

State of Illinois
Rod R. Blagojevich, Governor

Department of Public Health
Damon T. Arnold, M.D., M.P.H., Director



2007 Illinois Suicide Prevention Strategic Plan



EXECUTIVE SUMMARY

This plan is dedicated to all people in Illinois whose lives have been affected by suicide.

Between 2001 and 2004, the statewide effort to address suicide began, and flourished, with facilitation from the Illinois Department of Public Health. The first meeting of the suicide prevention group was convened in 2002. The main task of the group was to develop a state plan for suicide prevention. By 2003, a rough draft of the plan was completed, which included key recommendations for suicide prevention. Members of the Illinois Suicide Prevention Coalition (ISPC), which is facilitated by the Illinois Department of Public Health (IDPH) and assists IDPH to mobilize agencies and individuals around the issue of suicide prevention, provided specific recommendations on the action steps of the plan and organized workgroups to begin these action steps. ISPC includes a wide range of people from across the state concerned with preventing suicide and suicide attempts.

In 2004, the Suicide Prevention, Education and Treatment Act (Public Act 093-0907) was passed by the Illinois General Assembly and signed into law by Gov. Rod R. Blagojevich. Public Act 093-0907 (<http://www.ilga.gov>) directed the Illinois Department of Public Health to appoint an advisory board entitled the Illinois Suicide Prevention Strategic Planning Committee. The committee represents statewide organizations and other agencies that focus on the prevention of suicide and the improvement of mental health treatment, or that provide suicide prevention or survivor support services. The committee is charged with the development and implementation of the Illinois Suicide Prevention Strategic Plan. In addition to the strategic plan, it also is charged with implementing: 1) a statewide suicide prevention conference, 2) a media campaign, 3) a public awareness campaign, 4) education initiatives, and, 5) if funds are appropriated, five pilot programs to provide training and direct service.

In 2007, an alliance was formed between the Illinois Suicide Prevention Strategic Planning Committee and the Illinois Suicide Prevention Coalition, unifying the strengths of these groups to continue to advance the plan. The joint mission of this alliance is “to reduce suicide and its stigma throughout Illinois by collaboratively working with concerned stakeholders from the public and private sectors to increase awareness and education, provide opportunities to develop individual and organizational capacity in addressing suicide prevention, and advocate for access to treatment.”

Suicide represents a major national public health problem. Each year -

- More than 1,000 Illinoisans die by suicide.
- A greater number of suicide deaths occur than deaths by homicide, HIV disease or impaired driving. In the years between 1999 and 2002, 5.5 percent more Illinoisans died from suicide than homicide.
- Suicide fluctuates between the second and third leading cause of death for adolescents in Illinois.
- Suicide attempts result in 650,000 emergency department visits and 30,000 deaths nationally.
- It is estimated there are approximately six immediate family members and close friends significantly affected by each suicide death. In many situations, the number of

people affected is far greater. This is especially true when the person who dies by suicide is a young person.

- In addition to the pain of loss by suicide, in Illinois, the annual estimated cost of suicide and medically treated youth suicide attempts is \$539 million.

Suicide is recognized as a chronic epidemic. Despite the overwhelming numbers, the tragedy of suicide is hidden by stigma, myth and shame. The stigma surrounding suicide serves to restrict prevention and intervention. Additionally, many people have the mistaken notion that talking about suicide causes it to happen. Today, experts agree that **suicide is preventable**. We must, as a society, reverse the many years of stigma that continue to keep people from discussing suicide.

Illinois is responding to this problem through the Illinois Suicide Prevention Strategic Plan, which extends the continued national efforts to address suicide. The U.S. Surgeon General's National Strategy for Suicide Prevention, published in 2001 by the U.S. Department of Health and Human Services, stated that the nation will "increase the proportion of states with comprehensive prevention plans by 2005 that (a) coordinate across government agencies, (b) involve the private sector, and (c) support plan development, implementation and evaluation in its communities."

The recommendations in the plan are comprehensive, complex and ambitious, as they should be. The scope of the suicide problem in Illinois demands the strongest and most professional response/aftercare.

The Illinois Department of Public Health extends its appreciation to those dedicated individuals who contributed time and expertise to the development of the plan. These included survivors, clinicians, professors, youth workers, elder care workers, psychiatrists, educators, researchers, human service personnel, clergy, law enforcement officers, coroners, suicide prevention experts, public health officials, health care providers, firearm safety advocates, violence prevention workers, and families and friends who have lost someone to suicide.

This 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 in this state. Together, we can ensure a better environment and better outcomes for persons with depression and other mental illnesses, and for persons whose life situations have brought seemingly unbearable pain. Quite simply, the plan challenges Illinois to save lives.

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Terms and Definitions:

Prevention¹ – A strategy or approach that does one of the following: 1) reduces the likelihood of onset of a health problem, 2) delays the onset of health problems or 3) reduces the harm resulting from conditions or behaviors.

Primary (universal) prevention – targets the general population (public education campaigns, media guidelines and school-based suicide prevention programs).

Secondary (selective) prevention – targets groups with a greater risk of becoming suicidal than the general population, often identified through screening mechanisms or by applying suicide prevention activities (gatekeeper training, crisis response/aftercare services, screening and social skills training).

Tertiary (indicated) prevention – targets individuals who exhibit clear signs of suicidal ideation or related emotional distress (case management, hospitalization, medication, support training and crisis response/aftercare services).

Intervention¹ – A strategy or approach that is intended to prevent an adverse outcome or to alter the course of an existing condition (such as strengthening social support in a community).

Crisis response/aftercare (also known as postvention¹) – A strategy or approach that is implemented after a crisis or traumatic event has occurred.

Suicidal ideation² - Any self-reported thought of engaging in suicide-related behaviors.

