



Illinois Suicide Prevention Alliance

State Agency Review and Initial Recommendations Report

**Recommendations of policy and program
changes to support suicide prevention**

April 2008

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EXECUTIVE SUMMARY

A groundswell of independent, grassroots suicide prevention efforts has been growing in Illinois for the last decade. After the Surgeon General's Call to Action on suicide in the early part of the decade, the groundswelling became a movement. The movement became a statewide suicide prevention in 2001 under the guidance of the Illinois Department of Public Health (Department). It was named "The Illinois Suicide Prevention Coalition" (ISPC). As the effort moved forward, it became evident that there was a need for the implementation of suicide prevention services throughout the state system. In 2004, the Illinois General Assembly unanimously passed the Suicide Prevention, Education and Treatment Act (Public Act 93-0907). This act created the Illinois Suicide Prevention Strategic Planning Committee, which is now entitled the Illinois Suicide Prevention Alliance (Public Act 095-0109). This advisory board is comprised of appointed representatives of state agencies and a range of other organizations; all of whom share the goal of suicide prevention.

In addition to the development and implementation of an Illinois Suicide Prevention Strategic Plan, the alliance was charged with reviewing the statutorily prescribed missions, policies and procedures of the Illinois departments of Public Health, Human Services and Aging and the State Board of Education. This report is a compilation of that review and includes recommendations to incorporate suicide prevention in the missions, policies and procedures of these state agencies.

The act correctly identified an important truth: in order to adequately address suicide in Illinois, it is necessary that prevention, education and treatment be integrated throughout the services delivered by state government. For this integration to be successful, the state agencies must work collaboratively. To this end, the alliance established the State Agency Review and Support Subcommittee in October 2006. The subcommittee consists of alliance members who represent various state agencies and it has met consistently since its inception.

The subcommittee began with an informal review of the statutory missions, policies and procedures of each state agency identified in the statute. This review was conducted by searching agency Internet and intranet Web sites for the term "suicide," as well as an introductory review of relevant administrative rules and statutes available on these sites. The results of this review are outlined below.

In addition to the review, the subcommittee examined national and state resources such as the National Strategy for Suicide Prevention, the draft Illinois Suicide Prevention Strategic Plan, and the best practices registries from the Suicide Prevention Resource Center and the Substance Abuse and Mental Health Services Administration (SAMHSA) to identify potential recommendations to include in this report. A review of legislation from other states was completed, and input was gained from the workgroups of the Illinois Suicide Prevention Alliance. Lastly, a review of local suicide prevention activities was conducted in order to identify potential local activities that could be recommended for implementation statewide.

SECTION 1: WEB PRESENCE REVIEWS

ILLINOIS DEPARTMENT OF PUBLIC HEALTH (DEPARTMENT)

The mission of Illinois Department of Public Health is to promote the health of the people of Illinois through the prevention and control of disease and injury. References related to suicide and suicide prevention are included in the larger category of injury.

Suicide and suicide prevention are topics that appear in many areas of the Department's Web site. The following are some examples:

- The Suicide Prevention, Education and Treatment Act (410 ILCS 53/), naming the Department as the lead in suicide prevention and mandating certain suicide prevention activities.
- Suicide and suicide attempt data – vital statistics, fatal occupational injury data, hospital discharge data, violent death reporting system and poison center reports. The data collected and used for statistics and reporting come from a broad range of sources and cover many different categories that address suicide specifically.
- Joint Committee on Administrative Rules has an administrative code on assessing suicide risk.
- Health Care Facility Requirements and Nursing Home standards has procedures on addressing suicide risk.

ILLINOIS DEPARTMENT OF HUMAN SERVICES (IDHS)

Illinois Department of Human Services is a large agency, with multiple specialized divisions that serve persons in specific circumstances. A broad overview was completed as part of this project. A more comprehensive review is needed to fully cover rules, procedures, policies and statutes applicable to its many entities. Mission statements for the IDHS divisions of Mental Health, Alcoholism and Substance Abuse, and the Office of the Inspector General, and the multiple offices within the Division of Community Health and Prevention contain no specific references to suicide or suicide prevention.

Suicide and suicide prevention are topics that appear in many areas of the IDHS Web site. The following are some examples:

- The work of the Illinois Suicide Prevention Coalition is included on the Web site. Multiple links refer readers to the Coalition's Web site.
- The Office of School Health, School Health Centers, and the Mental Health Subcommittee of the Coalition for School Health Centers have suicide-related information on the Web site. An example is a document entitled "Suicide Assessment and Management: Guidelines for Illinois." This is a helpful reference for data pertinent to suicide and attempted suicide in Illinois high schools. It also provides information on suicide-related resources.

- Maternal and Child Health Services have multiple measures used for analyzing their work. Several of these are specific to suicide.
- There is a link to the U.S. Food and Drug Administration's Children and Tobacco Homepage, which has a wide range of suicide-related links.
- Division of Alcoholism and Substance Abuse (DASA) has a Web presence that includes a wide range of resources relevant to suicide prevention.

One of the most important laws for IDHS' mental health services is the Mental Health and Developmental Disabilities Code. A substantial portion of this code spells out the steps that can be taken to protect someone from suicidality, and the situation in which these steps can be taken. An in-depth review is needed to fully research laws that address suicide and suicide prevention and are applicable to IDHS.

Although not included in the Web presence, it should be noted that IDHS's Division of Mental Health includes multiple state hospitals for persons with mental illnesses. A large percentage of the people in the state hospitals enter the hospitals for protection against suicidal impulses.

