year after emergency department discharge, patients who visited for a sedative/hypnotic overdose had suicide rates nine times higher than the general population (Goldman-Mellor, S., Olfson, M., Lidon-Moyano, C., & Schoenbaum, M. (2020). *Mortality following nonfatal opioid and sedative/hypnotic drug overdose.* American Journal of Preventive Medicine).

Goal 8. Implement a comprehensive suicide prevention program.

All health care providers, including behavioral health care providers, primary care providers, hospitals, and emergency departments, should make suicide prevention a core component of their services. Additionally, state- and county-operated residential facilities, including corrections, behavioral health, youth, senior care, and veterans' facilities, have an obligation to keep their residents safe and should make suicide prevention a core component of their service. This requires the adoption of a comprehensive suicide prevention program with zero suicide as an aspirational goal.

Objective 8.1: Adopt zero suicide as an aspirational goal.

Health care systems should implement a suicide prevention program that aspires to prevent suicide by its patients . . . ever. The concept of "zero suicide" is to make the prevention of all suicides an aspirational goal and to implement comprehensive policies involving the entire health care organization. A comprehensive suicide prevention program includes the following:

- Screen all patients for suicide risk.
- Assess the level of risk of patients that screening indicates are at risk for suicide.
- Provide intervention appropriate for the level of risk, including lethal means counseling and development of safety plans.
- Refer patients determined to be at risk for suicide to treatment and community resources, providing effective transitions to ensure care is sought and provided.
- Ensure immediate and continuous follow-up after discharge of patients determined to be at risk for suicide.

- Continuously monitor performance and update procedures, particularly in response to suicides and attempted suicides.

Other elements of a comprehensive plan include: environmental risk assessment, documentation of the assessment of the severity of a patient's risk for suicide and critical treatment plan determinations, training of personnel that is appropriate for their role, and development of partnerships with mental health providers and community resources for treatment and the provision of support services.

Numerous public and private organizations provide toolkits, training, sample documents, and other resources for individual components of a suicide prevention program. These include the Suicide Prevention Resource Center, The Joint Commission, National Action Alliance for Suicide Prevention, National Institute for Mental Health, and Educational Development Center's Zero Suicide Institute.

Resources also exist for medical specialties. For example, resources are offered by the American College of Emergency Physicians https://www.acep.org/patient-care/iCar2e/ and the American Academy of Child and Adolescent Psychiatry.

https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Suicide_Resource_Center/Home.aspx.

Objective 8.2: Deliver services to individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.

Services to persons with high suicide risk should utilize culturally appropriate strategies and should promote collaboration and shared responsibility. Patients and families or significant others should be engaged in the collaborative process. Services should utilize least restrictive strategies consistent with safety, including alternatives to coercion, restraint, and involuntary treatment as ways to ensure the safety of patients in crisis.

Objective 8.3: Provide timely access to assessment, intervention, and effective care to individuals with a heightened risk for suicide.

Timely access to care for those with a heightened risk for suicide should be available 24 hours a day, seven days a week. It should include services that can provide anonymity, such as crisis hotlines and online crisis chat/ intervention services, as well as services that are provided by crisis outreach teams, or peer support or behavioral health professionals using remote or virtual care. Treatment for those with a high risk for suicide should use evidence-based suicide prevention therapy, including dialectical behavior therapy (DBT), brief cognitive behavioral therapy (BCBT), cognitive behavior therapy for suicide prevention (CBT-SP), and collaborative assessment and management of suicidality (CAMS).

Objective 8.4: Promote the safe disclosure of suicidal thoughts and behaviors by all patients.

Settings that provide care to patients with suicide risk must be nonjudgmental and psychologically safe places in which to receive services. Such settings should be designed to overcome patients' potential embarrassment guilt and fear of loss of autonomy or the ability to make their own treatment decisions. Collaborative and non-coercive approaches should be used whenever possible and health care providers and other caregivers must have the training and skills required to promote disclosure.

Such settings should also carefully balance the need to reduce access to means of suicide, such as the environmental risk assessment measures recommended by The Joint Commission, against the need to provide a psychologically safe place. For example, ligature resistant environmental settings and determinations made by surveyors from IDPH should prioritize patient safety, but also maintain an environment that fosters patient recovery. State surveyors interpreting The Joint Commission and federal guidelines should have special consideration for shared spaces under observation, as existing requirements may or may not be interpreted to remove items that are healthy outlets for patients to relieve stress and to develop healthy coping mechanisms (e.g.,

exercise bikes, games, wall art). For ligature-free environments, state surveyors should give special consideration to interpretations of ligature risk made within patient rooms integrating medical and behavioral health care. Behavioral health patients are at risk of high comorbidities and conditions that may require a specialized medical bed for elevating the head of the bed, lower beds for patients to be able to get out safely, and physical disability requirements. These environments must balance suicide risk with active treatment for patients with medical comorbidities, including use of critical medical equipment like continuous positive airway pressure (CPAP) machines, insulin pumps, and vacuum-assisted closure of wounds (i.e., wound VACs). Finally, state surveyors should work with The Joint Commission and other accrediting bodies to ensure there is alignment of survey interpretations when evaluating ligature risk, to limit or eliminate dueling determinations.

Objective 8.5: Provide enhanced assessment of suicide risk and intervention to patients with high risk of suicide.

Assessment for suicide risk and intervention should be more frequent and more focused for those people known to have risk factors, such as mental or substance use disorders, chronic pain, or disability, or who have survived a suicide attempt. Regularly scheduled monitoring should focus on evaluating changes in symptoms of medical and mental health conditions; changes in protective factors, such as social networks; the occurrence and impact of stressful events; and the recurrence of suicidal ideation, plans, or intent. Interventions for patients at risk for suicide should combine care for underlying conditions with strategies that directly address suicide risk.

GOAL 8 ACTIVITIES

Health Care Systems, Insurers, and Clinicians

- Implement a comprehensive suicide prevention program with zero suicides as an aspirational goal.
- Implement patient-informed alternatives to hospitalization for individuals with suicide risk.

- Implement policies and practices that include families or significant others in discharge planning, development of safety plans, and education after discharge of a patient at risk for suicide.
- Educate family members and significant others about appropriate steps they can take to support individuals at suicide risk during treatment and/or after discharge.
- Integrated behavioral health care in primary care using resources, such as those provided by the National Council for Behavioral Health at https://www.thenationalcouncil.org/integrated-health-coe.
- Provide 24/7 availability of support using telehealth or other forms of virtual care, ensuring HIPAA compliance and ease of use by providers and patients.
- Emergency departments, hospitals, behavioral care facilities, and primary care providers implement separate algorithms or clinical pathways for children and adults at risk for suicide.
- Develop alternatives to treatment in an emergency department, such as same-day scheduling for behavioral health services and in-home crisis care.
- Provide periodic follow-up contact for a period of six months after discharge.
- Create, maintain, and use feedback loops that report post discharge outcomes for patients identified as at risk.

