What is VORP?

The Veterans Outreach and Recovery Program (VORP) connects Veterans to community services, provides case management and support, with a special focus on treatment and recovery.

Support Services

VORP staff work with community partners and professionals to provide assistance and connection to:

- Mental Health Services
- Substance Abuse Treatment
- Financial Assistance
- Housing and Utilities
- Claims and Benefits Assistance
- Employment and Education
- Transportation
- And many other services

VORP funding may be available to assist with treatment and emergency services. Contact your field representative in your region.

Education

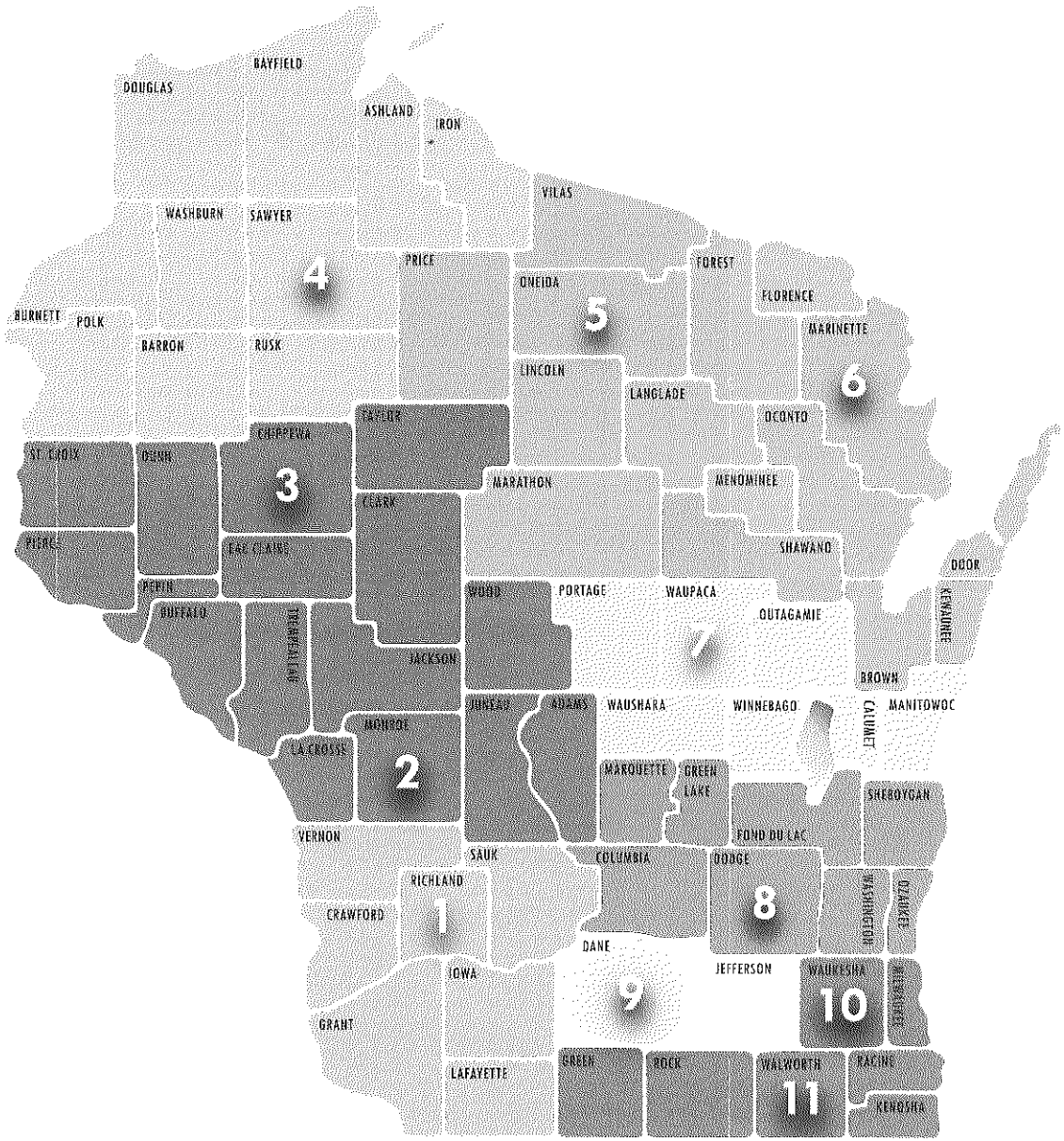
VORP is available to educate service providers and organizations on military culture, current issues, benefits, mental health intervention and prevention practices.

Who does VORP serve?

All who have served in any component of the US Armed Forces including those that have previously served and continue to serve in the National Guard and Reserve.

Veterans Outreach and Recovery Program Locations

72 Counties - 11 Regions



VORP Field Representative

11 Regions

- Region 1 608-306-0390
- Region 2 608-881-9116
- Region 3 608-381-1525
- Region 4 715-558-2557
- Region 5 715-401-4821
- Region 6 920-246-7277
- Region 7 715-409-3767
- Region 8 920-226-9898
- Region 9 608-215-6897
- Region 10 414-209-2064
- Region 11 262-225-7636

Call or text!

The goal of VORP is to assist and support Veterans with all aspects of daily living with a focus on:

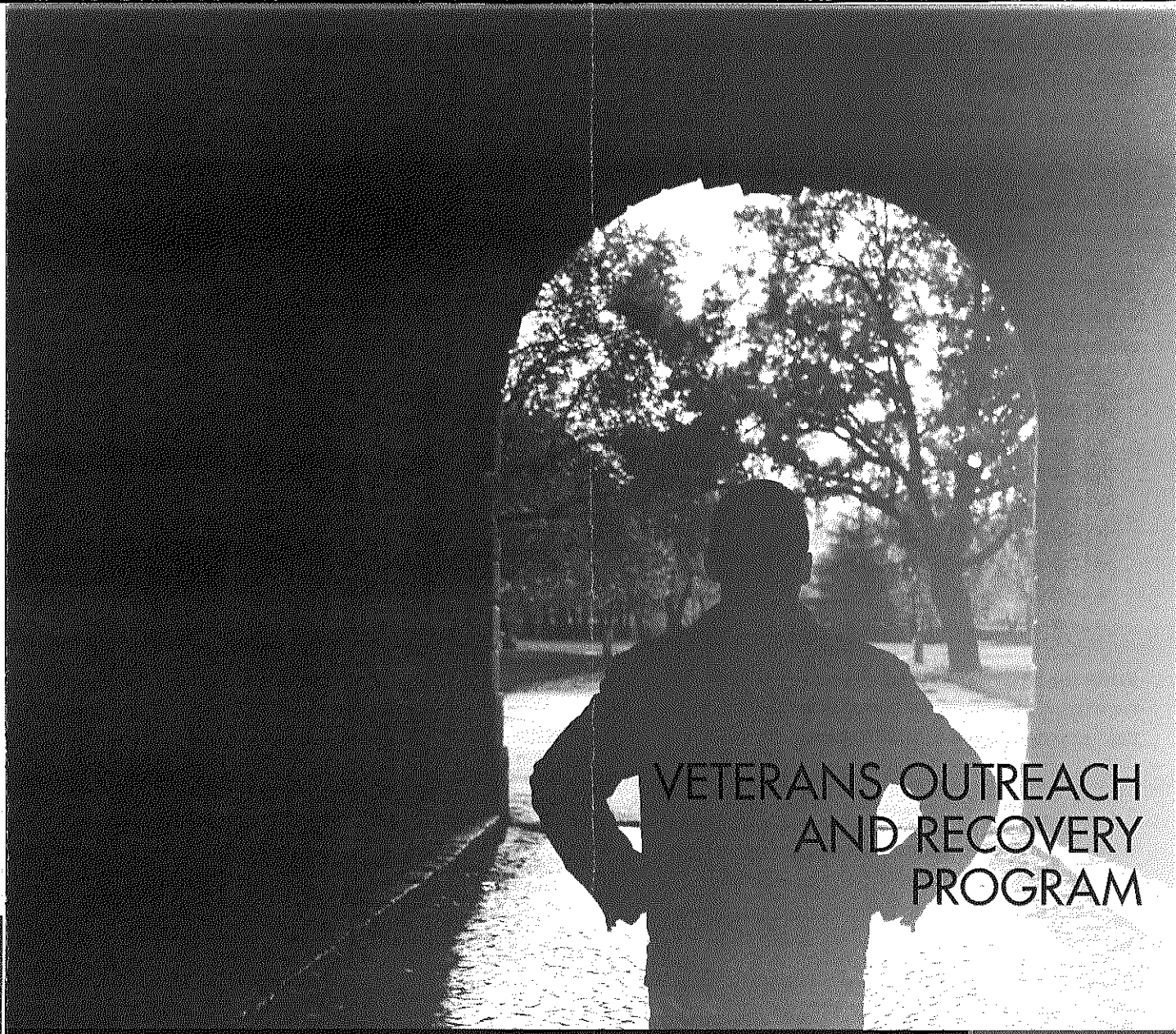
Home
Assistance in obtaining and maintaining a stable, safe place to live.

Health
Assistance in managing conditions and making choices that support well-being.

Recovery
Assistance overcoming mental health and/or substance use issues with funding available for treatment in some situations.

Purpose
Assistance in conducting meaningful daily activities to participate in society.

Community
Assistance in building relationships and social networks.



VETERANS OUTREACH AND RECOVERY PROGRAM

Learn more about our State Programs and Services >
1-800-WIS-VETS (947-8387) | WisVets.com

WDVA
Wisconsin Department of Veterans Affairs

VETERANS FORWARD

B2000 7/19

What are the components of the program?

- **Telephone** – Our telephone service provides callers with immediate assistance from trained professionals regarding information, support, assessment, intervention, emergency mental health service coordination and referral for additional, alternative or ongoing services. (Provided by NWC)
- **Mobile** – Our mobile crisis service provides an on-site and in-person intervention for individuals experiencing a mental health crisis. Each mobile team is located within the county they serve. (Provided by NWC)
- **Walk-In** – A walk-in service provides face-to-face support and intervention at an identified location or locations on an unscheduled basis. (Provided by the county department, a mobile crisis worker or an outpatient mental health provider)
- **Linkage and Coordination** – Linkage and coordination services connect consumers to their supports and/or support cooperation in the delivery of emergency mental health care within the county in which the program operates. (Provided by the county department following initial contact)
- **Stabilization** – This is an optional program component whereby an individual may receive emergency mental health services within one of the following settings (outpatient clinic, school, detention center, jail, crisis hotel, adult family home, CCI, or an individual's own home), during a transitional period of crisis. (Provided by the county department or another community provider)

NORTHWEST Connections

How are Emergency Mental Health Services programming funded?

Our program components are funded by county human services departments. Each county department may choose to become certified in emergency mental health services and in turn, have the ability to bill Medical Assistance and private insurance companies for these services. To add, counties have experienced significant cost reductions as result of program implementation.

What is the role of crisis planning in an Emergency Mental Health Services program?

Crisis prevention plans are developed to improve the overall treatment approach for the individual. Individuals should be engaged in the development of and agree with the crisis plan. Individuals are empowered to utilize natural supports and develop coping skills in the process. Crisis plans allow crisis workers to have access to important treatment information that can facilitate an intervention that fits within the goals of the overall treatment process. The planning facilitates a more effective, efficient treatment approach with the individual.

What are crisis worker qualifications?

Our crisis workers meet the requirements of DHS34.21. In addition, we focus on employing individuals who are competent, inquisitive, solution-focused, and empathetic. Each crisis worker receives extensive training in the area of crisis assessment and intervention. Our trainings focus on some of the following topics: basic mental health concepts, psychopharmacology, alcohol and other substances, crisis assessment, crisis intervention, and de-escalation techniques.