ILLINOIS STATE BOARD OF EDUCATION (ISBE)

Illinois State Board of Education operates under a vision statement and system, mission and leadership goals. No specific references to suicide prevention activities are included in the vision statement and goals. Areas where suicide prevention is addressed include the following:

The Illinois School Code

The Illinois School Code contains two sections related to suicide prevention; one deal with employees and the other concerns students. The 2006 Illinois School Code References to Suicide Prevention states:

- Adolescent and Teen Suicide Detection and Intervention Training is mandated for school guidance counselors, teachers, and other school personnel who work with students in grades seven through 12 (School Code Section 105ILCS 5/34-18.7 and 5/10-22.39)
- Self Destructive Behavior training is optional for grades six through 12 (School Code Section 105ILCS 5/34-18.7 and 5/27-23.2)

Periodic ISBE Surveys

ISBE as part of its cooperative agreement with the U.S. Centers for Disease Control and Prevention (CDC) conducts two surveys that contain questions related to suicide prevention.

The School Health Profile is given to a random statewide sample of health education teachers at the middle/junior and senior high school levels in even numbered years. The most recent survey (2006) asked the following questions regarding emotional and mental health, and suicide prevention:

(Question #3) Percentage of schools in which teachers tried to increase student knowledge on each of the following topics: 1) Emotional and Mental Health (96%) 2) Suicide Prevention (80%)

(Question #15) Percentage of schools in which the lead health education teacher has received staff development on each of the following topics during the past two years: 1) Emotional and Mental Health (39%) 2) Suicide Prevention (25%)

(Question #16) Percentage of schools in which the lead health education teacher would like to receive staff development on each of the following health topics: 1) Emotional and Mental Health (64%) 2) Suicide Prevention (74%)

Youth Risk Behavior Survey (YRBS) is a statewide random sample of high school (nine through 12) students conducted in odd numbered years. The 2007 YRBS contains the following five questions about suicide:

(Question #23) 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?

(Question #24) During the past 12 months, did you ever seriously consider attempting suicide?

(Question #25) During the past 12 months, did you make a plan about how you would attempt suicide?

(Question #26) During the past 12 months, how many times did you actually attempt suicide?

(Question #27) 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?

Social/Emotional Learning Standards (SEL)

The SEL Standards were adopted by the Illinois State Board of Education in December 2005. The Performance Descriptors were then created during 2006. Although these generally refer to social, emotional and mental health issues, some of the items may be relevant to suicide prevention as well. These can be viewed at http://www.isbe.net/ils/social_emotional/descriptors.htm.

ILLINOIS DEPARTMENT OF AGING (IDoA)

The mission of the Department on Aging is to serve and advocate for older Illinoisans and their caregivers by administering programs and promoting partnerships that encourage independence, dignity, and quality of life. The vision for the Illinois Department on Aging is that, united with local communities and the public and private sector, it will be both a leader and a partner in helping all older Illinoisans.

These programs include (<http://www.state.il.us/aging/laboutidoa/programs.htm>):

Older Americans Act services are provided by the Federal Older Americans Act with support from state funds; these community-based services are offered to individuals 60 and older. The services include the following: Senior Centers, Illinois Family Caregiver Support Program, Meals, Information and Assistance, Transportation, Outreach, Employment and Circuit Breaker and Pharmaceutical Assistance Program.

Elder Rights programs support the right and benefits of Illinois' vulnerable older population, including residents of long-term care facilities and victims of abuse, neglect and exploitation. The Elder Abuse and Neglect program is established through state law and is predominantly funded with state General Revenue Funds. Ombudsman and Legal Assistance are established under the Federal Older Americans Act with the Ombudsman program receiving some state

funding. The programs include the following: Elder Abuse and Neglect, Self-Neglect, Long-Term Care Ombudsman and Legal Assistance.

Community Care Program [Illinois Act on Aging, Chapter 20, Executive, (20 ILCS 105/]. Administrative Code – Title 89: Social Services, Chapter II: Illinois Department on Aging; Part 240: Community Care Program] is designated to help older adults live independently by providing in-home and community-based services to eligible older adults for each month. Case management program is provided.

Pursuant to Public Act 93-1031, the Department is mandated, in collaboration with the Illinois Department of Healthcare and Family Services, the Illinois Department of Public Health and other relevant agencies to work in consultation with the Older Adult Services Advisory Committee to transform Illinois' current older adult service delivery system from a primarily facility-based system to a primarily home- and community-based service delivery system.

As a part of the restructuring of the older adult service delivery system, the statute mandates the Department to implement a statewide holistic approach to case management. A comprehensive approach that assesses factors that contribute to individuals' quality of life and their ability to live independently in the community.

As part of the implementation of holistic case management, a new Comprehensive Care Coordination (CCC) assessment/reassessment tool has been developed and includes data depression and suicide/suicide prevention. Data analysis also will be used from the assessment/reassessment. However, there have not been any rules, policies and / or procedures. The programs include the following: Homemaker, Adult Day Service, Senior Companion, Choices for Care, and Emergency Home Response.

Community Services, Communications and Training – IDoA is to provide information, education and assistance to older adults, their caregivers and to the various target groups that have a stake in an aging society. The programs include the following: Senior HelpLine, Grandparents Raising Grandchildren, Gatekeeper Program, Training, and Publication, Audio Visual Resources, Speakers Bureau and Special Events.

WEB SITES:

- 1, https://www.aoa.gov/prof/notes/notes_suicide.asp
2. <http://www.apa.org/pi/aging/depression.html> (leads to many resources from that Web Site)

ADDITIONAL REVIEW AND INPUT

In addition to this review, subcommittee members also reviewed the Illinois Suicide Prevention Strategic Plan and solicited input from members of the Illinois Suicide Prevention Alliance to assist with identifying appropriate overriding and agency-specific recommendations.

INTER-STATE AGENCY RECOMMENDATIONS

Recommendations will be found below (see Page 10) for the Illinois departments of Public Health, Human Services and Aging and the State Board of Education. These were the four state entities that were required by law to conduct the reviews and formulate recommendations.