Suicide attempt² - Potentially self-injurious behavior with non-fatal outcomes, in which the evidence suggests: 1) the injury was self-inflicted, and 2) there was intention to kill one's self. Suicide attempts do not have to result in an actual injury.

Suicide² - A death that results from self-inflicted injury in which there is evidence that the person intended to kill him/herself.

*(Note: **Non-fatal attempt** is a preferable term to using terms such as “unsuccessful” or “failed.” Use of the term **suicide** is preferable to the phrase “successful suicide.”)*

Gatekeepers¹ – those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

¹ Glossary of Suicide Prevention Terms - National Strategy for Suicide Prevention: Goals and Objectives for action. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2001

² O'Carroll *et al*/O.Carroll, P.W., Berman, A.L., Maris, R.W., Moscicki, E.K., Tanney, B.L., and Silverman, M.M. (1996). Beyond the tower of Babel: A nomenclature for suicidology. *Suicide and Life-Threatening Behavior*, 26, 237-252.

ILLINOIS GOALS AND OBJECTIVES

The goals and objectives of this plan reflect the input of public and private organizations and stakeholders concerned with mental health. The plan is designed to reduce suicide through a positive public health approach.

Goal 1: Ask About Suicide

Educate everyone -- especially all mental health, social service, clergy, law enforcement and school personnel -- to ask about suicidal ideations and intentions.

Short-term Objective 1.1: By 2010, establish a technical assistance group (TAG) to assist all communities in their suicide prevention efforts.

Long-term Objective 1.1: By 2012, offer year-round suicide risk/depression/anxiety health screenings through 200 sites in Illinois; collect and evaluate data from the screening program to identify the most effective interventions.

Long-term Objective 1.2: By 2012, distribute suicide prevention information packets to major professional associations.

Long-term Objective 1.3: By 2012, offer free suicide screening, prevention, intervention and crisis response/aftercare information through the Illinois Department of Public Health, local health departments and health care providers.

Goal 2: Know Your Neighbor

Encourage networks of relatives, friends, neighbors and members of the faith community to decrease isolation, which is one of the strongest risk factors for suicide.

Short-term Objective 2.1: By 2010, host 100 community-based advisory collaboration committees to address isolation; target rural areas.

Long-term Objective 2.1: By 2012, sustain year-round public service awareness and collaboration activities in 200 communities to decrease isolation, increase neighbor-to-neighbor outreach and identify at-risk persons.

Goal 3: Treatment Works

Advocate for a comprehensive continuum of care for those at highest risk for suicide.

Short-term Objective 3.1: By 2010, broadly disseminate public education materials about current Medicare, Medicaid and private insurance benefits that support mental health services.

Long-term Objective 3.1: By 2012, distribute a report that addresses consumer needs regarding suicide prevention, mental health care and peer-to-peer support.

Goal 4: Ensure Safety to Live and Love

Promote utilization of suicide prevention services for victims of harassment and violence.

Short-term Objective 4.1: By 2010, develop and distribute information on the relationship between harassment, violence and suicide risk through health departments and schools, elementary through higher education.

Long-term Objective 4.1: By 2012, present educational opportunities in 50 different human service settings on the relationship between violence, harassment and suicide risk.

Goal 5 Knowledge is Power

Increase awareness of and competency in suicide prevention and treatment for first responders, educational personnel, health care providers, clergy, physicians, law enforcement, mental health professionals and social service personnel.

Short-term Objective 5.1: By 2010, offer at least 10 targeted continuing education opportunities on suicide prevention annually, throughout the state.

Long-term Objective 5.1: By 2012, influence higher education institutions to offer coursework on suicide screening, prevention and/or treatment.

Long-term Objective 5.2: By 2012, collaborate with schools to work toward compliance with the self-destructive (suicide) curricula requirements in the Illinois School Code.

Goal 6: Everyone Deserves Care

Increase access to mental health care.

Short-term Objective 6.1: By 2010, establish an advisory council on rural suicide prevention.

Short-term Objective 6.2: By 2010, establish sustainable activities and collaborations to disseminate information about existing public sector health insurance availability and community-based resources.

Long-term Objective 6.1: By 2012, organize and implement legislative advocacy in collaboration with other stakeholders for expanded mental health parity.

Goal 7: Data Counts

Improve suicide-related data collection.

Short-term Objective 7.1: By 2010, identify strengths and weaknesses of Illinois suicide data and the process of data collection.

Long-term Objective 7.1: By 2012, influence key stakeholders to expand Illinois' participation in the National Violent Death Reporting System.

Goal 8: Suicide is Everyone's Business

Increase public awareness of the benefits of restricting access to means of suicide.

Short-term Objective 8.1: By 2010, develop and initiate an advocacy campaign about the risks of suicide and preventing access to means of suicide.

Long-term Objective 8.1: By 2012, impact legislation and increase resources for the purpose of restricting means to suicide.

Goal 9: Help Break the Stigma

Reduce the stigma of suicide and increase the public's awareness that mental health care is a critical part of health care.

Short-term Objective 9.1: By 2010, implement a statewide speaker's bureau for presentations on suicide prevention.

Long-term Objective 9.1: By 2012, host suicide prevention week activities, town hall meetings, and/or suicide prevention presentations in 100 communities.

Long-term Objective 9.2: By 2012, collaborate with no fewer than 10 major statewide efforts to reduce the stigma of receiving mental health care.

Goal 10: Bank on Saving Lives

Develop sustainable funding sources for implementing suicide prevention, intervention and crisis response/aftercare programs in Illinois and for evaluation of the results in order to save more lives

Short-term Objective 10.1: By 2010, actively expand participation in suicide prevention lobby day advocacy efforts.

Short-term Objective 10.2: By 2010, develop sustainable funding streams for suicide prevention efforts.

Short-term Objective 10.3: By 2010, annually assess the current suicide prevention legislation; develop enhancements as needed.