Northwest Connections Contact Information:

402 Technology Drive E, Menomonie, WI 54751
Phone: 888-552-6642 Fax: 715-235-0129

Ashley Williams, MSW, LCSW, Emergency Services Director; Call Center Clinical Coordinator
Phone: 715-939-0436 E-mail: AshleyWi@nwcgc.com

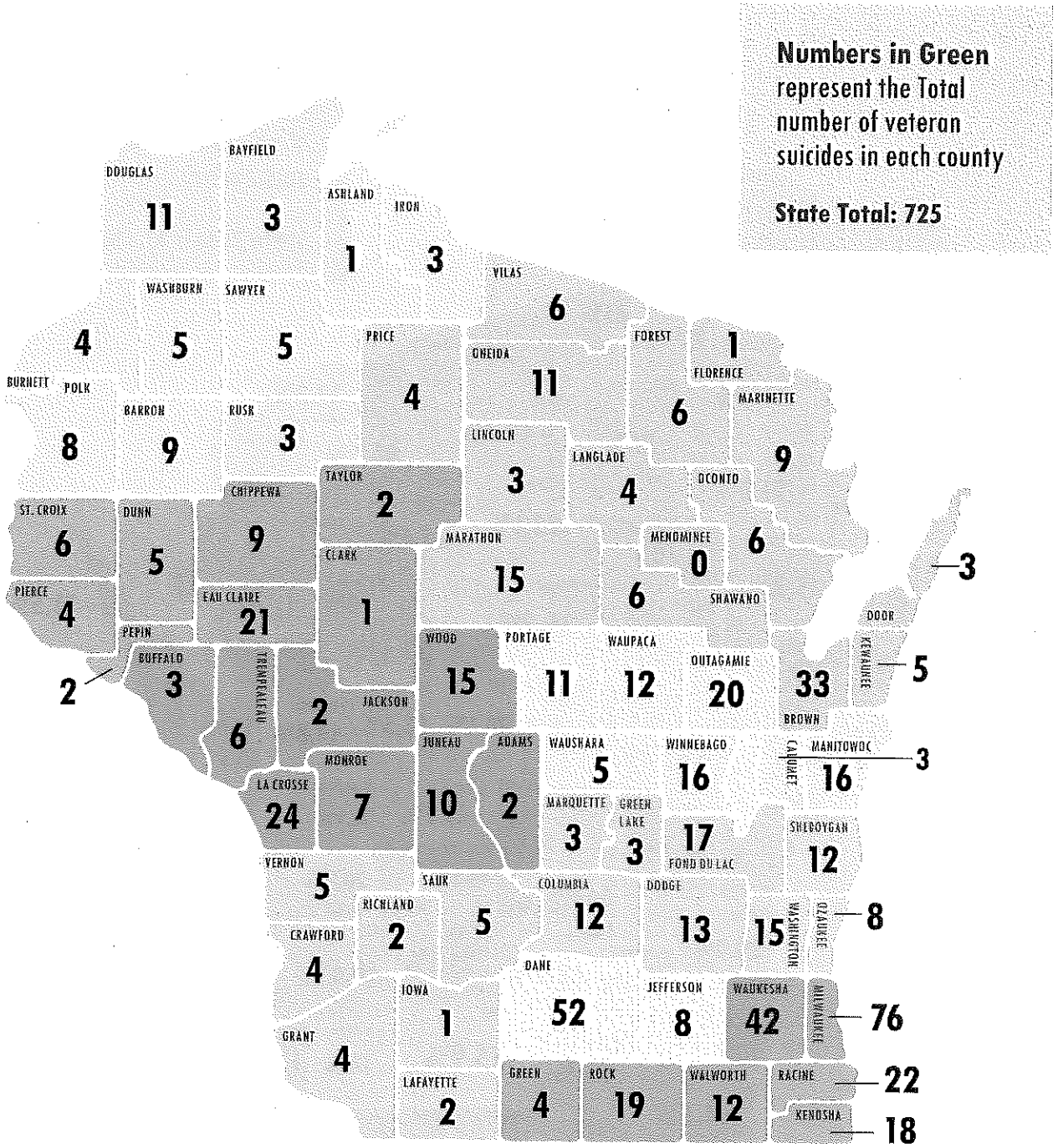
Heather Hainz, LPC, Northern Regional Clinical Coordinator
Phone: 715-937-5077 E-mail: HeatherH@nwcgc.com

Kathryn Erb, MSW, LCSW, Southern Regional Clinical Coordinator
Phone: 715-645-0243 E-mail: KatieE@nwcgc.com

Kayla Sessions, Call Center Supervisor
Phone: 888-552-6642 E-mail: KaylaS@nwcg.com

Wisconsin Veteran Suicides by County, 2013-2017

In Wisconsin, 3,382 adults died by suicide between 2013-2017.
Of these, 725, or 17.7 percent, were veterans.



Veterans Outreach and Recovery Program

The Wisconsin Department of Veterans Affairs' Veterans Outreach & Recovery Program (VORP) connects Wisconsin veterans to community services and provides case management and support, with a special focus on treatment and recovery. Regional Veterans Outreach and Recovery coordinators across the state, in collaboration with community providers and professionals, provide assistance and connection to: mental health services, substance use treatment, financial and employment assistance, housing and utilities, transportation, and more. Learn more at **WisVets.com**.

Thank you for forming this Task Force and asking for public comment on this issue. I won't speak to the science and facts of the emotional effects of suicide on families and loved ones, because I assume that is the motivating factor for this Task Force.

While I'm grateful for the press the Extreme Risk Protection law has received since our most recent mass shootings, I'm also concerned about the **focus** coming from our news media.

The focus seems to be on this law **"taking the gun or weapon away"** from a person who is identified as violent, and/or mentally ill.

The focus or intent of the Extreme Risk Protection Law is intended to be this:

Establishing a quick – usually 48 to 72 hour period – when law enforcement, a family member, or a qualified Mental Health provider can request that a person, felt to be exhibiting violent behavior, appear before a judge. The judge can assess the facts, and **require assessment for possible Mental Health treatment,** for that person. Yes, the judge can also temporarily remove weapons from the person. A well written law has penalties for falsely accusing a person of being dangerously violent.

The human capabilities of conscience, empathy, reasoning and hope are strengthened with this law. Why?

Because that CONSCIENCE alarm pings in our head, calling us to do something! ***Don't ignore what you see any longer.

EMPATHY allows us to feel the person's anguish and despair. Violently angry people are not happy people!

REASONING gives us the skills to design legislation to help with the problem.

HOPE, the most difficult emotion to maintain at times, is fueled by legislators helping families, Mental Health providers and law enforcement with this troubling and increasingly occurring issue.

The PURPOSE, the FOCUS of this law is to identify the violent person BEFORE they become a criminal and part of our incarceration system.

I heard a funny definition of a dysfunctional family recently.

It is "any family with more than one member".