Individuals and Families

- Participate in discharge planning and education after a loved one is determined to be at risk for suicide.
- Provide appropriate follow-up support to family members of individuals after discharge, ensuring that they comply with treatment plans.
- Learn how to contact treatment providers or emergency services for loved ones who are at risk for suicide.
- Volunteer at a local crisis hotline or text line service.

State and Local Government

- Provide financial support and disseminate information about the National Suicide Prevention Lifeline, Crisis Text Line, and other local or regional crisis lines.
- Coordinate collaboration among crisis centers, law enforcement, mobile crisis teams, and social services.
- Provide support for training of behavioral health professionals in evidence-based suicide prevention therapy.
- Educate communities and individuals on HIPAA guidelines regarding confidentiality of psychological information and exceptions to limitations.
- State: IDOI/HFS ensure that processes in a comprehensive suicide prevention program are recoverable through patients' medical insurance.
- State: To the extent that suicide prevention services cannot be covered by Medicaid payments, request a waiver of federal guidelines pursuant to Section 1115 of the Social Security Act.
- Include the effectiveness of a health care provider's suicide prevention program as an element of regular review, licensing, and accreditation.
- State: HFS include the effectiveness of health care provider's suicide prevention program as an element in the determination of financial incentives/penalties in Medicaid payments.
- State and counties: Adopt a comprehensive suicide prevention program, with zero suicides as an aspirational goal, in state- or county-run facilities, including corrections, behavioral health, youth, senior care, and veterans' facilities.
- State: Surveyors from IDPH should consider the recommendations in Objective 8.4 for ligature-resistant environmental settings and determinations.

Goal 9. Provide effective care transitions.

It is important that patients discharged from inpatient care or emergency department care and referred to behavioral health care or support services receive effective continuity of care. Persons at risk for suicide are particularly vulnerable and at risk during the period between inpatient and outpatient behavioral health care services. A study of Veterans Health Administration inpatient mental health units between 2002 and 2015 found 141 reports of suicide within seven days of discharge (*Discharge Death by Suicide Within 1 Week of Hospital Discharge: A Retrospective Study of Root Cause Analysis Reports*. Authors: Riblet N, Shiner B, Watts, BV, Mills P, Rusch B, Hempbill RR J Nerv Ment Dis. 2017 Jun;205(6):436-442). Similarly, patients referred to social service support services are at an elevated-risk until they begin receiving those services. Thus, it is important that systems are implemented to ensure effective care transitions.

Objective 9.1 Provide continuity of care to patients referred to out-patient behavioral health care.

Continuity of care is crucial for patients leaving an emergency department or hospital inpatient unit after a suicide attempt or determined to be at a high risk for suicide. Continuity of care includes:

- Making a follow-up appointment for the patient before discharge.
- Development of care transitions in collaboration with the patient, family, friends, and significant others.
- Making follow-up contacts.
- Developing agreements among hospitals and behavioral health providers to facilitate safe transitions between settings.
- Ensuring seamless transmission of patient health information, safety plans, medication, and treatment plans to referral providers.
- Providing patients with information regarding urgent care clinics and crisis centers

Objective 9.2. Establish linkages with community-based programs for non-medical services that can reduce risk factors and promote protective factors.

Health care providers should develop linkages with community-based supports, such as community agencies for suicide prevention, mental

health advocacy organizations, aging services organizations, veterans support organizations, and programs providing social services and peer support services. These programs can help foster a sense of connection and belonging and provide critically needed services, including employment and vocational help, housing assistance, social interactions that are not focused on illness, and peer support.

GOAL 9 ACTIVITIES

Businesses and Employers

- Develop and implement peer support groups for substance use disorders, mental health, suicide prevention, and suicide loss survivors.

Health Care Systems, Insurers, and Clinicians

- Establish partnerships between primary care providers and behavioral health providers and develop continuity of care procedures for patients at risk for suicide.
- Coordinate with community-based social service organizations and support services to assist discharged patients in their recovery.

Nonprofit, Community, and Faith-Based Organizations

- Coordinate community-based social service and peer-support programs for persons at risk for suicide with health care providers.

Schools, Colleges, and Universities

- Colleges and universities: Coordinate the services of campus peer-support programs with providers of mental health and substance use disorder services.

State and Local Government

- Provide support to community-based organizations providing social services and peer support to persons at risk for suicide.

Goal 10. Provide care and support to individuals affected by suicide deaths and attempts.

Those who have attempted suicide or been exposed to the suicide of another need care and support, but they are also a resource for others similarly affected. Care and support for individuals who have attempted suicide and to those who have been affected by a suicide attempt or death should be designed to promote healing and implement community strategies to help prevent further suicides.

Objective 10.1. Support the grief of individuals bereaved by suicide.

Those affected by the suicide of another person experience emotions that are unique to this form of death. The complicated grief and stigma that accompanies suicide may include feelings of being alone, shocked, responsible, angry, abandoned, ashamed, guilty, and relieved. Individuals bereaved by suicide should be provided culturally appropriate care and support for this unique form of grief.

Objective 10.2. Provide appropriate clinical care to individuals affected by a suicide.

Exposure to a suicide attempt or death by a family member, friend or a member of one's community can increase the risk for suicide. Thus, individuals affected by suicide must also have access to knowledgeable professional services and supports.

Objective 10.3. Engage loss survivors and persons with lived experience in suicide prevention and support activities.

Promoting the positive engagement of those who have lost a loved one to suicide and those with lived experience (persons who have attempted suicide or struggled with suicide ideation) can aid in their recovery and provide valuable insight and credibility in programing for the prevention of suicide and support. Appropriate peer support plays an important role in the treatment of mental and substance use disorders and holds a similar potential for helping loss survivors and those at risk for suicide.

Objective 10.4. Prevent suicide clusters and contagion.

Suicide contagion occurs when exposure to suicidal behaviors personally or through the media can leads to increased suicidal behaviors. A suicide cluster occurs when a group of suicides or suicide attempts occur closer together in time and space than would normally be expected in a given community.

Objective 10.5. Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide.