Next Steps to Advance Suicide Prevention in Illinois

The alliance between the Illinois Suicide Prevention Strategic Planning Committee and the Illinois Suicide Prevention Coalition seeks to develop and enhance comprehensive suicide prevention, early intervention, and crisis response/aftercare programs and services across Illinois, building vital supports across diverse communities.

The following initiatives are recommended next steps in carrying out the goals of the strategic plan:

- * **Develop and Evaluate Five Model Suicide Prevention Comprehensive Pilot Programs (three-year programs)** - To develop and evaluate five comprehensive model programs statewide that include suicide prevention, intervention, and crisis response/aftercare in order to provide replicable, evidenced-based outcomes that other communities and service providers can use with adaptations.

- * **Implement a Suicide Prevention, Early Intervention and Training Initiative** – To:
 - 1) Develop and enhance the capacity of community gatekeepers statewide through community-based mini-grants to increase suicide prevention and early intervention skills through local education by experts in the field.
 - 2) Assess the current capacity and network of crisis lines.
 - 3) Enhance professional development abilities through a statewide conference on suicide prevention.
 - 4) Develop and enhance the capacity of health service providers statewide to increase suicide prevention and early intervention skills through local education by experts in the field.
 - 5) Develop and enhance the capacity of service providers to the aging population on suicide prevention and early intervention skills. To develop and enhance service provider skills to traumatized children in the child welfare system on suicide prevention and early intervention.

- * **Implement the Suicide Prevention Public Awareness Campaign** - To develop and implement a public awareness campaign to reduce the stigma of suicide, and increase awareness of risk factors, including mental illnesses, and promote linkage to human services for at-risk individuals.

- * **Develop and Implement a Suicide Prevention Community Outreach Initiative** - To build capacity across the state to promote local suicide prevention efforts by building/expanding 20-25 new effective and efficient coalitions and partnerships.

- * **Improve and Implement Suicide Prevention School-based Initiatives** - To support and build the following school-based initiatives:
 - 1) Professional development related to suicide prevention.
 - 2) Grants to school districts to develop and implement suicide prevention initiatives within their curricula, increase in-school mental health support, conduct staff development, and educate students and parents/other caregivers.

- * **Improve Suicide Prevention Data Collection and Analysis** – To:
 - 1) Develop and implement the Illinois Violent Death Reporting System (IVDRS) statewide in order to collect more effective and accurate data on suicide deaths in Illinois.
 - 2) Work with an epidemiologist to analyze suicide attempt data statewide, train providers on how to collect better data, and provide reports on data by county.

- * **Support Suicide Prevention Evaluation and Research** - To support research-based evaluation methods and technical assistance to plan for replication of suicide prevention efforts in Illinois according to outcome measures.

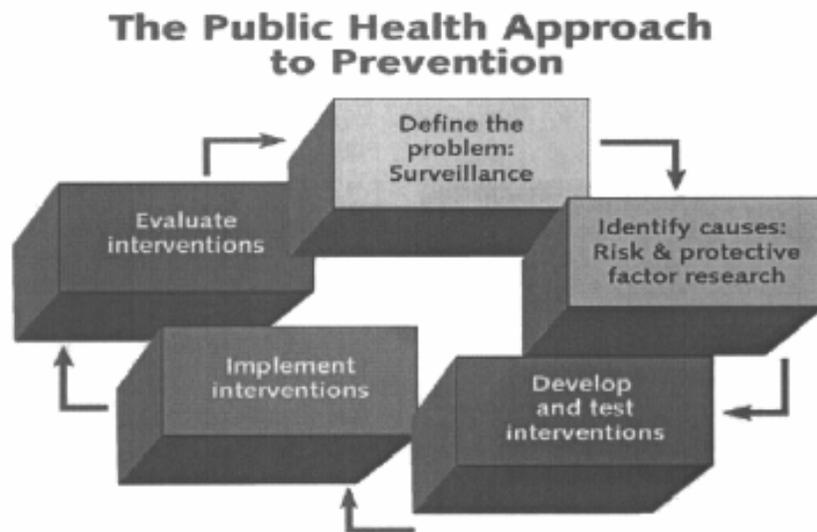
- * **Inventory Suicide Prevention, Intervention and Crisis Response/Aftercare Activities Within State Agencies** – To ensure suicide prevention, intervention and crisis response/aftercare services are implemented throughout the state system through the following activities:
 - 1) Identify suicide-related activities and programming that has occurred among state agencies.
 - 2) Identify additional suicide-related activities and programming from state agencies to implement.
 - 3) Identify avenues for implementing the action steps of the Illinois Suicide Prevention Strategic Plan.

SUICIDE AS A PUBLIC HEALTH PROBLEM

The National Center for Injury Prevention and Control (NCIPC) is working to raise awareness of suicide as a serious public health problem and is focusing on science-based prevention strategies to reduce injuries and deaths due to suicide. **The Surgeon General's Call to Action**, published in 1999, introduced a blueprint for addressing suicide – Awareness, Intervention and Methodology (AIM). The AIM methodology targets the risks inherent in undetected and under treated substance use and psychiatric disorders.

The public health approach to suicide prevention is a system of collecting data and organizing prevention efforts with a focus on identifying and addressing patterns of suicide and suicide-related behaviors in the population.

PUBLIC HEALTH APPROACH TO PREVENTION



Source: Suicide Prevention Resource Center

The steps may be sequential, or overlap. For example, the techniques used to define the problem, such as determining the frequency with which a particular problem arises in a community, may be used in assessing the overall effectiveness of prevention programs. Evaluating interventions must be built into implementation, and information gained from evaluations should guide the development of new interventions.

SUICIDE IN ILLINOIS: *

Statistics on suicide in Illinois reveal the broad impact of this public health problem. In the pages that follow, data is presented that depict overall trends related to suicide in the state.