The State Agency Review and Support Subcommittee recommends that this process be expanded to include the review of all other state agencies. Such a move would highlight, and increase understanding of the suicide prevention, intervention, and crisis response/aftercare services that currently exist in the state system. The subcommittee also recommends the implementation of the Illinois Suicide Prevention Strategic Plan within all state agencies. A cursory review of additional agencies suggests that suicide prevention and intervention are not adequately addressed in the missions, policies and procedures of state agencies that were not included in the legislation.

The following steps have been identified in order to conduct a successful review of state agencies and implementation of the strategic plan.

IDENTIFY SUICIDE-RELATED ACTIVITIES AND PROGRAMMING THAT HAS OCCURRED AMONG STATE AGENCIES.

The subcommittee recommends that a consultant be engaged to conduct an inventory of suicide-related activities and programming that has taken place among all state agencies. This consultant should be broadly familiar with suicide prevention issues as they pertain to state government. The consultant, along with the state agency subcommittee, should first develop a semi-structured interview tool that can be used during personal interviews with state agency officials to gather the necessary information. A pilot agency should be chosen to test the survey and interview protocol. Once the protocol has been tested and any modifications made, the consultant should conduct the survey interviews with representatives from all state agencies. Appropriation of funding will be necessary to implement this recommendation.

At the conclusion of the interviews, the subcommittee should conduct an exit interview with the consultant to document the process, his or her experiences, reactions, any barriers encountered, and lessons learned. The subcommittee should then compile the survey results.

IDENTIFY ADDITIONAL SUICIDE-RELATED ACTIVITIES AND PROGRAMMING FOR STATE AGENCIES TO IMPLEMENT.

Upon completion of the compilation of the survey results, the subcommittee should review the results to identify similarities amongst agencies as well as areas of gaps in suicide prevention activities in the state. Using this information, the subcommittee should develop recommendations for the incorporation of suicide prevention into each state agency's mission, policies and procedures.

The subcommittee should then create a report, including the results of the survey and the recommendations, to be submitted to the Illinois General Assembly and the directors or other appropriate officials of each state agency that participated in the survey. This will provide legislators and agency officials with an understanding of the suicide prevention, intervention,

and crisis response/aftercare services that can be implemented in the state system to ensure system-wide care.

IDENTIFY AVENUES FOR IMPLEMENTING THE ACTION STEPS OF THE ILLINOIS SUICIDE PREVENTION STRATEGIC PLAN WITHIN STATE AGENCIES.

State agency representatives on the subcommittee should review the Illinois Suicide Prevention Strategic Plan and identify appropriate portions of the plan that could be implemented in their respective agencies. It is recommended that this process include the executive leadership of each state agency. State agency representatives who are not on the subcommittee should similarly be given the opportunity to review the strategic plan and identify proposed action steps, as well. Each representative should then collaborate with the appropriate work group to implement the steps. State agency representatives also are encouraged to communicate with their agencies' legislative liaisons about the elements of the Illinois Suicide Prevention Strategic Plan.

DEVELOP EMPLOYEE ASSISTANCE FOR SUICIDE PREVENTION.

The state of Illinois is one of Illinois' major employers. The National Strategy for Suicide Prevention recommends that the proportion of employers that ensure the availability of evidence-based prevention strategies for suicide is increased. Employers play an important role in suicide prevention. It is in the interest of employers to prevent suicide and suicidal behaviors.

According to Suicide Prevention Resource Center, "a large number of suicides and suicide attempts are related to treatable emotional conditions including depression and other mood disorders as well as alcohol and drug abuse. People may be embarrassed by those problems or fear that public disclosure will hurt their careers - although the Americans with Disabilities Act (ADA) prohibits discrimination in employment because of mental impairment." Even if an employee doesn't disclose mental health problems, the employer is in a unique position to recognize if an employee is struggling with these issues. Because an employer sees an employee on a regular basis, he or she may recognize changes in the employee's behavior, personality or mood. The most important thing an employer can do is to help the employee find professional help. Other appropriate suicide prevention activities for employers include:

1. Educating the workforce about the warning signs of suicide
2. Disseminating information about the sources of help available for persons who are feeling depressed or suicidal
3. Crisis response/aftercare for coworkers of an employee who has died by suicide. For employers with Employee Assistance Programs (EAPs), these would be good entities within which to locate such services. Employers without EAPs can still be encouraged to embrace suicide prevention activities.

RECOMMENDATIONS TO THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH**RECOMMENDATIONS TO THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH (IDPH)****ENHANCE DATA COLLECTION SYSTEMS WITH RESPECT TO SUICIDE**

- Mandate hospitals (including emergency departments) collect uniform and reliable data on suicidal behavior by coding external cause of injuries utilizing the categories included in the International Classification of Diseases.
- Implement the Illinois Violent Death Reporting System statewide.
- Identify and/or develop ways of using suicide death data in order to quickly identify changes in trends and needs.
- Encourage enhanced emergency room data collection on suicide attempts.
- Produce annual report on suicide and suicide attempts.

EDUCATION AND AWARENESS FOR CLIENTS AND THE GENERAL PUBLIC

- Require crisis response/aftercare suicide information to be given to all families and clients upon discharge from hospitals for suicide attempts or ideations and to families of persons who have died by suicide.
- Require hospital emergency departments to routinely provide immediate post-trauma psychological support and mental health education for all victims of sexual assault and/or physical abuse.
- Offer suicide prevention, intervention and crisis response/aftercare information, through the Illinois Department of Public Health, to local health departments and health care providers.
- Develop, or identify, and distribute information on the relationship between harassment, violence and suicide risk through health departments.
- Develop educational materials to make parents aware of safe ways of storing and dispensing common pediatric medications.

EDUCATION AND AWARENESS FOR SURVIVORS

- Identify and/or create resource packets and promote to local health departments.