Clinicians, first responders, emergency personnel, and other medical professionals who lose a patient to suicide should be provided with support to deal with the emotional aftermath of this traumatic event. Mechanisms for review of such deaths should avoid blaming the caregiver and instead be designed to implement systematic changes to prevent future suicides.

GOAL 10 ACTIVITIES

Businesses and Employers

- Provide grief counseling to employees bereaved by suicide.
- Develop and maintain a response plan for suicide or attempted suicide by employees.
- Support a peer support program for employees bereaved by suicide.

Health Care Systems, Insurers, and Clinicians

- Provide counseling services that recognize the special issues faced by those exposed to suicide.
- Develop procedures for support of personnel in the event of death of a person under their care.

Individuals and Families

- Participate in peer support programs for those bereaved by suicide.

Nonprofit, Community, and Faith-Based Organizations

- Organize and support peer support programs for those bereaved by suicide.
- Engage the media to ensure they follow guidelines for reporting on suicide to prevent clustering.

Schools, Colleges, and Universities

- Develop and maintain a response plan for suicide or attempted suicide by staff, faculty, or students.
- Provide presentations from/by a suicide attempt survivor to reduce prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.
- Colleges and Universities: Facilitate the creation of and support campus suicide loss survivor groups.

State and Local Government

- Update and revise government publications addressing community, employer, and educational institution responses after a suicide or suicide attempt.

STRATEGIC DIRECTION 4.

Surveillance, Research, and Evaluation

Surveillance is the public health process of systematically collecting, analyzing, and interpreting data to plan, implement, and evaluate public health practices. This requires timely and comprehensive data and the means to evaluate that data. Next it is necessary to ensure that programs have a scientific basis. This requires research into the causes of suicide, interventions, and treatments that will allow the design of effective suicide prevention programs. Finally, suicide prevention programs of the stakeholders discussed in this plan should be regularly evaluated and modified.

Goal 11. Improve the timeliness and usefulness of data and the ability to use that data.

Timely, accurate, and comprehensive data related to suicide attempts and deaths can assist the state and local jurisdictions, community organizations, and health care systems design effective suicide prevention policies. The Suicide Prevention Resource Center recently released a guideline for states (*Data Infrastructure: Recommendations for State Suicide Prevention)* to understand the resources and systems needed to effectively identify, share, analyze, and use data to direct prevention efforts.

That guideline provided the following recommendations:

- Establish core leadership positions and leadership buy-in for building data infrastructure to support suicide prevention.
- Establish partnerships, coalitions, and/or prevention centers to support data infrastructure.
- Establish a system for identifying data sources and sharing data.
- Establish a system for analyzing data.
- Establish a system for using data.
- Collect, analyze, and use data from state systems.

http://www.sprc.org/sites/default/files/StateInfrastructureDataSupplement.pdf

Those recommendations provide a roadmap for Illinois to develop an effective suicide surveillance system.

A key data resource in Illinois is the Illinois Violent Death Reporting System (IVDRS), which is part of the National Violent Death Reporting System (NVDRS). This surveillance system pools more than 600 unique data elements associated with violent deaths (primarily homicide and suicide) from multiple sources into a usable, anonymous database. Because the IVDRS captures the circumstances surrounding a suicide, it allows the identification of trends and opportunities for intervention to prevent suicides. The IVDRS does not yet have agreements with law enforcement agencies, medical examiners, and/or coroners in all Illinois counties. Another challenge is to obtain timely, complete, and consistent data from all reporting organizations.

Objective 11.1. Improve the timeliness of reporting vital records data.

Timeliness of reporting of statistics on suicide mortality is a core issue. Without it, it is difficult to know when suicide rates change within regions of Illinois or the entire state. Such knowledge would be useful to plan interventions or to know if suicide prevention efforts are having an effect. The Illinois Violent Death Reporting System (IVDRS) has standardized the information that should be reported by counties, but it does not have agreements with every county in the state. All counties should participate in the IVDRS. Moreover, electronic transfer of that information to IVDRS would be more cost efficient and timely.

Objective 11.2. Improve the usefulness and quality of suicide-related data.

Consistent suicide-related data can help public health practitioners better understand the scope of the problem, identify high-risk groups, and monitor and evaluate the effects of suicide prevention programs. EMTs, police, medical examiners, and coroners may all contribute to the collection of these data. There is a need to improve the quality and accuracy of death scene investigations by providing training to these responders. Attention must also be given to improving the quality and accuracy of suicide attempt data.

Efforts to link and analyze information coming from separate data systems, such as the IVDRS, law enforcement, emergency medical services, and hospitals, are also needed. This would best be accomplished by streamlining interagency data share agreements to

facilitate meaningful data linkage for suicide prevention. Such linked data can provide much more comprehensive information about an event, circumstances leading up to it, the occurrence and severity of injury, the type and cost of treatment received, and the outcome in terms of both morbidity and mortality.

Objective 11.3. Improve state and local public health capacity to use suicide-related data.

The state and local public health authorities should have the ability to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions. There is a need to promote the development of local reports on suicide and suicide attempts, and to integrate data from multiple data management systems. For example, the Illinois Criminal Justice Information Authority recently published a study that integrates IVDRS data with criminal arrest and prison admission data. Among its other findings, that study showed 40% of those who died by suicide was involved in the criminal justice system. The study recommended that those with a criminal history who are receiving treatment for behavioral health conditions should receive continuity of care and continued risk assessment. The authors concluded: “This study offered an example of how public health and criminal justice data sources can be linked to gain a nuanced understanding of the societal problem of violent deaths and inform on prevention and outreach initiatives.”

https://icjia.illinois.gov/researchhub/articles/prior-criminal-justice-involvement-of-persons-experiencing-violent-deaths-in-illinois

Data should allow the tracking of trends in attempts, suicides, methods used, and underlying risk factors for different geographic and cultural communities. The IDPH’s Opioid Data Dashboard https://idph.illinois.gov/OpioidDataDashboard/ is a good example of the presentation of data that would be useful in informing suicide prevention planning.

Meeting this objective require two steps. First, Illinois should establish an infrastructure to support and facilitate use of data in local, regional, and state planning. Second, it is necessary to educate potential data

consumers on data available and its uses to ensure data dissemination responsive to user needs.

GOAL 11 ACTIVITIES

Health Care Systems, Insurers, and Clinicians

- Routinely document suicide-related information (e.g., alcohol use, drug use, description of intent) for suicides and suicide attempts and facilitate linkage of that data for use by IVDRS and other research organizations.