And lastly, my take as a parent – a mom, grandmother and great-grandmother :

Most parents know that if 1 of their kids is beating 1of their siblings over the head with a toy - even if it's a Teddy Bear - you run over and take the " toy" away. Then comes the behavior lesson. That is the Extreme Risk Prevention Law, and required Mental Health Treatment is the lesson.

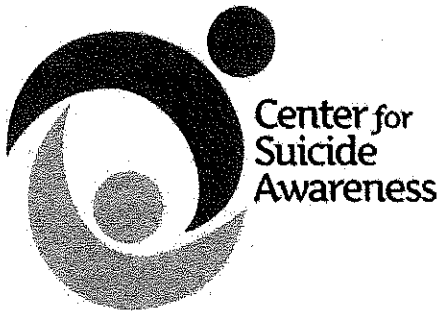
Once more with feeling.

The PURPOSE is to identify the violent person BEFORE they become a criminal and part of our incarceration system.

Janet Frase, 2516 E. Princeton Ave., Eau Claire 715-514-2157

member of the Communition Coalition for Non-Violence

Ljfrase2516@gmail.com



Mike Crum Veterans Education and Outreach

Center for Suicide Awareness

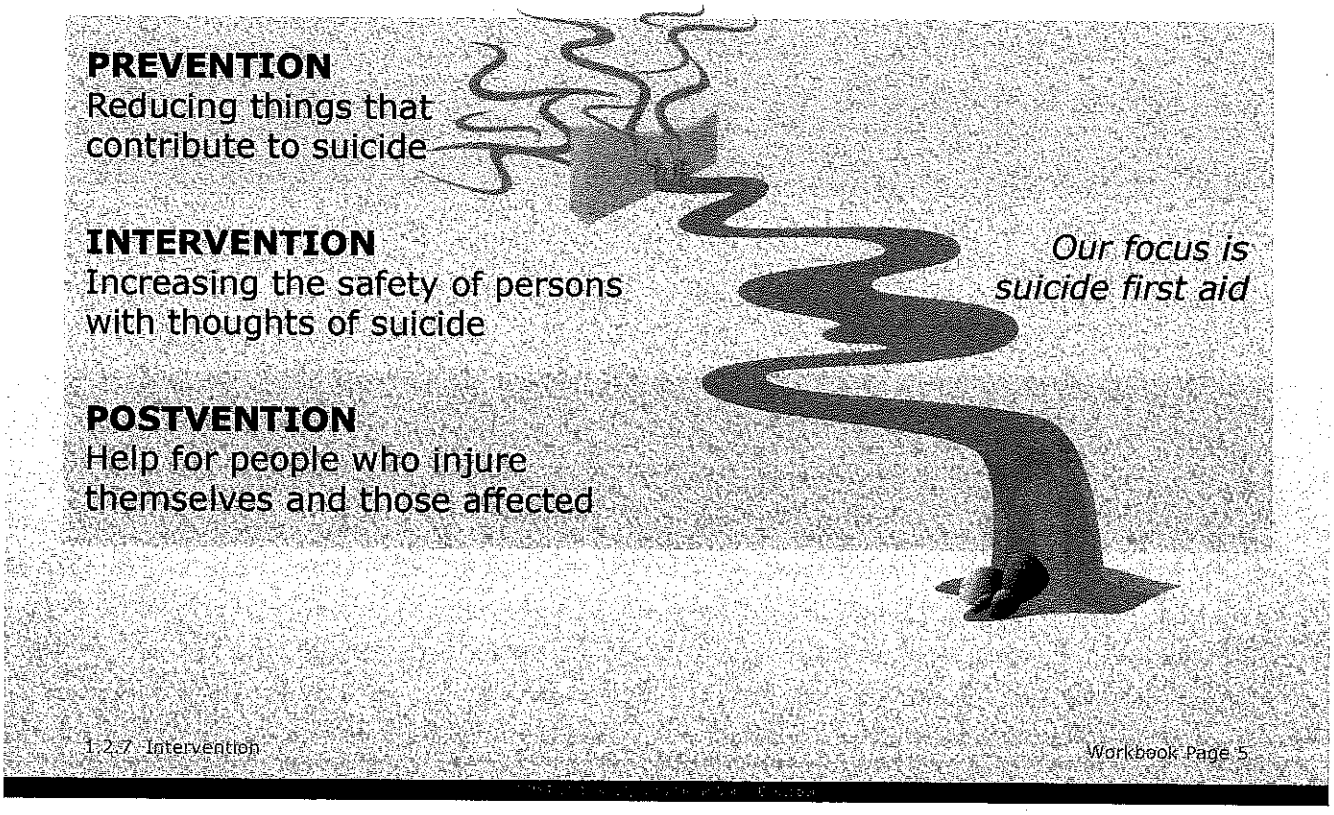
There are 3 ways to think about Suicide. The two most common are Prevention – and Post-vention. In Prevention those are our community organizations having the discussion about suicide, training, collaborations, and helping community members at risk of suicide.

We focus on Postvention, those who attempt suicide, those affected by suicide, community resources, those who died by suicide, family members, help a community understand what happened, post vention is going into schools to help students cope with the trauma.

Another way of Reducing Suicide is focusing on intervention. Creating more systems, data, and real time crisis response that can help Persons with thoughts of suicide in real time or within 48 – 72 hours.

This Morning I would like to focus on areas of Intervention and make recommendations to the Task Force on how to focus on Intervention.

Ways of Preventing Suicide



Having Accurate Data

- According to the U.S. Department of Veterans Affairs Between 2007 and 2011 there were 598 Wisconsin Veteran Suicides
- According to the 2014 Burden of Suicide Report in Wisconsin in that same period of 2007 – 2011 680 Wisconsin Veterans died by suicide
- This is a difference of 82 Veterans not reported properly
- In a different Report the VA shows that in 2014 there were a total of 133 Wisconsin Veteran suicides. The most being veterans within the age range of 55-74 and the next highest being 35-54.
- Based on two reports from the U.S. Department of Veterans Affairs, one Report suggests that 109 Wisconsin Veterans Died by suicide, in a separate report it shows that 106 Wisconsin Veterans Died by Suicide.
- In 2016 The U.S. Department of Veterans Affairs reported that there were 132 Veterans Suicides. The most being in the age range of 55-74 and next highest being in the age range of 35-54.
- Female Veterans suicide rate is 2 to 3 times higher than the female civilian population, and female veterans are more likely to use lethal means like firearms to attempt/complete suicides.
- The Wisconsin Department of Veterans Affairs does not track Veterans suicide.