EDUCATION AND AWARENESS FOR STAFF

- Require training of those who provide key services to suicide survivors (e.g., emergency medical technicians) that addresses their own exposure to suicide and the unique needs of suicide survivors.

- Review local emergency medical services protocols for suicide scene procedures and revise as needed.
- Train emergency room data collectors to improve quality of data collection.
- Work with nursing academic leaders to define minimum course objectives for providers of nursing care in assessment and management of suicide risk, and identification and promotion of protective factors. Explore with nursing academe and leaders about the best ways to incorporate such material into curricula for nursing care providers at all professional levels.
- Encourage IDPH and other large agencies to ensure communication and coordination of suicide prevention activities among all the divisions.

SCREENING

- Coordinate public health policy with the Joint Commission standards with respect to suicidality.
- Disseminate examples of good interview techniques (such as the American Psychiatric Association guide) broadly to hospital emergency departments.
- Offer free suicide screening through local health departments and health care providers.
- Develop or identify, and then disseminate, an emergency department screening tool to assess the presence of lethal means in the home.
- Increase the proportion of health care providers who routinely assess the presence of lethal means (including firearms, drugs and poisons) in the home and educate about actions to reduce associated risks.
- Develop or identify standardized suicide assessment guidelines for primary care physicians when assessing elderly patients.
- Collaborate with professionals, associations and stakeholders to develop or identify guidelines for assessment of suicidal risk among persons receiving care in primary health care settings, emergency departments, and specialty mental health and substance use disorder treatment centers.
- Work with the relevant trade, professional, consumer, and other stakeholder entities in order to encourage incorporation of screening for depression, substance use disorder and suicide risk in a minimum standard of care for assessment in primary care settings, emergency departments, specialty mental health treatment centers, specialty substance use disorder treatment centers, hospice services, intermediate care nursing facilities and skilled nursing facilities for all federally-supported health care programs (e.g., Medicaid, CHAMPUS/TRICARE, CHIP, Medicare).

- Work with stakeholders – including academe and professional groups – to develop curricula for staff working in facilities mandated to conduct suicide assessments and to response to suicidal crises.

TREATMENT

- Encourage follow-up between hospital staff and community agencies after a hospital discharge for suicide attempt.
- Implement stricter discharge standards.
- Develop guidelines for hospitals and health delivery systems that ensure adequate resources to implement confirmation of mental health follow-up appointments.
- Identify guidelines for aftercare treatment programs for individuals exhibiting suicidal behavior (including those discharged from inpatient facilities). Implement these guidelines in a proportion of these settings. Incorporate into licensure and certification requirements.

RECOMMENDATIONS TO THE ILLINOIS DEPARTMENT OF HUMAN SERVICES

RECOMMENDATIONS TO THE ILLINOIS DEPARTMENT OF HUMAN SERVICES (IDHS)

EDUCATION AND AWARENESS FOR CLIENTS AND THE GENERAL PUBLIC

- All state supported provider programs should be strongly encouraged to have information on suicide prevention to distribute.

EDUCATION AND AWARENESS FOR FAMILIES

- Develop or identify guidelines for providing education to family members and significant others of persons at risk for death by suicide who receive care for the treatment of mental health and substance use disorders. Implement the guidelines in all relevant treatment centers (including general and mental hospitals, mental health clinics, and substance use disorder treatment centers). **Note: Full implementation of this suggestion will require collaboration with the Department, which has statutory responsibility for oversight for general hospitals and nursing homes.**

EDUCATION AND AWARENESS FOR STAFF

- The following education components must be included in provider and state agency educational programming: suicide prevention, intervention and crisis response/aftercare.
- Offer educational opportunities within different integrated human service settings on the relationships between violence, harassment and suicide risk. Suicide related components should be able to deliver continuing education unit opportunities for those involved.
- Link more IDHS divisions to Illinois Suicide Prevention Alliance (ISPA) resources.
- Encourage IDHS and other large agencies to ensure communication and coordination of suicide prevention activities among all the divisions.

SCREENING

- Coordinate policy with the U.S. Centers for Medicare and Medicare Services standards with respect to suicidality.
- Determine the proportion of licensed mental health, substance use disorder, and health care treatment centers that have policies, procedures and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behaviors among their patients. (This goal also is shared by IDPH).
- Initiate a collaborative project with Illinois Department of Public Health and the private sector with the following goals: 1) Enhance coordination of the Illinois agencies that have a formal relationship with the National Suicide Prevention Lifeline; 2) Enhance the crisis response capacity of these agencies.

TREATMENT

- Increase the proportion of persons treated in the public mental health system for mood disorders who complete a course of treatment or continue treatment as recommended.

RECOMMENDATIONS TO THE ILLINOIS STATE BOARD OF EDUCATION

RECOMMENDATIONS TO THE ILLINOIS STATE BOARD OF EDUCATION (ISBE)

EDUCATION AND AWARENESS FOR CLIENTS AND THE GENERAL PUBLIC

- Develop and distribute information on the relationship between harassment, violence and suicide risk through schools.
- Require suicide prevention instruction in grades five through 12.
- Increase the proportion of school districts with evidence-based programs designed to address serious childhood and adolescent distress to prevent suicide.

EDUCATION AND AWARENESS FOR STAFF

- Collaborate with schools to work toward compliance with the self-destructive (suicide) curricula requirements in the Illinois School Code.
- Require teachers, counselors and social workers and other personnel to receive instruction in screening for depression and suicide prevention.
- Add two hours of suicide prevention education to certified staff mandatory continuing education hours.
- Implement training for school nurses to identify mental health conditions that contribute to a risk for suicide.
- Collaborate with the Illinois Suicide Prevention Alliance to provide rated curricula choices for schools to implement 2006 Illinois School Code Section 105ILCS 5/34-18.7, 5/10-22.39,5/34-18.7,5/27-23.2.
 - Provide Funding for 2006 Illinois School Code Section 105ILCS 5/34-18.7, 5/10-22.39,5/34-18.7,5/27-23
- Encourage ISBE and other large agencies to ensure communication and coordination of suicide prevention activities among all the divisions.