Individuals and Families

- Participate in surveys and other data collection efforts addressing suicide and related behaviors.
- Cooperate with coroner or medical examiner investigations to provide information on suicides by family members.

State and Local Government

- Ensure officials and staff responsible for reporting to the IVDRS are provided necessary training and resources.
- Improve data linkage of suicides and attempts across organizations, including the health care system, social services, and the justice system.
- State: Increase the efficiency of state-based processes for certifying, amending, and reporting vital records related to suicide deaths.
- State: Provide funding and coordination necessary to expand the IVDRS to all counties.
- State: Ease interagency linkage/data share requirements and coordinate documentation of suicide-related information recording (e.g., alcohol use, drug use, description of intent) for suicides and suicide attempts by persons in state-operated facilities.
- Implement the recommendations in the SPRC's Data Infrastructure: Recommendations for State Suicide Prevention.

Goal 12. Promote and support suicide prevention research.

Suicide is the 10th leading cause of death in the United States, yet suicide prevention research has lagged far beyond research into other causes of death. Illinois institutions can play a role in changing that dynamic.

Objective 12.1 Promote and support suicide prevention research.

Research in suicide prevention can cover a wide area of topics. For example, the National Action Alliance for Suicide Prevention has established the following research priorities:

- Why do people become suicidal?
- How can we better or optimally detect/predict risk?
- What interventions are effective? What prevents individuals from engaging in suicidal behavior?
- What services are most effective for treating the suicidal person and preventing suicidal behavior?
- What other types of preventive interventions (outside health care systems) reduce suicide risk?
- What new and existing research infrastructure is needed to reduce suicidal behavior?

https://theactionalliance.org/sites/default/files/agenda.pdf

The National Institute of Mental Health, recently announced that its suicide prevention research priorities for the next five years will be directed toward the following:

- Better understanding of the efficacy and implementation of evidence-based practices into primary and specialty care settings.
- Testing the integration and implementation of suicide prevention measures into collaborative care models.
- Understanding the impact of suicide prevention practices on long-term patient outcomes; implementing and evaluating risk prediction algorithms in clinical and research settings.
- Continuing to identify and test the feasibility, safety, and efficacy of treatment protocols for rapid-acting interventions.

Gordon, J. A., Avenevoli, S., & Pearson, J. L. (2020). *Suicide prevention research priorities in healthcare*. JAMA Psychiatry. doi:10.1001/jamapsychiatry.2020.1042

Public and private funding is regularly made available for research into suicide prevention. Federal sources for funding for suicide prevention research include the Substance Abuse and Mental Health Services Administration, the National Institute of Mental Health, the Centers for Disease Control and Prevention, and the U.S. Department of Defense. Researchers at Illinois institutions, such as its universities, colleges, and medical schools, should seek funding for suicide prevention research and share their work with those who could benefit from the research.

GOAL 12 ACTIVITIES

Health Care Systems, Insurers, and Clinicians

- Initiate and participate in suicide prevention research on effective screening, intervention, and treatment. Such research should include screening tools, interventions and treatments used, populations targeted (diagnosis based or universal screening), and outcomes.

Schools, Colleges, and Universities

- Conduct research to identify new, effective policy and program interventions to reduce suicide and suicidal behavior.
- Share suicide-related research findings with state and local suicide prevention coalitions, health care providers, and other relevant practitioners.

State and Local Government

- Assist Illinois institutions in applying for suicide-related research grants, conducting research and disseminating results.

Goal 13. Evaluate the impact and effectiveness of suicide prevention programs.

It is important to constantly monitor the impact of suicide prevention programs and make appropriate changes to those programs to reflect findings from internal evaluations as well as data generated from Goal 11 and research findings from Goal 12.

Objective 13.1. Evaluate the impact and effectiveness of suicide prevention programs and make changes indicated by those evaluations.

Suicide prevention programs include those that educate and those that provide intervention and treatment. The effectiveness of each program should be regularly evaluated to determine effectiveness and to make necessary changes. Evaluations depend upon the program and can include behavioral outcomes (suicide attempts and deaths), changes in attitudes and knowledge toward suicide, and participation metrics (number of people participating in a program).

Programs that address risk factors for suicide, such as substance use disorder programs or violence prevention programs, should be encouraged to incorporate suicide prevention components and related measures in their program design and evaluation plans.

Program evaluations should reflect the different geographic and cultural communities being served to design the delivery structures that are most efficient and effective for each.

GOAL 13 ACTIVITIES

Businesses and Employers

- Regularly evaluate the effectiveness of workplace wellness programs in reducing suicide risk.

Health Care Systems, Insurers, and Clinicians

- Initiate continuous quality improvement studies to determine the effectiveness of policies and procedures of the comprehensive suicide prevention plan.

Individuals and Families

- Participate in the evaluation of suicide prevention programs.

Nonprofit, Community, and Faith-Based Organizations

- Include suicide prevention metrics in the evaluations of programs that share risk factors and protective factors.

Schools, Colleges, and Universities

- Regularly evaluate the effectiveness of student anti-bullying, suicide prevention, and wellness programs.

State and Local Government

- Regularly evaluate the effectiveness of suicide prevention programs at state-operated facilities.
- Regularly evaluate the effectiveness of suicide prevention programs required at schools, colleges, and universities.
- Regularly evaluate the effectiveness of this Illinois Suicide Prevention Plan.

SUICIDE PREVENTION ACTIVITIES BY ORGANIZATION

STAKEHOLDER	GOAL
BUSINESSES AND EMPLOYERS	
Designate a member of the organizations' leadership team as a champion for suicide prevention and the promotion of mental health.	1
Promote suicide prevention through professional associations and funding behavioral health, suicide awareness and prevention efforts.	1
Promote social connectedness among employees by offering opportunities to engage in community service work or recreational activities as teams.	1
Provide written materials and hold workshops promoting employee behavioral health.	2
Implement organizational changes (e.g., work schedules, leave time, duties, and responsibilities) to promote employees' mental health.	3
Implement employee physical, mental, emotional, and spiritual wellness programs.	3
Increase the visibility of behavioral health and suicide prevention services provided by employee health plans and create a culture that removes the stigma of their use.	3
Promote awareness and education during May, Mental Health Awareness Month.	3
Provide employees with behavioral health and suicide prevention awareness education.	5
Ensure that employee health insurance provides coverage for behavioral health that is comparable to physical and surgical coverage.	5
Promote suicide awareness and prevention during September, National Suicide Prevention and Awareness Month.	5
Provide employees with an online depression screening and referral program providing anonymity and confidentiality.	5
Employee assistance counselors provide lethal means counseling where appropriate.	6
Provide suicide prevention education and training to supervisors and staff.	7
Ensure that counselors in an employee assistance program are trained to assess and manage suicide risk.	7
Develop and implement peer support groups for substance use disorders, mental health, suicide prevention, and suicide loss survivors.	9
Provide grief counseling to employees bereaved by suicide.	10
Develop and maintain a response plan for suicide or attempted suicide by employees.	10
Support a peer support program for employees bereaved by suicide.	10