Big picture

- More than 1,000 Illinoisans die each year by suicide. This number exceeds the number of deaths by homicide or HIV disease.
- Suicide is the 11th leading cause of death.
- For every adult suicide, there are an estimated 25 to 35 attempted adult suicides.

Race

- Suicide rates are 2.3 times higher for Caucasians than for African Americans.
- In recent years, a concerning trend of increasing suicide rates has been noted among African-American persons.

Gender

- Suicide rates are four times higher for males than females.

Adolescent and Young People

- In any given year, suicide is either the second or third leading cause of death for adolescents. The first leading cause of death is unintentional injury. Additional deaths go unrecognized as suicides.
- Thirteen percent of suicide deaths occur among young people between 15 and 24 years of age.
- More young people – ages 15 to 24 – die by suicide than by cancer and heart disease, COMBINED.
- For every adolescent suicide, there are an estimated 100 adolescent suicide attempts.

Urban vs. Non-Urban Counties

- The suicide rate for non-urban counties is nearly 5.25 percent higher than the rate for urban counties.

Firearms

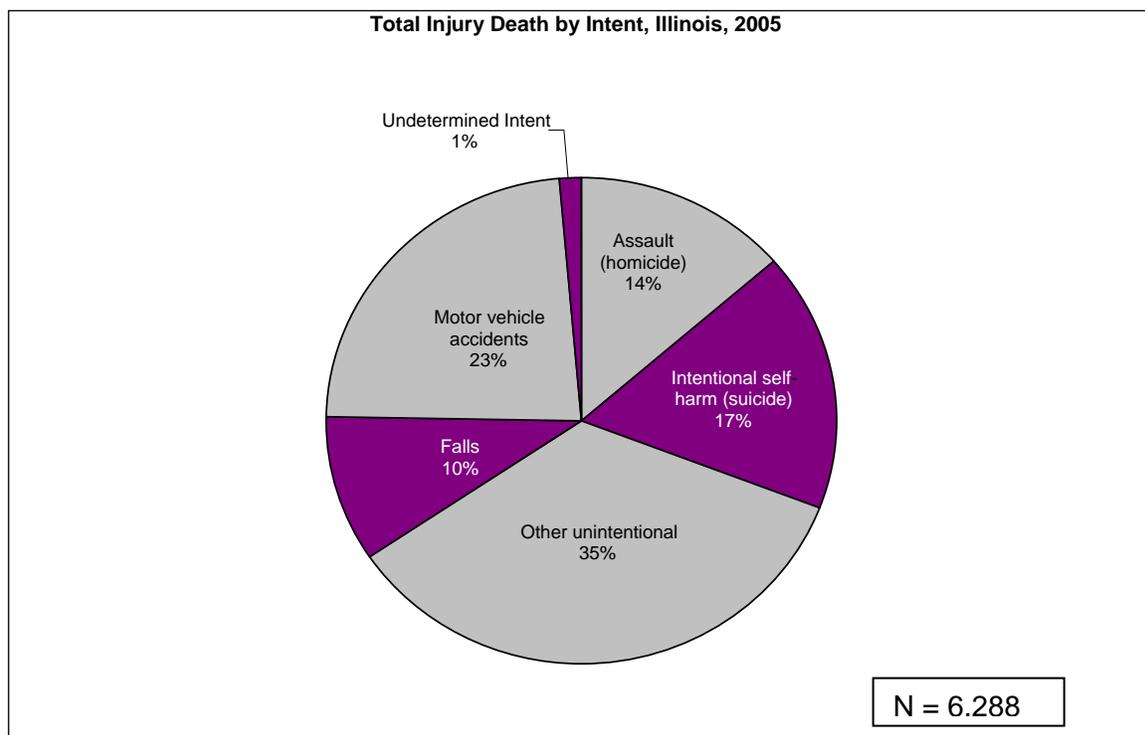
- Firearm suicide deaths comprise 39 percent of suicides.
- Homes with firearms experience a higher rate of suicide than homes without firearms which explains, in part, the reason why non-urban counties have a 15 percent higher rate of suicide than urban counties, since there is a higher percentage of homes with firearms in non-urban counties.

Cost

- The horrible pain of the loss of a loved one to suicide simply cannot be measured. The estimated annual cost of completed and medically treated youth suicide acts is \$539 million (Children Safety Network Economics and Insurance Resource Center, 1999).

BURDEN OF SUICIDE IN ILLINOIS:

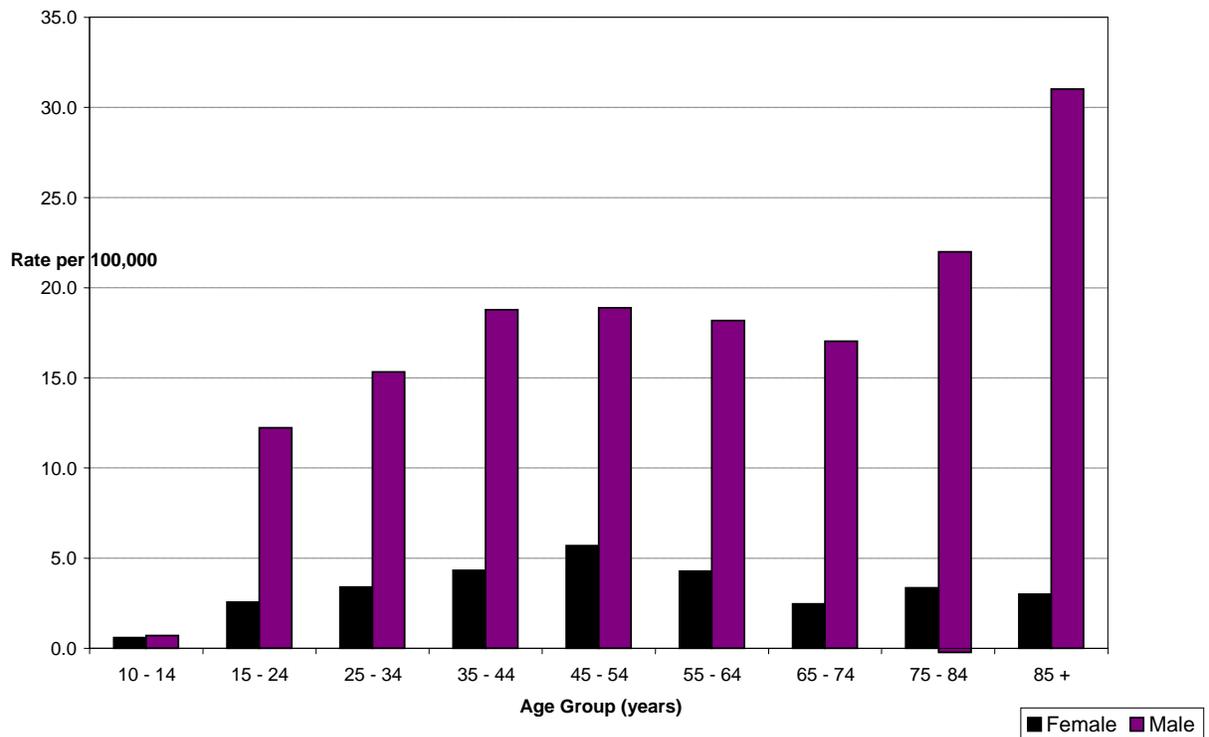
** Unless otherwise noted, data comes from the Illinois Department of Public Health*



Some Key Points:

- Motor vehicle related deaths account for 23 percent of total injury deaths. It is unknown how many of these are intentional crashes, yet it is assumed that a portion are suicides.
- In 2005, 1,073 suicides were reported.
- Homicide (14%) actually accounts for a smaller percentage of injury deaths than does suicide (17%).

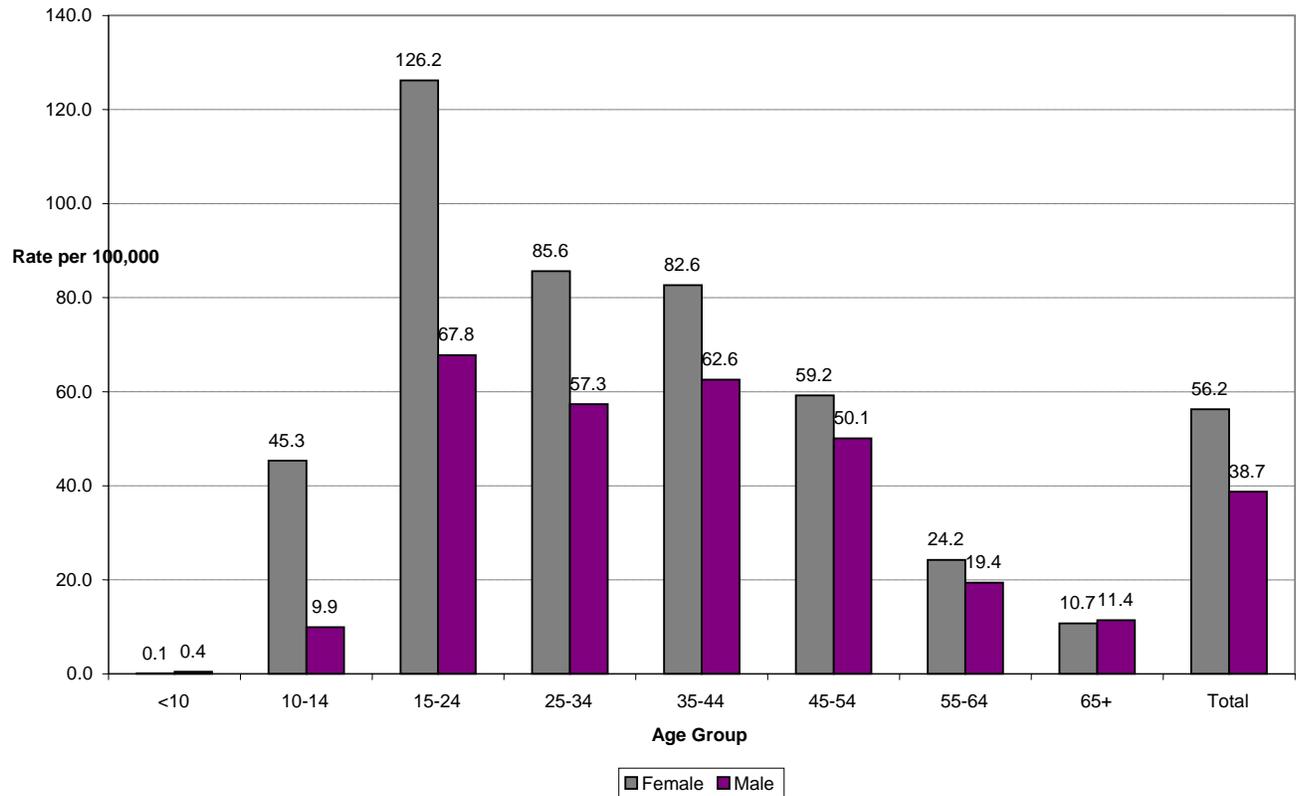
Average Annual Suicide Rates by Age Group and Sex, Illinois, 2003-2005



Some Key Points:

- Male suicide rates are 4.25 times higher than female rates.
- Female suicide rates peak for women in the age group of 45-54 years.
- Male suicide rates are higher in age group 85-plus years.
- Suicide is the third leading cause of death in the age group of 10-34 years after unintentional injuries and homicide.
- Suicide accounts for 10 percent of adolescent deaths.