SCREENING

- Define guidelines for mental health (including substance use disorder) screening and referral of students in schools. Implement those guidelines in a proportion of school districts.

TREATMENT

- Develop guidelines for schools on appropriate linkages with mental health and substance use disorder treatment services and implement those guidelines in a proportion of school districts.

RECOMMENDATIONS TO THE ILLINOIS DEPARTMENT ON AGING

RECOMMENDATIONS TO THE ILLINOIS DEPARTMENT ON AGING (IDoA)

EDUCATION AND AWARENESS FOR THE AGING NETWORK

- Require all aging network staff to receive instruction in suicide prevention.
- Add training requirements for suicide/suicide prevention to Case Coordination Units and service providers.
- Provide education and awareness to the aging network and allow CEUs for professional and paraprofessional job classifications. Efforts should be made to connect training requirements with continuing education requirements of professional and paraprofessional staff.
- Include suicide prevention education and awareness on the IDoA Web page.
- Include speakers trained on suicide awareness within the IDoA speakers bureau.
- Encourage IDoA and other large agencies to ensure communication and coordination of suicide prevention activities among all the divisions.
- Require that aging networks have evidence-based suicide prevention programs designed to identify and refer for treatment elderly people at risk for suicidal behavior.

REPORT

- Include data and information regarding suicide prevention within the aging networks in the IDoA annual reports.
- Include suicide prevention resources in Title III Area Plans, Department Annual Report and Human Services plan.
- Assist in developing a national strategic plan for preventing suicides among the older adult population.

CONCLUSION

The Illinois Suicide Prevention Alliance respectfully submits these recommendations. In order to raise public awareness and reduce suicide in Illinois, it is necessary that suicide prevention, intervention, and crisis response/aftercare services be effectively implemented throughout all state systems. Effective implementation will require the collaborative efforts of state agencies and public and private organizations. We believe that the recommendations provided in this report will lead to an Illinois where life is affirmed and no one is touched by suicide.

APPENDIX

APPENDIX 1: EVIDENCE-BASED PRACTICES

EVIDENCE-BASED PRACTICES – PER SPRC/AFSP BEST PRACTICES PROJECT

Per the Suicide Prevention Resource Center/American Foundation for Suicide Prevention Best Practices Project, the following have been proven evidence-based:

Community-based Programs

- U.S. Air Force Suicide Prevention Program
http://www.sprc.org/featured_resources/bpr/ebpp_PDF/airforce.pdf - The U.S. Air Force suicide prevention program is a comprehensive, institution-wide intervention that focuses on enhancing protective factors and decreasing risk factors for suicide. Major goals of the program include:
 - Promoting awareness of the range of risk factors related to suicide;
 - Educating the community regarding available mental-health services; and,
 - Reducing the stigma related to help-seeking behavior.

These goals were achieved through the development of 11 initiatives (see table below) that targeted strengthening social support, promoting development of effective coping skills, and changing policies and norms so as to encourage effective help-seeking behaviors. Because of the universal nature of the risk and protective factors targeted by the program, reductions in other violent behavior also can be expected.

Eleven Key Initiatives of the US Air Force Program

1. Leadership Involvement
 2. Professional Military Education
 3. Guidelines for Commanders on Use of Mental Health Services
 4. Community Preventive Services
 5. Community Education and Training
 6. Investigative Interview Policy
 7. Critical Incident Stress Management
 8. Integrated Delivery System for Human Services Prevention
 9. Limited Patient Privilege
 10. Behavioral Health Survey
 11. Epidemiological Database and Surveillance System
 - **The above intervention addressing suicide also is listed on the National Registry of Evidence-based Programs and Practices Registry as a prevention program.**
- Reduced Analgesic Packaging -
http://www.sprc.org/featured_resources/bpr/ebpp_PDF/analgesic_limits.pdf - In response to an increasing number of self-poisonings with analgesics (acetaminophens and salicylates) in the United Kingdom, Parliament passed legislation in 1998 limiting the pack sizes of these drugs. Before the legislation, pharmacies could sell unlimited amounts of analgesic tablets. After legislation, pharmacies were limited to 32 tablets per sale and non-pharmacy outlets were limited to 16 tablets per sale. In addition to packaging limits, specific printed warnings about the dangers of overdose with these analgesics were included with all sales.

Emergency Department Programs

- ER Means Restriction Education for Parents
http://www.sprc.org/featured_resources/bpr/ebpp_PDF/emer_dept.pdf - The goal of this intervention is to educate parents of youth at high risk for suicide about limiting access to lethal means for suicide. Education takes place in emergency departments and is conducted

by department staff (an unevaluated model has been developed for use in schools). Emergency department staffs are trained to provide the education to parents of children who are assessed to be at risk for suicide. Lethal means covered include firearms, medications (over-the-counter and prescribed), and alcohol. To help with the safe disposal of firearms, collaboration with local law enforcement or other appropriate organizations is advised.