Regularly evaluate the effectiveness of workplace wellness programs in reducing suicide risk.	13
HEALTH CARE SYSTEMS, INSURERS, AND CLINICIANS	
In their role as employers of the health care workforce, take every action recommended for "Businesses and Employers" in this plan.	1
Collaborate with behavioral health providers to develop and to provide local information, resources, and professional development/training opportunities.	1
Collaborate with, and where necessary, advocate, with insurance carriers and relevant state agencies, such as the Illinois Department of Insurance and the Illinois Department of Healthcare and Family Services, to ensure that reimbursement rates for behavioral health care are sufficient and that reimbursement can be provided for all services required under a comprehensive suicide prevention program.	1
Provide the local community with information about behavioral health and local resources.	2
Participate in community awareness campaigns to promote wellness and reduce the stigma of behavioral health conditions and suicide.	3
Communicate messages of resilience, hope, and recovery to patients with mental health conditions and substance use disorders.	3
Health care professionals should discuss the public health aspect of suicide, the complexity of its causes, and provide a message of hope and recovery when interviewed on the subject.	4
Identify content experts who can speak with media on issues related to suicide prevention including best practices for media reporting on suicide events.	4
Implement behavioral health services that increase availability to underserved communities.	5
Advocate for insurance reimbursement for all elements of a comprehensive suicide prevention program.	5
Participate in community suicide prevention awareness activities during September, National Suicide Prevention and Awareness Month.	5
Implement crisis services, including 24-hour mobile crisis units, crisis contact, and crisis respite services.	5
Incorporate lethal means counseling in all suicide prevention activities.	6
Host and promote evidence-based behavioral health, suicide awareness, screening, and prevention programs for the community.	7
Provide training to all personnel necessary for implementation of a comprehensive suicide prevention program targeted to their role (screening, assessment, intervention, treatment, follow-up, recordkeeping, billing).	7
Support training mental health professionals to provide evidence-based suicide prevention therapy (DBT, BCBT, CBT-SP, CAMS).	7
Include behavioral health, suicide awareness and prevention training in medical school curriculum.	7
Credentialing and accreditation bodies: Include suicide prevention as a core educational requirement for health care systems and professionals.	7
Implement a comprehensive suicide prevention program, with zero suicides as an aspirational goal.	8

Implement patient-informed alternatives to hospitalization for individuals with suicide risk.	8
Implement policies and practices that include families or significant others in discharge planning, development of safety plans, and education after discharge of a patient at risk for suicide.	8
Educate family members and significant others about appropriate steps they can take to support individuals at suicide risk during treatment and/or after discharge.	8
Integrated behavioral health care in primary care using resources, such as those provided by the National Council for Behavioral Health at https://www.thenationalcouncil.org/integrated-health-coe.	8
Provide 24/7 availability of support using telehealth or other forms of virtual care, ensuring HIPAA compliance and ease of use by providers and patients.	8
Emergency departments, hospitals, behavioral care facilities, and primary care providers implement separate algorithms or clinical pathways for children and adults at risk for suicide.	8
Develop alternatives to treatment in an emergency department, such as same-day scheduling for behavioral health services and in-home crisis care.	8
Provide periodic follow-up contact for a period of six months after discharge.	8
Create, maintain, and use feedback loops that report post discharge outcomes for patients identified as at risk.	8
Establish partnerships between primary care providers and behavioral health providers and develop continuity of care procedures for patients at risk for suicide.	9
Coordinate with community-based social service organizations and support services to assist discharged patients in their recovery.	9
Provide counseling services that recognize the special issues faced by those exposed to suicide.	10
Develop procedures for support of personnel in the event of death of a person under their care.	10
Routinely document suicide-related information (e.g., alcohol use, drug use, description of intent) for suicides and suicide attempts and facilitate linkage of that data for use by IVDRS and other research organizations.	11
Initiate and participate in suicide prevention research on effective screening, intervention, and treatment. Such research should include screening tools, interventions and treatments used, populations targeted (diagnosis based or universal screening), and outcomes.	12
Initiate continuous quality improvement studies to determine the effectiveness of policies and procedures of the comprehensive suicide prevention plan.	13
INDIVIDUALS AND FAMILIES	
Participate in grassroots community organizations promoting behavioral health and preventing suicide.	1
Share your story with policymakers during behavioral health and suicide prevention advocacy.	2

Build strong, positive relationships with family and friends.	3
Become involved in their community (e.g., mentor or tutor youth, join a faith or spiritual community, reach out to older adults in the community).	3
Volunteer to help in forums, health fairs, safety events addressing behavioral health, suicide awareness and prevention.	3
Encourage open conversation and dialogue about suicide among family, friends, and other social networks.	3
Volunteer to speak as a person who has lost a loved one to suicide, has struggled against suicide, or has lived with a mental health condition or substance use disorder.	3
Support or participate in peer networks that promote behavioral health, prevent suicide, or support suicide loss survivors.	3
Participate in local organizations influencing school curriculum and policies, such as an advisory council, PTA, or school board and ensure compliance with suicide prevention and anti-bullying laws.	5
Participate in behavioral health, suicide awareness and prevention trainings.	5
Learn the signs and symptoms of suicide and suicidal behaviors and how to reach out to those who may be at risk.	5
Advocate for the promotion of behavioral health and suicide prevention at the federal, state, and local governmental level.	5
Store household firearms locked and unloaded with ammunition locked separately and take additional measures if a household member is at high risk for suicide.	6
Dispose of unwanted medications, particularly those that are toxic or abuse-prone, and take additional measures (e.g., a medication lock box) if a member of the household is at high risk for suicide.	6
Participate in discharge planning and education after a loved one is determined to be at risk for suicide.	8
Provide appropriate follow-up support to family members of individuals after discharge, ensuring that they comply with treatment plans.	8
Learn how to contact treatment providers or emergency services for loved ones who are at risk for suicide.	8
Volunteer at a local crisis hotline or text line service.	8
Participate in peer support programs for those bereaved by suicide.	10
Participate in surveys and other data collection efforts addressing suicide and related behaviors.	11
Cooperate with coroner or medical examiner investigations to provide information on suicides by family members.	11
Participate in the evaluation of suicide prevention programs.	13
NONPROFIT, COMMUNITY, AND FAITH-BASED ORGANIZATIONS	
In their role as employers, nonprofit, community, and faith-based organizations should take all the actions recommended for "Businesses and Employers" in this plan.	1
Faith-based organizations: utilize the SPRC support of the faith community resources https://www.sprc.org/settings/faith-communities.	1