A recent report by America's Warrior Partnership and their Operation Deep Dive Research Proejct on Veterans Suicide States that their biggest issue in collecting data, is that Veterans suicides are not collected and maintained in a Systematic Way Nationwide. (Operation Deep Dive Report 2018)

As the data above shows Data is inconsistet, and lacks demographics. We cannot fully understand the problem is we have no mandatory system of reporting.

Along with this demographics are not determined beyond age. How many Female Veterans, Male Veterans, Female Veterans with Kids, Combat vs non combat veterans, National Guard Soldiers and Branch of Service.

Having this identifying information would be helpful in creating stratetgies to reduce veterans Suicide.

17	2005	Midwest	Wisconsin	Total	123	27.5	610	15.0
18	2005	Midwest	Wisconsin	18-34	<10	--	183	15.5
19	2005	Midwest	Wisconsin	35-54	50	40.3	272	16.5
20	2005	Midwest	Wisconsin	55-74	39	19.6	106	11.6
21	2005	Midwest	Wisconsin	75+	20-30	--	49	14.9
397	2006	Midwest	Wisconsin	Total	118	26.6	654	15.4
398	2006	Midwest	Wisconsin	18-34	<10	--	158	12.6
399	2006	Midwest	Wisconsin	35-54	55	45.1	342	20.6
400	2006	Midwest	Wisconsin	55-74	40	20.3	119	12.5
401	2006	Midwest	Wisconsin	75+	10-20	--	35	9.6
677	2007	Midwest	Wisconsin	Total	109	24.5	711	16.6
678	2007	Midwest	Wisconsin	18-34	10	34.5*	203	16.2
679	2007	Midwest	Wisconsin	35-54	44	37.6	324	19.5
680	2007	Midwest	Wisconsin	55-74	35	17.7	138	14.0
681	2007	Midwest	Wisconsin	75+	20	19.8	46	12.3
957	2008	Midwest	Wisconsin	Total	124	28.6	730	16.9
958	2008	Midwest	Wisconsin	18-34	<10	--	186	14.7
959	2008	Midwest	Wisconsin	35-54	45	39.5	322	19.6
960	2008	Midwest	Wisconsin	55-74	45	23.4	176	17.2
961	2008	Midwest	Wisconsin	75+	20-30	--	46	12.4
1237	2009	Midwest	Wisconsin	Total	124	29.3	696	16.0
1238	2009	Midwest	Wisconsin	18-34	10	33.3*	171	13.2
1239	2009	Midwest	Wisconsin	35-54	39	36.1	310	19.1
1240	2009	Midwest	Wisconsin	55-74	46	24.9	164	15.4
1241	2009	Midwest	Wisconsin	75+	29	29.0	51	13.8
1517	2010	Midwest	Wisconsin	Total	141	33.7	762	17.5
1518	2010	Midwest	Wisconsin	18-34	<10	--	203	16.0
1519	2010	Midwest	Wisconsin	35-54	43	41.3	312	19.5
1520	2010	Midwest	Wisconsin	55-74	56	30.9	187	16.9
1521	2010	Midwest	Wisconsin	75+	30-40	--	60	15.9
1797	2011	Midwest	Wisconsin	Total	103	25.0	715	16.3
1798	2011	Midwest	Wisconsin	18-34	10	31.3*	218	17.0
1799	2011	Midwest	Wisconsin	35-54	28	28.6	293	18.7
1800	2011	Midwest	Wisconsin	55-74	44	23.9	153	13.4
1801	2011	Midwest	Wisconsin	75+	21	21.4	51	13.4
2077	2012	Midwest	Wisconsin	Total	95	23.2	697	15.8
2078	2012	Midwest	Wisconsin	18-34	14	43.8*	209	16.2
2079	2012	Midwest	Wisconsin	35-54	31	32.6	282	18.2
2080	2012	Midwest	Wisconsin	55-74	34	18.8	159	13.4
2081	2012	Midwest	Wisconsin	75+	16	15.8*	47	12.2
2357	2013	Midwest	Wisconsin	Total	123	30.7	825	18.6
2358	2013	Midwest	Wisconsin	18-34	19	57.6*	226	17.5
2359	2013	Midwest	Wisconsin	35-54	34	37.4	328	21.5
2360	2013	Midwest	Wisconsin	55-74	40	22.9	210	17.1
2361	2013	Midwest	Wisconsin	75+	29	28.4	61	15.8

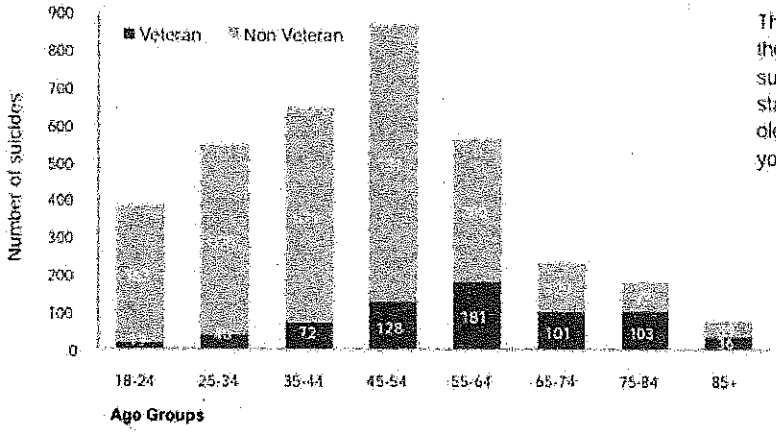
2637	2014	Midwest	Wisconsin	Total	115	29.3	736	16.5
2638	2014	Midwest	Wisconsin	18-34	11	33.3*	208	16.1
2639	2014	Midwest	Wisconsin	35-54	28	32.2	291	19.3
2640	2014	Midwest	Wisconsin	55-74	49	28.2	191	15.1
2641	2014	Midwest	Wisconsin	75+	27	27.3	46	11.7
2917	2015	Midwest	Wisconsin	Total	109	28.4	850	19.0
2918	2015	Midwest	Wisconsin	18-34	13	38.2*	232	18.1
2919	2015	Midwest	Wisconsin	35-54	25	30.1	320	21.4
2920	2015	Midwest	Wisconsin	55-74	49	28.5	242	18.6
2921	2015	Midwest	Wisconsin	75+	22	23.2	56	14.2
3197	2016	Midwest	Wisconsin	Total	132	35.3	831	18.5
3198	2016	Midwest	Wisconsin	18-34	23	69.7	242	18.8
3199	2016	Midwest	Wisconsin	35-54	33	40.7	312	21.3
3200	2016	Midwest	Wisconsin	55-74	50	30.1	217	16.2
3201	2016	Midwest	Wisconsin	75+	26	27.7	60	15.1