- ER Intervention for Teen Females and Their Mothers - http://www.sprc.org/featured_resources/bpr/ebpp_PDF/spec_emergency_rm.pdf - This intervention provides specialized emergency department care for female adolescent suicide attempters and their mothers. It involves three primary components: (1) Emergency department physicians and staff (psychiatrists, pediatricians, nurses, security guards and admitting clerks) engage in a single two-hour training session. The sessions have three goals: to enhance positive staff/patient interactions, reinforce the importance of outpatient treatment, and to recognize the seriousness of suicide attempts. (2) Suicide attempters and their parents view a 20-minute video. The video is designed to highlight the importance of and instill realistic expectations regarding outpatient treatment. (A Spanish language version of the video is available.) (3) Suicide attempters and their parents meet with a crisis therapist who discusses the video, screens for additional suicide risk, conducts a therapy session, and contracts for follow-up outpatient treatment.
 - **The above intervention addressing suicide also is listed on the National Registry of Evidence-based Programs and Practices Registry as a prevention program.**

Primary Care

- PROSPECT (Care Management for Elderly) http://www.sprc.org/featured_resources/bpr/ebpp_PDF/prospect.pdf - The Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) intervention combines treatment guidelines for community-dwelling elderly populations with care management for patients diagnosed as depressed. Guidelines consist of a clinical algorithm for treating geriatric depression in a primary care setting, with citalopram being the first-line recommendation for pharmacotherapy. Care management is conducted by a “depression care manager” who works with the primary care physician (PCP) and a supervising psychiatrist. As described in the PROSPECT protocols:
 - “In PROSPECT, a specially trained master-level clinician works in close collaboration with a depressed patient’s PCP to implement a comprehensive disease management program. When a patient had been diagnosed with a depressive syndrome that requires treatment, PROSPECT health specialists implement the various clinical tasks necessary for a successful treatment outcome, including educating older depressed patients and their family about depression, identifying and addressing comorbid physical and psychiatric conditions interfering with antidepressant treatment, monitoring adherence, managing treatment-emergent adverse effects and regularly assessing change in depressive symptoms to evaluate whether the current treatment is effective or whether it needs to be modified.” (Mulsant et al., 2001, p. 586).
 - **PROSPECT also is listed on the SAMHSA National Registry of Evidence-based Program as a prevention program**
 - **The above intervention addressing suicide also is listed on the National Registry of Evidence-based Programs and Practices Registry as a prevention program.**

School-based Programs

- **C-Care/CAST - C-Care/CAST**

http://www.sprc.org/featured_resources/bpr/ebpp_PDF/ccare_cast.pdf - Counselors-Care (C-Care) is a school-based intervention for students at risk for suicide. It combines one-on-one counseling with a series of small-group training sessions. C-Care provides an interactive, personalized assessment and a brief motivational counseling intervention. It is delivered in two sessions: a two-hour, one-to-one computer-assisted suicide assessment called the Measure of Adolescent Potential for Suicide (Eggert, Thompson, & Herting, 1994) and a two-hour motivational counseling intervention designed to:

1. Deliver empathy and support;
2. Provide personal information;
3. Reinforce coping skills and help-seeking behaviors;
4. Increase access to help; and
5. Enhance access to social support.

CAST (Coping and Support Training) is a small group skills training intervention. Twelve one-hour sessions incorporate key concepts, objectives and skills that are outlined in a standardized implementation guide. Sessions target mood management (depression and anger management), drug use control, and school performance by helping youth apply newly acquired skills and gain support from family and other trusted adult leaders. The implementation guide also specifies the motivational preparation and coaching activities required of the CAST leader (generally a master's level high-school teacher, counselor or nurse).

- **The above intervention addressing suicide also is listed on the National Registry of Evidence-based Programs and Practices Registry as a prevention program.**

- **Columbia University TeenScreen -**

http://www.sprc.org/featured_resources/bpr/ebpp_PDF/columbia-teenscreen.pdf - The purpose of the Columbia TeenScreen Program (CTSP) is to identify youth who are at risk for suicide and potentially suffering from mental illness and then ensure they receive a complete evaluation. While screening can take place in any number of venues, including juvenile justice facilities, shelters, and doctor's offices, the program has been primarily conducted in school settings. The program involves the following stages:

1. All students who have appropriate parent permission and who themselves assent to participation complete one of three self-administered screening instruments: (1) the Columbia Health Screen (CHS), (2) the Columbia Depression Scale (CDS), or (3) the Diagnostic Predictive Scales (DPS). The CHS is a 14-item self-report measure of suicide risk; the CDS is a 22-item depression screen; and the DPS is a computerized screen for depression, anxiety and substance use disorder.
2. Students who screen "positive" on the selected screening tool are interviewed by a clinician to determine if further evaluation is necessary.
3. Students who are found to require additional services are connected with a case manager to arrange for appropriate intervention.

Recognizing that schools differ in regards to administrative structure and resources, TeenScreen provides examples of several intervention models for students who screen positive and are deemed "at risk." These include existing staff, external team and one-person models.

- **The previous intervention addressing suicide also is listed on the National Registry of Evidence-based Programs and Practices Registry as a prevention program.**
- Lifelines – http://www.sprc.org/featured_resources/bpr/ebpp_PDF/lifelines.pdf - Lifelines is a school-based suicide prevention curriculum comprised of four 45-minute lessons. Lesson content includes:
 1. Information and attitudes about suicide, help seeking, and school resources;
 2. A discussion of warning signs of suicide and role-playing exercises for students who may encounter a suicidal peer (including an emphasis on seeking adult help); and
 3. Two videos: one that depicts appropriate and inappropriate responses to a suicidal peer, and one that documents an actual response of three eighth-grade boys to a suicidal peer after they had participated in Lifelines.

The program also includes school-based model policies and procedures for responding to at-risk youth, suicide attempts, and completions; presentations for educators and parents; and a one-day workshop to train teachers to provide the curriculum.