Participate in local coalitions of stakeholders to promote and to implement comprehensive suicide prevention efforts at the community level.	1
Sponsor, support, and/or promote training programs for behavioral health, suicide awareness and prevention.	1
Advocate for and support increased opportunities and funding initiatives that promote behavioral health and prevent suicide.	1
Collaborate with governmental and non-governmental behavioral health and suicide prevention stakeholders to share knowledge and resources.	1
Advocate for effective oversight of the providers of private insurance and Medicaid to ensure that coverage for behavioral health services is comparable to coverage for physical illness services.	1
Advocate for constituents with their insurance providers to ensure coverage for behavioral health services.	1
Develop suicide and behavioral health awareness written and online communications that are culturally, linguistically, geographically, and age-appropriate.	2
Work with educational authorities to develop and/or provide age-appropriate behavioral health and suicide prevention curriculum for K-12 students.	2
Conduct or host forums, health fairs, and safety events addressing behavioral health and suicide prevention.	2
Provide policymakers with geographically and culturally specific data relevant to their constituency.	2
Provide opportunities for social participation and inclusion for those who may be isolated or at risk.	3
Sponsor, provide, support, and/or promote peer-based support groups for substance use disorder, mental health, suicide prevention, and suicide loss survivors.	3
Recruit persons with lived experience who are willing to serve as speakers, provide them support and opportunities to share their experiences.	3
Use timely and widely covered news events to engage the media in targeted discussion about suicide prevention.	4
Engage reporters, columnists, and news directors after suicide stories, informing them of positive and negative aspects of their reporting.	4
Disseminate Recommendations for Reporting on Suicide to news organizations.	4
Participate in efforts to educate entertainment media of appropriate depiction of suicide, mental health conditions, and substance use disorders.	4
Implement suicide prevention programs that address the needs of groups at risk for suicide and that are geographically, culturally, linguistically, and age-appropriate.	5
Provide suicide crisis hotline and text numbers in written materials and advocate their publication in media contacts.	5
Organize or join coalitions advocating for laws and policies at the federal, state, and local level that promote behavioral health, suicide awareness and prevention.	5
Develop suicide prevention written and on-line materials providing suicide risk factors, warning signs, and ways to help.	5

Organize suicide prevention awareness activities during September, National Suicide Prevention and Awareness Month.	5
Educate clergy, parent groups, schools, juvenile justice personnel, rehabilitation centers, defense and divorce attorneys, and others about the importance of promoting efforts to reduce access to lethal means among individuals at risk for suicide.	6
Initiate partnerships with firearm advocacy groups (e.g., retailers, shooting clubs, manufacturers, firearm retail insurers) to increase suicide awareness.	6
Promote the use of the Firearms Restraining Order Act.	6
Use the VA/AFSP/NSSF Safe Firearm Storage Toolkit to form a community effort to promote safe firearm storage.	6
Train staff and volunteers in suicide awareness and prevention, ensuring that the training is appropriate for the needs of the at-risk populations faced by the organization.	7
Coordinate community-based social service and peer-support programs for persons at risk for suicide with health care providers.	9
Organize and support peer support programs for those bereaved by suicide.	10
Engage the media to ensure they follow guidelines for reporting on suicide to prevent clustering.	10
Include suicide prevention metrics in the evaluations of programs that share risk factors and protective factors.	13
SCHOOLS, COLLEGES, AND UNIVERSITIES	
In their roles as employers of the educational workforce, every educational institution should take the actions recommended for "Businesses and Employers" in this plan.	1
Create a working partnership with local behavioral health providers serving their area.	1
Identify and disseminate information about behavioral health and suicide prevention resources available within the community to students and to staff.	1
Develop written and online communication messages for teachers, administration, students, and parents about resources available for behavioral health and suicide prevention.	2
Conduct or host forums, health fairs, and safety events on suicide and behavioral health awareness.	2
Support wellness promotion activities during times of stress and transition.	2
Colleges and universities: Increase the visibility of behavioral health and suicide prevention services provided by student health plans and create a culture that removes the stigma of their use.	2
Implement programs and policies to prevent abuse, bullying, violence, and social exclusion.	3
Implement programs and policies to build social connectedness and promote positive mental and emotional health.	3
Sponsor and support groups/clubs to promote a setting of togetherness and mental wellness for students and/or engaging in suicide prevention efforts.	3

Provide and support student activities for mental health awareness during May, Mental Health Awareness Month.	3
K-12: implement an anti-bullying policy required by 105 ILCS 5/27-23.7 and regularly review its effectiveness and make appropriate changes.	3
K-12: Promote resiliency and protective factors in health curriculum.	3
Provide opportunities for those with lived experience to share their story.	3
Colleges and universities: Integrate information about the responsible depiction of suicide and suicide-related behaviors into the curricula of schools of journalism, film, and other communications disciplines.	4
Identify content experts who can speak with media on issues related to suicide prevention, particularly regarding youth suicide.	4
Colleges and universities: All colleges and universities (not just public colleges and universities) provide the mental health awareness and suicide prevention measures required by Public Act 101-0251, *Mental Health Early Action on Campus Act.*	5
Collaborate with behavioral health providers on local information, resources, and professional development/training opportunities.	5
Incorporate suicide prevention and awareness into freshman orientation.	5
Provide and support student activities during September, National Suicide Prevention and Awareness Month.	5
Colleges and universities: Ensure that student health insurance provides coverage for behavioral health that is comparable to physical and surgical coverage.	5
K-12: Implement suicide awareness and prevention policy required by 105 ILCS 5/2-3.166 and regularly review its effectiveness and make appropriate changes.	5
K-12: Host and support training on behavioral health awareness and suicide prevention for parents.	5
Student health service and behavioral health counselors provide lethal means counseling where appropriate.	6
Colleges and universities: All colleges and universities (not just public colleges and universities) provide training for school personnel required by Public Act 101-0251, *Mental Health Early Action on Campus Act*.	7
K-12: Provide mental health awareness and suicide prevention training to staff required by state law (105 ILCS 5/34-18.7 and 105 ILCS 5/10-22.39).	7
Colleges and universities: Integrate appropriate core suicide prevention competencies into relevant curricula (e.g., nursing, medicine, allied health, pharmacy, social work, education).	7
Colleges and universities: Coordinate the services of campus peer-support programs with providers of mental health and substance use disorder services.	9
Develop and maintain a response plan for suicide or attempted suicide by staff, faculty, or students.	10
Provide presentations from/by a suicide survivor to reduce prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders.	10
Colleges and universities: Facilitate the creation of and support campus suicide loss survivor groups.	10