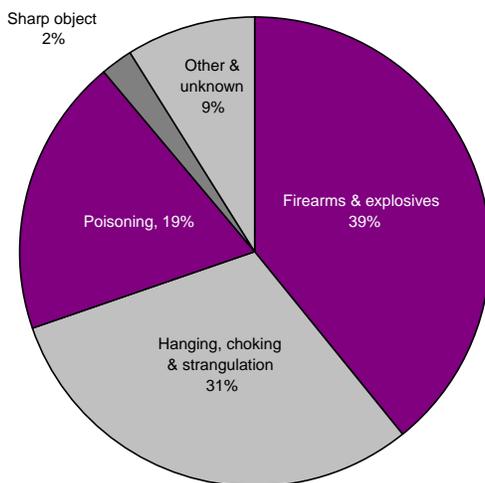
Self-inflicted Injury Hospital Discharges by Age and Sex, Illinois Residents, 2006



Some Key Points:

- Self-inflicted injuries, measured by discharges from hospitals for such injuries, are higher for females than for males.
- Self-inflicted injury rates for both males and females are highest in the age group of 15-24 years.
- The highest self-inflicted injury rate is in the age group of 15-24 years.
- One-third of self-inflicted injuries occur in young people in the age group of 15-24 years.
- Three-fourths of self-inflicted injuries occur in the age group of 15-44 years.

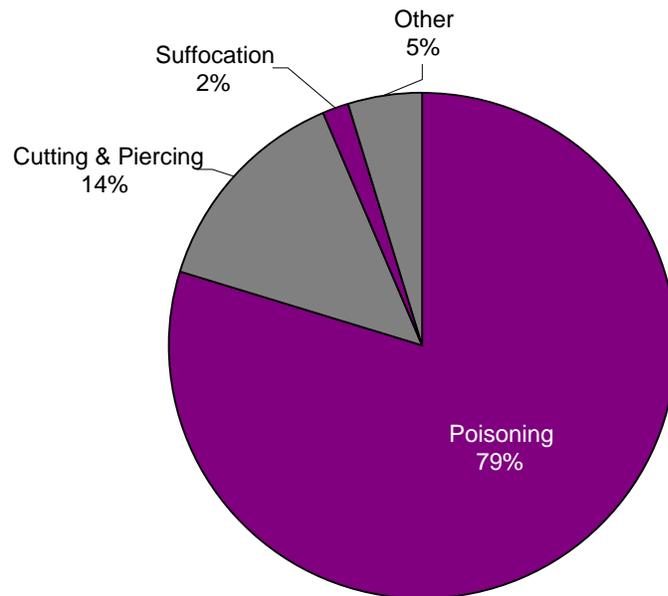
Suicide by Method, Illinois, 2003-2005



Some Key Points:

- Firearms is the number one method of suicide-related deaths.
- Suffocation, hanging and strangulation is the second leading mechanism for suicide-related deaths accounting for 25 percent of total completed suicides.
- Poisoning accounts for 19 percent of total suicides making it the third leading mechanism for suicide-related deaths. In comparison to the chart on the next page, illustrates that poisoning accounts for the leading mechanism for self-inflicted injury hospitalizations.

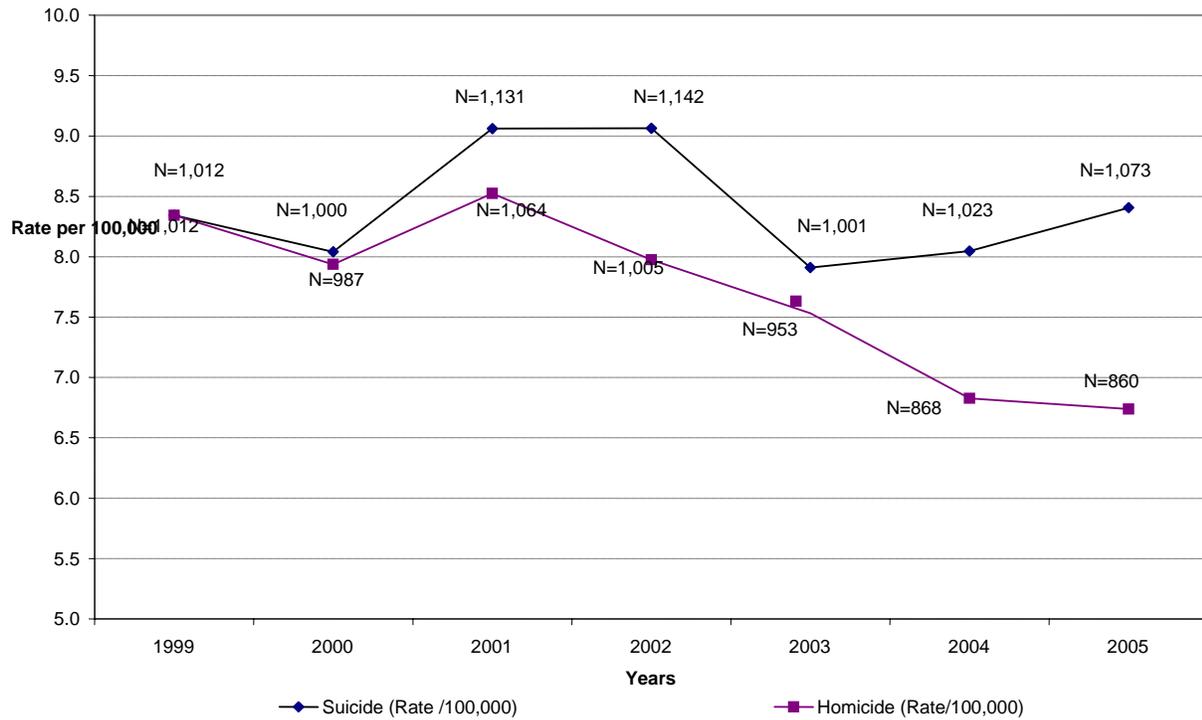
Self-inflicted Injury Hospital Discharges by Method, Illinois Residents, 2006



Some Key Points:

- The total number of self-inflicted injury hospitalizations in 2006 was 6,112.
- Poisoning accounted for 79 percent of total self-inflicted injury hospitalizations.
- Cutting and piercing accounted for 14 percent of self-inflicted injury hospitalizations.
- It is important to remember that the phrase “self-inflicted injury” is not synonymous with suicide. Many people who injure themselves have no desire to die.