Source: https://www.mentalhealth.va.gov/mentalhealth/suicide_prevention/data.asp

Veteran Status

Recent research suggests that military experience serves as a risk factor for a number of negative health outcomes including PTSD, intimate partner violence, substance abuse, depression, and suicide (Prigerson, Maciejewski, & Rosenheck, 2002; Rudd, Goulding, & Bryan, 2011). In order to address suicide and contributing health issues among Wisconsin veterans, we must examine how suicide affects this population.

From 2007–2011, there were **680 veterans who died by suicide in Wisconsin, accounting for 19.0% of all suicides among people aged 18 and over** in the state (see Figure 15 and Appendix, Table 14). By comparison, only 9.7% of Wisconsin residents over age 18 were veterans (American Community Survey, 2008–2012). Therefore, veterans were overrepresented among suicides in Wisconsin.



The proportion of those who died by suicide with veteran status was greater in older age groups than younger age groups.

Figure 15. Suicides by age and veteran status, Wisconsin residents, 2007–2011.

The proportion of suicides in which the decedent was a veteran was greater in older age groups. Veterans constituted 5.0% of suicides among decedents aged 18–24, 7.3% of suicides among those aged 25–34, and over 30% of suicides in all age groups after age 54 (see Figure 15). Among suicide decedents aged 75–84, 57.2% were veterans. The majority (95.9%) of suicide decedents with veteran status were male. The percentage of male suicide decedents with veteran status was lowest among 18–24-year-olds and increased in older age groups. The percentage of veterans in the population of male Wisconsin residents also increases with age. The percentage of females with veteran status who died by suicide ranged from 0% among women aged 55–74 and 85+ to 5.9% among women aged 45–54. No clear trend is apparent regarding the relationship between age and veteran status among females who died by suicide.

Source: https://www.dhs.wisconsin.gov/publications/p0/p00648-2014.pdf

Wisconsin
Veteran Suicide Data Sheet

The U.S. Department of Veterans Affairs (VA) conducted the Nation's most comprehensive analysis of Veteran suicide rates in the United States. The resulting report, released in 2016, examined more than 55 million records from 1979 to 2014 in all 50 states, Puerto Rico, and the District of Columbia. Data from the report have allowed us to examine Veteran suicide rates in each state and region.

This Wisconsin Veteran Suicide Data Sheet is based on a collaborative effort among VA, the U.S. Department of Defense (DoD), and the National Center for Health Statistics (NCHS). The statistics herein are derived from multiple data sources, including the VA Office of Enterprise Integration, the VA Serious Mental Illness Treatment Resource and Evaluation Center, VA Post-Deployment Health Services, the VA Center of Excellence for Suicide Prevention, and the Defense Suicide Prevention Office. Cause of death was identified through the NCHS National Death Index (NDI). For additional information, please email Dr. Megan McCarthy, Deputy Director, Suicide Prevention, VA Office of Mental Health and Suicide Prevention, at megan.mccarthy@va.gov.

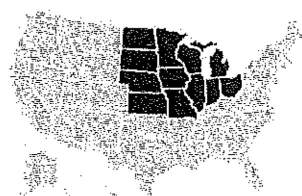
Wisconsin Veteran Suicide Deaths, 2014

Sex	*Veteran Suicides*
Total	133
Male	120–130
Female	<10

[illegible]

Midwestern Region

Illinois
Indiana
Iowa
Kansas
Michigan
Minnesota
Missouri
Nebraska
North Dakota
Ohio
South Dakota
Wisconsin



Wisconsin, Midwestern Region[a], and National Veteran Suicide Deaths[b,c], by Age Group, 2014

Age Group	*Wisconsin Veteran Suicides*	*Midwestern Region Veteran Suicides*	*National Veteran Suicides*	*Wisconsin Veteran Suicide Rate*	*Midwestern Region Veteran Suicide Rate*	*National Veteran Suicide Rate*
Total	133	1,516	7,388	36.1	36.4	38.4
18–34	17	250	1,171	63.7*	79.2	70.4
35–54	38	495	2,193	48.8	52.3	47.7
55–74	55	517	2,594	32.3	27.4	30.4
75+	23	255	1,430	24.7	25.2	32.0

* Denotes that this rate was calculated with fewer than 20 in the numerator and thus rate should be considered unstable.

After accounting for differences in age, the Veteran suicide rate in Wisconsin was not significantly different from the national Veteran suicide rate (p=0.7149)[d].

Wisconsin
Veteran Suicide Data Sheet, 2015

The 2015 state data sheets contain the most up-to-date Veteran suicide information for all 50 states, the District of Columbia, and Puerto Rico. These sheets reflect the U.S. Department of Veterans Affairs' expanded analysis of suicide rates and include data that has become available since the release of the 2014 state data sheets.

This Wisconsin Veteran Suicide Data Sheet is based on a collaborative effort among the U.S. Department of Veterans Affairs (VA), the U.S. Department of Defense (DoD), and the National Center for Health Statistics (NCHS). The statistics herein are derived from multiple data sources, including the VA Office of Enterprise Integration, the VA Serious Mental Illness Treatment Resource and Evaluation Center, VA Post-Deployment Health Services, the VA Center of Excellence for Suicide Prevention, and the Defense Suicide Prevention Office. Cause of death was identified through the NCHS National Death Index (NDI). For additional information, please email Dr. Megan McCarthy, National Deputy Director for Suicide Prevention, VA Office of Mental Health and Suicide Prevention, at megan.mccarthy@va.gov.