Conduct research to identify new, effective policy and program interventions to reduce suicide and suicidal behavior.	12
Share suicide-related research findings with state and local suicide prevention coalitions, health care providers, and other relevant practitioners.	12
Regularly evaluate the effectiveness of student anti-bullying, suicide prevention, and wellness programs.	13
STATE AND LOCAL GOVERNMENT	
Advocate for and support increased opportunities and funding initiatives for suicide prevention activities by state and local government and private entities.	1
Collaborate with other suicide prevention stakeholders to share knowledge and resources for suicide prevention among citizens with mental and substance use disorders.	1
Promote the objectives, goals, and strategies of this 2020 Illinois Suicide Prevention Strategic Plan within government and to the public.	1
Provide resources for the delivery of Mental Health First Aid	1
In their roles as employers of the state and local governmental workforce, all levels of government should take every action recommended for "Businesses and Employers" in this plan.	1
State agencies and local government participate in the Illinois Suicide Prevention Alliance.	1
State: Ensure compliance with laws directing educational systems to prevent suicide and bullying.	1
State: Provide resources to the Illinois Department of Public Health necessary for it to comply with the provisions of 20 ILCS 2310/2310-455 that require it to implement activities associated with the *Suicide Prevention, Education, and Treatment Act.*	1
Collaborate with insurance carriers and health care providers to ensure reimbursement rates for behavioral health care are sufficient and reimbursement can be provided for all services required under a comprehensive suicide prevention program.	1
Increase reimbursement rates for behavioral health services under Medicare and Medicaid to a level that is sufficient to encourage providers to participate in those programs.	1
Each agency, department, bureau, office, or other organization of government provide suicide and behavioral health awareness communications to their constituency / client population that are culturally, linguistically, geographically, and age-appropriate.	2
Promote and share resources listing evidence-based programs and practices for suicide prevention	3
Identify the needs of groups at risk for suicide and coordinate the provision of culturally, linguistically, and age-appropriate programs with local government and community-based organizations.	5
Coordinate sharing of information, strategies, and resources of government and community-based organizations providing suicide prevention programs.	5

Offer suicide prevention and awareness trainings to agencies working in the community (e.g., school systems, senior centers, home health agencies).	5
Make available to the public local resources and referrals for suicide prevention.	5
Develop suicide prevention written and on-line materials providing risk factors, warning signs, and ways to help.	5
Coordinate activities in furtherance of the recommendations developed by the 2020 Illinois participation in the Veterans Administration's *Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families*.	5
State: ISBE monitor and enforce compliance with suicide prevention and anti-bullying laws directed at primary and higher education institutions.	5
Support crisis hot-line, text services, and peer support programs.	5
State: IDOI/HFS strictly enforce compliance with Illinois' parity law (215 ILCS 5/370c and 370c.1), including implementation of the annual treatment limitation reporting format for use by commercial and Medicaid health plans mandated by Public Act (PA) 100-1024.	5
State: Adopt programs and incentives to increase the behavioral health workforce.	5
Support "train the trainer" suicide awareness training to maximize the number of persons that can be reached.	5
Sponsor trainings and disseminate information on means restriction, including the Firearms Restraining Order Act, to behavioral health providers, professional associations, and patients and their families.	6
Sponsor medications take-back days and ongoing methods for the disposal of unwanted medications (e.g., secure collection kiosks at police departments or pharmacies).	6
Promote education of suicide awareness and prevention among the firearms owning community, for example, the Illinois State Police in its role overseeing Firearm Owner Identification licenses, or the Illinois Department of Veterans Affairs or Illinois Department of Aging providing information to the populations they serve.	6
Support measures designed to reduce suicide at hot spots (e.g., bridges, train platforms, atriums).	6
Incorporate suicide prevention training into professions that have exposure to traumatic events (e.g., law enforcement, EMS, fire and rescue, emergency department staff).	7
Support and promote crisis intervention team (CIT) training for law enforcement officers.	7
Provide financial and logistical support for suicide screening and suicide risk assessment to the public and to health care personnel.	7
Provide suicide prevention training to staff at state- or county-run facilities, including corrections, behavioral health, senior care, and veterans' facilities.	7
Provide schools and colleges with training and resources to assist in compliance with laws requiring suicide prevention training and education.	7
State: Include suicide prevention as a core educational requirement for the licensing of medical and behavioral health systems and professionals.	7
Provide financial support and disseminate information about the National Suicide Prevention Lifeline, Crisis Text Line, and other local or regional crisis lines.	8

Coordinate collaboration among crisis centers, law enforcement, mobile crisis teams, and social services.	8
Provide support for training of behavioral health professionals in evidence-based suicide prevention therapy.	8
Educate communities and individuals on HIPAA guidelines regarding confidentiality of psychological information and exceptions to limitations.	8
State: IDOI/HFS ensure that processes in a comprehensive suicide prevention program are recoverable through patients' medical insurance.	8
Include the effectiveness of a health care provider's suicide prevention program as an element of regular review, licensing, and accreditation.	8
State: HFS include the effectiveness of health care provider's suicide prevention program as an element in the determination of financial incentives/penalties in Medicaid payments.	8
State: To the extent that suicide prevention services cannot be covered by Medicaid payments, request a waiver of federal guidelines pursuant to Section 1115 of the Social Security Act.	8
State and counties: Adopt a comprehensive suicide prevention program, with zero suicides as an aspirational goal, in state- or county-run facilities, including corrections, behavioral health, youth, senior care, and veterans' facilities.	8
State: Surveyors from IDPH should consider the recommendations in Objective 8.4 for ligature resistant environmental settings and determinations.	8
Provide support to community-based organizations providing social services and peer support to persons at risk for suicide.	9
Update and revise government publications addressing community, employer, educational institution responses after a suicide or suicide attempt.	10
Ensure that officials and staff responsible for reporting to the Violent Death Reporting System are provided necessary training and resources.	11
Improve data linkage of suicides and attempts across organizations, including the health care system, social services, and the justice system.	11
State: Increase the efficiency of state-based processes for certifying, amending, and reporting vital records related to suicide deaths.	11
State: Provide funding and coordination necessary to expand the Illinois Violent Death Reporting System to all counties.	11
State: Ease interagency linkage/data share requirements and coordinate documentation of suicide-related information recording (e.g., alcohol use, drug use, description of intent) for suicides and suicide attempts by persons in state-operated facilities.	11
Implement the recommendations in the SPRC's Data Infrastructure: Recommendations for State Suicide Prevention.	11
Assist Illinois institutions in applying for suicide-related research grants, conducting research, and disseminating results.	12
Regularly evaluate the effectiveness of suicide prevention programs at state-operated facilities.	13
Regularly evaluate the effectiveness of suicide prevention programs required at schools, colleges, and universities.	13
Regularly evaluate the effectiveness of this Illinois Suicide Prevention Plan.	13