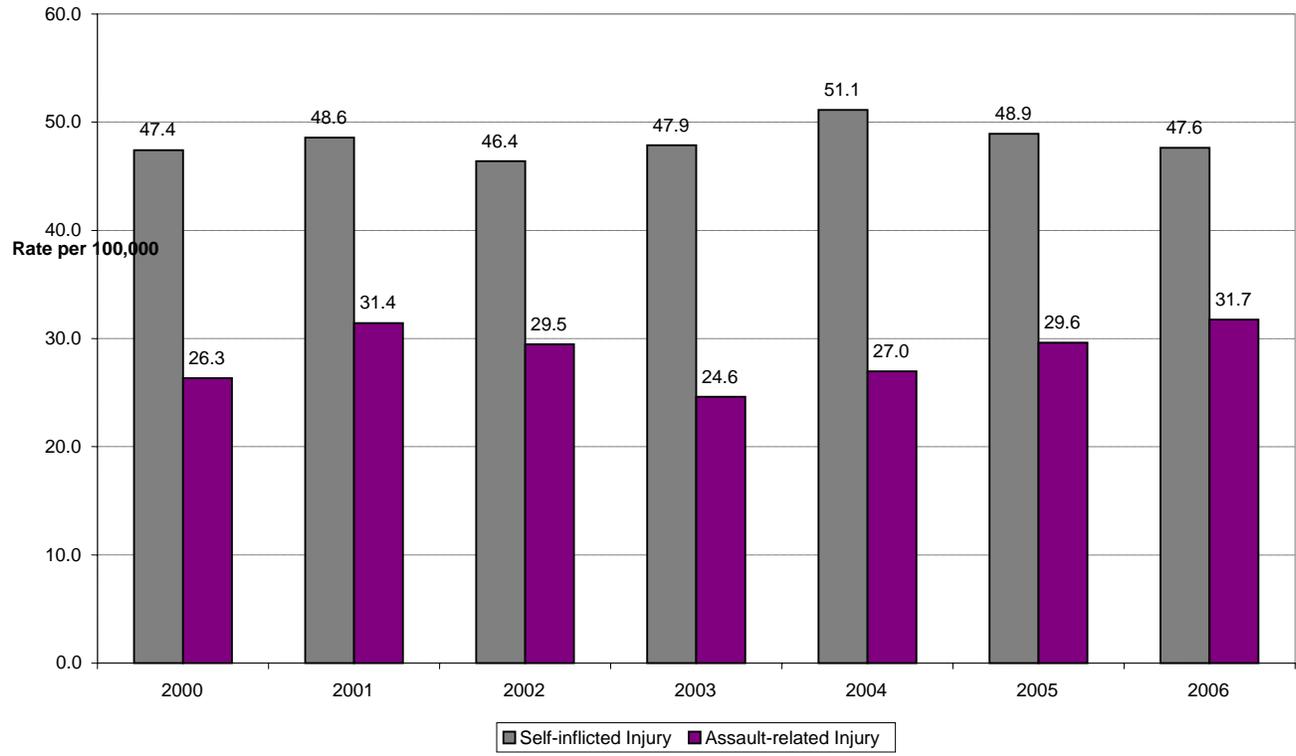
Trend in Suicide and Homicide, Illinois 1999-2005



Some Key Points:

- In 2005, the suicide rate was 1.25 times the homicide rate.
- In 2003-2005, the homicide rate decreased while the suicide rate increased.

Self-inflicted and Assault-related Injury Hospital Discharges, Illinois Residents, 1999-2006



Some Key Points:

- In 1999-2006, self-inflicted injury related hospital discharge rates consistently were higher than assault related hospital discharge rates.

RACIAL AND ETHNIC DIVERSITY AND SUICIDE PREVENTION

The growth of racial and ethnic minority groups in the United States has been well documented. Sadly, medical and mental health care systems are not adequately equipped to treat persons from diverse racial and ethnic backgrounds. Racial and ethnic minorities have more unmet mental health needs than Caucasians.