Wisconsin Veteran Suicide Deaths, 2015

50*	Veteran Suicides
Total	106
Male	100–110
Female	<10

Because some of Wisconsin's Veteran populations are relatively small, suicide deaths are presented in ranges rather than precise counts to protect confidentiality.

Midwestern Region

Illinois	Missouri
Indiana	Nebraska
Iowa	North Dakota
Kansas	Ohio
Michigan	South Dakota
Minnesota	Wisconsin

Wisconsin, Midwestern Region[a], and National Veteran Suicide Deaths by Age Group, 2015[b]

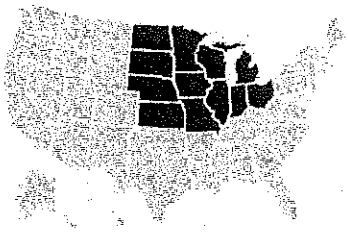
Age Group	Wisconsin Veteran Suicides	Midwestern Region Veteran Suicides	National Veteran Suicides	Wisconsin Veteran Suicide Rate	Midwestern Region Veteran Suicide Rate	National Veteran Suicide Rate
Total	106	1,209	6,115	27.0	27.4	29.7
18–34	13	165	785	38.2*	41.1	39.1
35–54	25	350	1,777	27.7	34.8	34.8
55–74	48	450	2,310	27.9	23.2	26.0
75+	22	230	1,241	23.3	32.6	27.1

* Rates calculated from suicide counts lower than 20 are considered unstable.

After accounting for differences in age, the Veteran suicide rate in Wisconsin was not significantly different from the national Veteran suicide rate[c].

Wisconsin

Veteran Suicide Data Sheet, 2016



The U.S. Department of Veterans Affairs (VA) is leading efforts to understand suicide risk factors, develop evidence-based prevention programs, and prevent Veteran suicide through a public health approach. As part of its work, VA analyzes data at the national and state levels to guide the design and execution of the most effective strategies to prevent Veteran suicide.

The 2016 state data sheets present the latest findings from VA's ongoing analysis of suicide rates and include the most up-to-date state-level suicide information for the United States.* This data sheet includes information about Wisconsin Veteran suicides by age, sex, and suicide method and compares this with regional and national data.

Midwestern Region

- Illinois
- Indiana
- Iowa
- Kansas
- Michigan
- Minnesota
- Missouri
- Nebraska
- North Dakota
- Ohio
- South Dakota
- Wisconsin

After accounting for age differences,† the Veteran suicide rate in Wisconsin:

- **Was significantly higher** than the national Veteran suicide rate
- **Was significantly higher** than the national suicide rate

Wisconsin Veteran Suicide Deaths, 2016

Sex	Veteran Suicides
Total	133
Male	120–130
Female	<10

To protect confidentiality, suicide death counts are presented in ranges when the number of deaths in any one category was lower than 10.

Wisconsin, Midwestern Region, and National Veteran Suicide Deaths by Age Group, 2016‡

Age Group	Wisconsin Veteran Suicides	Midwestern Region Veteran Suicides	National Veteran Suicides	Wisconsin Veteran Suicide Rate	Midwestern Region Veteran Suicide Rate	National Veteran Suicide Rate
Total	132	1,202	6,079	32.3	28.0	30.1
18–34	23	179	894	19.7	15.2	16.0
35–54	33	333	1,644	40.2	32.4	33.1
55–74	50	448	2,359	30.1	23.0	25.9
75+	26	242	1,224	27.2	24.2	29.3

Wisconsin Veteran and Total Wisconsin, Midwestern Region, and National Suicide Deaths by Age Group, 2016‡

Age Group	Wisconsin Veteran Suicides	Wisconsin Total Suicides	Midwestern Region Total Suicides	National Total Suicides	Wisconsin Veteran Suicide Rate	Wisconsin Suicide Rate	Midwestern Region Suicide Rate	National Suicide Rate
Total	132	841	9,422	43,427	32.3	18.5	18.0	17.5
18–34	23	243	2,789	11,997	19.7	14.8	17.9	16.0
35–54	33	312	3,485	15,456	40.2	27.3	32.1	31.0
55–74	50	237	2,413	12,542	30.1	16.2	16.6	17.7
75+	26	90	745	3,380	27.2	15.3	16.5	18.5

VA | U.S. Department of Veterans Affairs

The Proverbial Magic Wand

Wisconsin averages 118 Veterans Suicides per year. As we have seen the data is inconsistent and not reported properly. In order to fully understand the problem here are several recommendations:

1. To mandate/create policy that Coroners/Medical Examiners report all Veterans Suicide. Identify by Demographics of Male, Female, Combat Era or Non-Combat Era and Branch of Service etc…

2. Mandate reporting of Law Enforcement Suicide. There is currently no Federal or State Policy that mandates the reporting of Law Enforcement Suicide

3. Coroners/Medical examiners would report to a State Agency and an organization such as the Center for Suicide Awareness who can provide the resources, outreach and care.

4. The Coroner/Medical Examiner would be required to contact the County Veterans Service Officer to verify veteran status.

By having mandated reporting policy, Wisconsin could be the first State to potentially have accurate data, but also be able to identify within the Veterans Community where Resources, funding, and interventions need to take place.

How to Capture Data and Create Real Time Crisis Intervention

In 2017 Sen. Jon Erpenbach Introduced Senate Bill 818. This bill would have provided $200,000 to award a grant or grants to one or more persons to establish a Veterans Crisis Text Line, to operate 24 Hours a Day 7 Days a week.

The Bill failed to pass the Senate Joint Resolution.

Sen. Erpenbach also tried to create a Veterans Mental Health Voucher Program that would provide a voucher to Veterans seeking Mental Health Assistance. The Voucher would have been administered through the County Veterans Office.

This bill did not pass.

The Task Force should review these pieces of legislation and reintroduce them to provide the support and resources needed to reduce Veterans Suicide.

RECCOMENDATION: <u>Create a Veterans/Law Enforcement Crisis Text Line.</u>

- From the HOPELINE DATA we know that Veterans use texting to be discrete and seek help.
- The top 3 discussions for Veterans are Relationships – Isolation and Having Thoughts of Suicide.
- Having a Veterans/Law Enforcement Crisis Text Line we would be able to create a peer to peer network of trained Crisis Response Workers who can identify and work with Veterans/Law Enforcement who are seeking assistance
- We can track data for usage, conversations, demographics
- With the HOPELINE we provide real time crisis intervention
- Within 3 years over 100 Lives have been saved because of this
- Wisconsin would be the first take to implement their own Crisis Text Line for Veterans and Law Enforcement

Goal: To create a Veterans/Law Enforcement Crisis Text Line. To Provide Real Time Crisis Intervention to provide Peer to peer support.