- Reconnecting Youth - http://www.sprc.org/featured_resources/bpr/ebpp_PDF/reconnecting_youth.pdf - Reconnecting Youth (RY) is a school-based selective/indicated prevention program that targets young people in grades nine through 12 who show signs of poor school achievement, potential for school dropout, and other at-risk behaviors including suicide risk behaviors. RY teaches skills to build resiliency with respect to risk factors and to moderate early signs of substance use disorder, and depression/aggression. The program incorporates social support and life skills training with the following components:
 - The RY class is a semester-long (~ 80-90 days) class that is divided into the following five modules: (1) getting started, (2) self-esteem enhancement, (3) decision making, (4) personal control, and (5) interpersonal communication. Forty-one class sessions and 23 booster/review sessions are included in the curriculum; this leaves 16 class sessions for the social activities/school bonding components. The class integrates small-group work and life-skills training models to enhance personal and social protective factors of high-risk youth;
 - Social activities and school bonding for establishing drug-free social activities and friendships, healthy pleasant activities for abating depression, as well as improving a teen's relationship to school;
 - School system crisis response plan that addresses important school-wide suicide prevention and intervention approaches; and,
 - Parent involvement that includes active parental consent for student participation and at-home support of RY goals for their youth.

The RY program has been recognized by numerous governmental agencies as an effective, model program for reducing substance use disorder and similar at-risk behaviors in youth. It was evaluated by EBPP for its effect on risk and protective factors related to suicide risk.

- SOS Signs of Suicide – http://www.sprc.org/featured_resources/bpr/ebpp_PDF/sos.pdf - SOS incorporates two prominent suicide prevention strategies into a single program, combining a curriculum that aims to raise awareness of suicide and its related issues with a brief screening for depression and other risk factors associated with suicidal behavior. In the didactic component of the program, SOS promotes the concept that suicide is directly related to mental illness, typically depression, and that it is not a normal reaction to stress or emotional upset. The basic goal of the program is to teach high school students to respond to the signs of suicide as an emergency, much as one would react to signs of a heart attack. Students are taught to recognize the signs and symptoms of suicide and depression in themselves and others and to follow the specific action steps needed to respond to those signs.
 - **The above intervention addressing suicide also is listed on the National Registry of Evidence-based Programs and Practices Registry as a prevention program.**

- Zuni Life Skills Intervention - http://www.sprc.org/featured_resources/bpr/ebpp_PDF/zuni_life_skills.pdf -The Zuni Life Skills Development (ZLSD) curriculum is a culturally tailored intervention that targets high school students. It is based upon social cognitive theory, which proposes that suicidal behavior is affected through the interaction of modeling influences (peer and community), environmental factors, and individual characteristics. By developing competency in a range of life skills, program participants decrease known risk factors while increasing protective factors.

The ZLSD curriculum contains the following seven units:

1. Building self-esteem,
2. Identifying emotions and stress,
3. Increasing communication and problem-solving skills,
4. Recognizing and eliminating self-destructive behavior such as pessimistic thoughts or anger reactivity,
5. Receiving suicide information,
6. Receiving suicide intervention training; and
7. Setting personal and community goals.

In its evaluated state, the curriculum was presented three times a week for 30 weeks in a required language arts class.

- **The above intervention addressing suicide also is listed on the National Registry of Evidence-based Programs and Practices Registry as a prevention program.**

Service Delivery

- Psychotherapy in the Home - http://www.sprc.org/featured_resources/bpr/ebpp_PDF/psy_intervention.pdf - This intervention provides four sessions of psychotherapy for adults who deliberately poisoned themselves. According to Guthrie et al. (2001), "This therapy entails identifying and helping to resolve interpersonal difficulties which cause or exacerbate psychological stress" (p. 1). It is adapted from a model developed by Hobson (1985) for the treatment of depression. The intervention is delivered by nurse therapists in the patient's home. Four, 50-minute sessions are offered over the course of a month. During each session, therapists assessed the risk of suicide and communicated with the patient's general practitioner."

EVIDENCE-BASED PRACTICES – PER SAMHSA NATIONAL REGISTRY OF EVIDENCE-BASED PROGRAMS

Per Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs, the following suicide prevention programs have been proven evidence-based:

- SOS Signs of Suicide is a two-day secondary school-based intervention that includes screening and education. Students are screened for depression and suicide risk and referred for professional help as indicated. Students also view a video that teaches them to recognize signs of depression and suicide in others. They are taught that the appropriate response to these signs is to acknowledge them, let the person know you care, and tell a responsible adult (either with the person or on that person's behalf). Students also participate in guided classroom discussions about suicide and depression. The intervention attempts to prevent suicide attempts, increase knowledge about suicide and depression, develop desirable attitudes toward suicide and depression, and increase help-seeking behavior.

Prevention Programs

- PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) aims to prevent suicide among older primary care patients by reducing suicidal ideation and depression. The intervention components are: (1) recognition of depression and suicide ideation by primary care physicians, (2) application of a treatment algorithm for geriatric depression in the primary care setting, and (3) treatment management by health specialists (e.g., nurses, social workers, and psychologists). The treatment algorithm assists primary care physicians in making appropriate care choices during the acute, continuation, and maintenance phases of treatment. Health specialists collaborate with physicians to monitor patients and encourage patient adherence to recommended treatments. Patients are treated and monitored for 24 months.
 - **PROSPECT also is listed on the SPRC/AFSP Evidence-based Practices Project as a primary care program.**
 - **The above intervention addressing suicide also is listed on the National Registry of Evidence-based Programs and Practices Registry as a prevention program.**

Treatment

- Cognitive Behavioral Therapy (CBT) for Adolescent Depression is a developmental adaptation of the classic cognitive therapy model developed by Aaron Beck and colleagues. CBT emphasizes collaborative empiricism, the importance of socializing patients to the cognitive therapy model, and the monitoring and modification of automatic thoughts, assumptions and beliefs. To adapt CBT for adolescents, more emphasis is placed on (1) the use of concrete examples to illustrate points, (2) education about the nature of psychotherapy and socialization to the treatment model, (3) active exploration autonomy and trust issues, (4) focus on cognitive distortions and affective shifts that occur during sessions, and (5) acquisition of problem-solving, affect-regulation, and social skills. As teens frequently do not complete detailed thought logs, internal experiences such as monitoring cognitions associated with in-session affective shifts are used to illustrate the cognitive model. To match the more concrete cognitive style of younger adolescents, therapists summarize session content frequently. Abstraction is kept to a minimum, and concrete

examples linked to personal experience are used when possible. The treatment program is delivered in 12-16 weekly sessions.