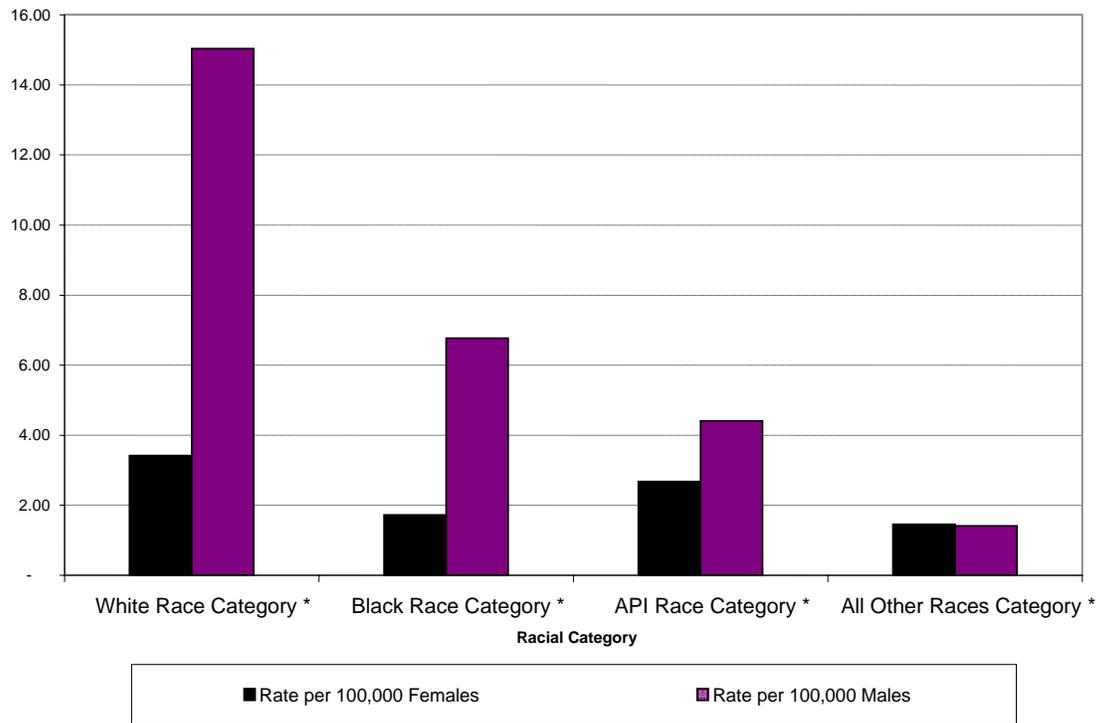
The Surgeon General has identified several barriers to health for racial and ethnic minorities. These include:

- Cost of care
- Stigma
- Disorganized, fragmented services
- Lack of awareness of cultural issues
- Bias
- Language limitations
- Racism and discrimination

Other authors speak of class-bound values, language bias and culture-bound values³. Racially diverse populations face more difficulties and challenges than the majority do, which may stress culturally bound coping skills and increase the risk of developing mental health issues.

³ Sue, D. W., and Sue, D. (1999). *Counseling the culturally different*. New York: Wiley & Sons.

Average Annual Suicide Rates by Race Category and Sex, Illinois, 2003-2005



* These are statistics race categories by the federal Office of Management and Budget (OMB)

Some Key Points:

- The white population has the highest overall suicide rate for both males and females.
- Male suicide rates are 4.4 times higher than female rates in the white population; 3.9 times in the black population; and 1.6 times in the Asian and Pacific Islander (API) population.
- Males have higher suicide rates than females, irrespective of race.

COMMUNITY NEEDS ASSESSMENT SURVEY – RESULTS

While preparing this strategic plan, a needs assessment was completed to gain ideas and suggestions about how to prevent suicide among Illinois citizens. Coalition members distributed the survey to state and local partners. The survey also was formatted as an on-line survey and the survey link was forwarded broadly. All survey results were inputted into a data base and the findings were computed.

Participants included a wide range of community sectors

Businesses	Media
Community-based Organizations	Parent Organizations
Counseling/Mental Health Organizations	Public Organizations
Faith Communities	Schools
Government (local/state) Agencies	Social Service Agencies
Legal/Criminal Justice/Juvenile Justice Agencies	Substance Abuse Prevention Agencies
Legislative Bodies	Survivors of Suicide
Health Care Organizations	Universities or Colleges

Need for programs

- 82 percent agreed that there is a significant need for suicide prevention programs for the citizens in their communities.
- 58 percent disagreed that people in their communities were receiving the treatment they needed for depression and other mental illnesses.

Question: Do you agree or disagree that the following factors would be barriers to development or implementation of a suicide prevention or intervention program for your community?

Barriers	Agree	Disagree
Funding	81%	5%
Stigma or fear of mental illness	66.5%	14%
Lack of staff or volunteers	64.3%	13%

	<u>Agree</u>	<u>Disagree</u>
Lack of technical assistance, training	53.3%	11.6%
Unmet need for good prevention models	47%	17.5%
Time constraints	45%	16.2%
Lack of interest	37%	32%
Potential negative parent response/aftercare	34%	29.5%

Question: Do you agree or disagree that your community needs the following tools to develop and implement a suicide prevention/intervention plan?

<u>Needs</u>	<u>Agree</u>	<u>Disagree</u>
Funding	79.6%	5%
Community support and participation	77.7%	5.1%
Staff and volunteers	77%	6.3%
Information on student reactions	73.4%	5.7%
Information on parent reactions	72.5%	5.7%
Consultation with communities that have developed programs	70.3%	7%
Research reports on program effectiveness	69.7%	5.7%
Information on how to develop a plan	67.4 %	11.3%
Legal input	66.0%	5.7%
Technical assistance with evaluation	65.4%	6.0%
Information on suicidal individuals	65%	9%

REFERENCE TO ISSUE PAPERS

Please note: Issue papers are being developed on a wide range of topics. Interested parties can contact the Illinois Department of Public Health to learn the status of these issue papers.

The following topics will be addressed:

- Access to Care for Persons Insured by Medicare
- Access to Means
- Access to Mental Health Care
- Child Abuse
- Clinical Depression
- College Students
- Cultural Issues Impacting Suicide
- Domestic Violence Related Suicide
- Educating Physicians
- Faith-based Role in Suicide Prevention
- First Responders
- Gender Issues Impacting Suicide
- Incarcerated Population
- Law Enforcement Role in Suicide Prevention
- Military
- Medical Illness
- Mental Illness
- Older Adults
- Role of the Media
- Rural Suicide Prevention and Access to Care
- Sexual Assault
- Sexual Identity
- Students
- Substance Abuse
- Survivors and Crisis Intervention in the Aftermath
- Youth in the Juvenile Justice System

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**“Suicide is not chosen;
it occurs when pain
exceeds resources for
dealing with pain.”**

— Dr. David Conroy

Sponsored by
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Copies of this plan are available from:
Illinois Department of Public Health, Injury and Violence Prevention Program
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