INFORMATION FOR THOSE AFFECTED BY SUICIDE

* If you or someone you know is in immediate danger to themselves or others contact 911

If you are experiencing suicidal thoughts

Many people have experienced suicidal thoughts at some point in their lives. Suicidal thoughts, or suicidal ideation, means thinking about or planning to end one's life. Thoughts can range from a fleeting consideration to forming a detailed plan. Many people experience suicidal thoughts when they are experiencing stress or depression. In many cases, these thoughts are temporary and can be treated. In other cases, they place the individual at risk if they decide to act on the suicidal thoughts. Anyone experiencing suicidal thoughts should seek help. If you, a loved one, or friend is having suicidal thoughts, help is available by accessing the resources below.

The National Suicide Prevention Lifeline:

Available 24 hours a day, seven days a week.

Call: 1 800-273-8255

Text: "help" to 741741.

Chat: www.suicidepreventionlifeline.org/chat

The Trevor Lifeline:

If you are an LGBTQ+ youth (up to age 25) experiencing suicidal thoughts, or in distress, contact the Trevor Lifeline.

Call: 1-866-488-7386

Text: START to 678678.

Trans lifeline at: 1-877-565-8860.

The Veterans Crisis Line:

Available 24 hours a day, seven days a week.

Call: 1-800-273-8255,press 1.

Confidential help is also available for veterans and their families through Confidential chat at: VeteransCrisisLine.net. Text: START to 838255.

If you are a suicide attempt survivor

Finding hope and coping with deep hurt after a suicide attempt is possible. Mental health help is available. To find mental health resources near you, access the Illinois Department of Human Services website at www.dhs.state.il.us/page.aspx?item=43695

If you are a suicide attempt survivor and might be at risk of suicide again, the My3App from the National Suicide Prevention Lifeline can be used to list your crisis contacts, make a safety plan, and utilize emergency resources. For more information visit: https://my3app.org

If you are concerned someone else might be at risk of suicide

You can help someone who may be at risk for suicide. Here are five easy steps you can take to help:

1. Look for warning signs. Some common warning signs of suicide risk are listed on page 16 and 17.
2. Show you care. This looks different depending on who you are and your relationship, but let the person know you have noticed something has changed and it matters to you. If appropriate, let them tell you how they are feeling and why.
3. Ask the question directly. Make sure you both understand whether this problem is about suicide. “Are you thinking about suicide?”
4. Help keep the person safe by assisting them with the removal of dangerous objects and substances from the places they live and spend time until they are no longer a danger to themselves.
5. Get help. This person may know who they want to talk to (a therapist, their guardian, their partner).

You can also call the National Suicide Prevention Lifeline 24 hours a day, seven days a week. Contact information listed above.

ADDITIONAL CONTACT INFORMATION

Hotlines

National Suicide Prevention Lifeline at 800-273-TALK (800-273-8255)

Disaster Distress Help Line- 800-985-5990

CARES line 800-345-9049 (SASS crisis services for children without insurance or covered by Medicaid, and mobile crisis response for adults on Medicaid)

Trevor Project for LGBTQ+ Youth - 866-488-7386

Trans Lifeline - 877-565-8860

Veterans Crisis Line - 800-273-8255, press 1

The Institute on Aging's Friendship Line (adults over 60 or with disabilities) - 800-971-0016

Boys Town Hotline - 800-448-3000

The Warm Line - 866-359-7953

Ayuda En Español

Lifeline ofrece 24/7, gratuito servicios en español, no es necesario hablar ingles si usted necesita ayuda - 888-628-9454

Live Chat or Text

Crisis Text Line-Text HOME to 741741

Veterans Crisis Line - Text 838255

National Suicide Prevention Chat - www.suicidepreventionlifeline.org/chat/

Veterans Crisis Line Chat - www.veteranscrisisline.net/get-help/chat

For speech and hearing impaired

Veterans Crisis Line-Support for deaf and hard of hearing - 800-799-4889

Boys Town-Speech and hearing-impaired: hotline@boystown.org

Multi-Lingual

Boys Town Spanish-speaking counselors and translation services for more than 100 languages also are available 24 hours a day hotline@boystown.org

For Local Resources

Chicago: Call 311 (NAMI is the vendor for the city of Chicago's 311 system for people calling for support or referrals for mental health care. Its direct line is 833-626-4244, M-F 9 a.m. to 8 p.m., Sa-Su 9 a.m. to 5 p.m.

All other regions: Call 211

Illinois Department of Human Services - www.dhs.state.il.us/page.aspx?item=30893

Illinois Websites

Suicide Prevention Resource Center for Illinois www.sprc.org/states/illinois

Illinois Department of Public Health Suicide Prevention www.dph.illinois.gov/topics-services/prevention-wellness/suicide-prevention

National Alliance on Mental Illness for Illinois - www.namiillinoisorg

National Websites

Suicide Prevention Lifeline - www.suicidepreventionlifeline.org/

Suicide Prevention Lifeline (Ayuda En Español) - www.suicidepreventionlifeline.org/help-yourself/en-espanol/

The Trevor Project for LGBTQ+ Youth - www.thetrevorproject.org/

Veterans Crisis - www.veteranscrisisline.net/

Center for Elderly Suicide Prevention - www.ioaging.org/services/all-inclusive-health-care/psychological-services/center-for-elderly-suicide-prevention

Centers for Disease Control and Prevention - www.cdc.gov/ViolencePrevention/suicide/index.html

Boys Town - www.boystown.org