- **The above intervention addressing suicide also is listed on the National Registry of Evidence-based Programs and Practices Registry as a treatment program.**
- Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual.
 - **The above intervention addressing suicide also is listed on the National Registry of Evidence-based Programs and Practices Registry as a treatment program.**

EVIDENCE-BASED PRACTICES – ADDITIONAL PRACTICES ENCOURAGED BY SAMHSA

The following are among additional evidence-based practices that are encouraged by the Substance Abuse and Mental Health Service Administration for serious mental illnesses:

- Assertive Community Treatment (ACT) is a multidisciplinary treatment model for persons with serious mental illnesses whose illnesses are too severe for participation in standard treatment to be practical or realistic. Services are delivered to people in their own environments rather than waiting for people to come into the clinic. One of the key principles of ACT is 24/7/365 availability of team members to the person with the illness. Crises are addressed, when they occur, by staff members who are familiar with the individual(s) involved. Staff: consumer ratios are kept very conservative so that the availability is more than just theoretical. ACT should be made much more available by treatment systems that work with persons who have serious mental illnesses such as schizophrenia or bipolar disorder. People are at higher risk for suicide after discharge from an inpatient psychiatric hospitalization, and people are at higher risk for suicide if they have an illness like schizophrenia or bipolar disorder. Decades of research on ACT have shown it to be very effective, particularly at times of crisis.
- Medication algorithm is an evidence-based practice that addresses one of the most serious problems in the treatment of depression and other serious mental illnesses that exists. The problem is that many people who have depression and other serious mental illnesses are not given the medications that are recommended for the illnesses. Moreover, when people are treated with the recommended medications, they are frequently treated with substandard doses. Medication algorithms establish a sequence for use of particular medications for a particular disorder, as well as dose ranges, criteria for response, and duration for each medication trial. They are an operationalization of medication treatment guidelines. The goal is for persons with serious mental illnesses to be adequately treated in

order to increase the possibility of recovery. Recovery from an illness that increases the risk of suicide reduces the suicide risk that inheres in that illness.

- Family Psychoeducation is one of the most effective ways to manage the terrible symptoms and sequellae of schizophrenia, according to the American Psychiatric Association and the Agency for Health Care Policy and Research. The risk of death by suicide when someone is ill with schizophrenia is very real. Research has shown that there is a reduction in relapse rates by at least 50 percent when family intervention, multi-family groups, and medication are used concurrently. The treatment involves teaching family members and loved ones about the illness, its treatment, and ways to enhance the recovery process. It also involves the clinician(s) learning as much as possible about the person with the illness, and what s/he is like when well, from the family. The person with the illness defines the word “family” for purposes of this treatment. The lengthiest and most impressive research history with respect to family psychoeducation pertains to schizophrenia. It is important to note, however, that a growing body of research is finding similar results with other illnesses that carry an increased risk of death by suicide, such as bipolar disorder and major depression.
- Integrated Dual Disorders Treatment (IDDT) is a process of treating two disorders. It is widely known that the risk of death by suicide is increased in a variety of serious mental illnesses as well as in a variety of substance use disorders. When a person has both kinds of illnesses, s/he has both kinds of risk factors, and faces many more challenges to recovery. Some of these challenges inhere in the combination of symptoms of both types of illnesses. One of the major challenges, however, is external: it lies in the history of the helping professions. In most places, treatments for substance use disorders and for mental illnesses were, historically, fragmented: one system evolved to address addictions, and a different system evolved to address serious mental illnesses. The person who had both types of illnesses, in the past, was left to negotiate two very different treatment bureaucracies. The differences in the treatment bureaucracies frequently, around the country, included interdisciplinary tensions, conflicting treatment philosophies, and, all too often, conflicting recommendations to the person with the illnesses. Integrated dual disorders treatment involves the following: (1) Use of clinicians who understand addictions and mental illnesses and their interactions, and who treat both classes of disorders. (2) Stage-wise treatment: Different services are helpful at different stages of recovery. A person who does not believe, for example, that s/he has an addiction will not likely benefit from a recommendation to enter residential alcoholism treatment. A person who is at the stage of denial is more likely to benefit from interventions geared toward helping him or her question whether continued drinking is a wise choice. Once the person reaches the point of believing that s/he needs help, s/he is in a different stage, and is then more likely to benefit from recommendations for specific types of treatment. (3) Motivational treatment: Clinicians use specific listening and counseling skills to help consumers develop awareness, hopefulness, and motivation for recovery.

APPENDIX 2: SOURCES

Draft Illinois Suicide Prevention Strategic Plan, 2007

National Strategy for Suicide Prevention: Goals and Objectives for Action, Rockville, Md.: U.S. Department of Health and Human Services, Public Health Service, 2001. Document number SMA 3517. <http://mentalhealth.samhsa.gov/suicideprevention>

Illinois Department of Public Health Web site - www.idph.state.il.us

Illinois Department of Human Services Web site - www.IDHS.state.il.us

Illinois State Board of Education Web site - www.isbe.net

Illinois Department on Aging Web site - www.state.il.us/aging

Suicide Prevention Resource Center and American Foundation for Suicide Prevention's Best Practices Registry (BPR) For Suicide Prevention, on-line resource - http://www.sprc.org/featured_resources/bpr/index.asp

APPENDIX 3: ILLINOIS SUICIDE PREVENTION ALLIANCE (ISPA) MEMBERS

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