Goal: To provide 3 years of funding for the Veterans/Law Enforcement Crisis Text Line with a staff position and marketing campaign.

Outcomes: Provide Data and more accurate understanding of the problem of Suicide within the Veteran and Law Enforcement Community.

Outcome: By providing real time crisis intervention, it may interrupt suicide attempts, provide proper medical care and

<u>Other Recommendations</u>

- Create a full time State Suicide Prevention Coordinator. By having a State Prevention Coordinator the coordinator would be able to bridge the gap between the community and policy makers. Minnesota, Georgia, Utah all have positions like this. Here is a sample of Utah State Legislation requiring a State Suicide Prevention Coordinator:

62A-15-1101 Suicide prevention -- Reporting requirements.

(1) The division shall appoint a state suicide prevention coordinator to administer a state suicide prevention program composed of suicide prevention, intervention, and postvention programs, services, and efforts.

(2) The coordinator shall:

(a) establish a Statewide Suicide Prevention Coalition with membership from public and private organizations and Utah citizens; and

(b) appoint a chair and co-chair from among the membership of the coalition to lead the coalition.

(3) The state suicide prevention program may include the following components:

(a) delivery of resources, tools, and training to community-based coalitions;

(b) evidence-based suicide risk assessment tools and training;

(c) town hall meetings for building community-based suicide prevention strategies;

(d) suicide prevention gatekeeper training;

(e) training to identify warning signs and to manage an at-risk individual's crisis;

(f) evidence-based intervention training;

(g) intervention skills training; and

(h) postvention training.

(4) The coordinator shall coordinate with the following to gather statistics, among other duties:

(a) local mental health and substance abuse authorities;

(b) the State Board of Education, including the public education suicide prevention coordinator described in Section 53G-9-702;

(c) the Department of Health;

(d) health care providers, including emergency rooms;

(e) federal agencies, including the Federal Bureau of Investigation;

(f) other unbiased sources; and

(g) other public health suicide prevention efforts.

(5) The coordinator shall provide a written report to the Health and Human Services Interim Committee, at or before the October meeting every year, on:

(a) implementation of the state suicide prevention program, as described in Subsections (1) and (3);

(b) data measuring the effectiveness of each component of the state suicide prevention program;

(c) funds appropriated for each component of the state suicide prevention program; and

(d) five-year trends of suicides in Utah, including subgroups of youths and adults and other subgroups identified by the state suicide prevention coordinator.

(6) The coordinator shall, in consultation with the bureau, implement and manage the operation of the firearm safety program described in Subsection 62A-15-103(3).

(7) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the division shall make rules:

(a) governing the implementation of the state suicide prevention program, consistent with this section; and

(b) in conjunction with the bureau, defining the criteria for employers to apply for grants under the Suicide Prevention Education Program described in Section 62A-15-103.1, which shall include:

(i) attendance at the suicide prevention education course described in Subsection 62A-15-103(3); and

(ii) distribution of the firearm safety brochures or packets created in Subsection 62A-15-103(3), but does not require the distribution of a cable-style gun lock with a firearm if the firearm already has a trigger lock or comparable safety mechanism.

(8) As funding by the Legislature allows, the coordinator shall award grants, not to exceed a total of $100,000 per fiscal year, to suicide prevention programs that focus on the needs of children who have been served by the Division of Juvenile Justice Services.

(9) The coordinator and the coalition shall submit to the advisory council, no later than October 1 each year, a written report detailing the previous fiscal year's activities to fund, implement, and evaluate suicide prevention activities described in this section.

- Marketing Funding – Many Veterans and Law Enforcement are unaware of the resources available to them. Of the 20 veterans a day who die by suicide only 14 utilize VA Care. Marketing will be able to provide outreach to rural areas and provide an alternative form of treatment for Veterans and Law Enforcement Officers seeking assistance.

- Provide funding for Challenge Coins and HOPELINE DECALS – By providing funding for these two resources, Police and Law Enforcement would be able to provide a resource and outreach to veterans in crisis.

In Closing

In closing, the biggest issue that needs to be addressed is having accurate data. The more we can have accurate data to understand Suicide within the Veteran and Law Enforcement Communities, the more we will be able to pinpoint where to focus our efforts of outreach, intervention, prevention and post-vention services.

Our goal as a community and as a Task Force should be to track data to have set outcomes of services provided and be able to track that programs are reducing suicide.

Continued funding for these recommendations and others is crucial to the survival of organizations doing Suicide prevention work. In 2017 Montana's Governor provide 1 Million dollars for Suicide Prevention Programs. https://leg.mt.gov/bills/2017/billhtml/HB0118.htm

I hope the Task Force Keeps in mind that we as a community don't need to reinvent the wheel. If we strengthen the community resources, provide marketing dollars, provide funding, and deal with Suicide Head on we should see a reduction in Suicide and Save Lives.

If anyone has follow up questions I can be reached at www.mike@centerforsuicideawareness.org

Thank you for your time and efforts on this Task Force.

STATE OF WISCONSIN
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August 12, 2019

Honorable Members of the Speaker's Task Force on Suicide Prevention,

My name is Dana Vike, and I am a Supervisor at the Wisconsin Department of Justice in the Division of Law Enforcement Services, Bureau of Training and Standards. I would like to thank you for including me in this important discussion on suicide prevention, and in particular, suicide prevention as it relates to law enforcement officers.

For the first eight months of 2019, there have been at least 114 officer suicides in the United States, according to Blue H.E.L.P., a non-profit organization that tracks law enforcement suicides. This number represents suicides that have been reported. There are likely many more officer suicides that go unreported. It is estimated that twice as many law enforcement officers every year die by suicide than are killed in either traffic accidents or assaults.[1]

Due in part to the stigma associated with suicide and the desire to protect survivors, little is known about the circumstances of law enforcement suicide or the actual number of officer suicides each year. Death by suicide can lead to a loss of survivor benefits or denial of funeral honors.[2]

While there are many unknowns about suicide and suicide as it relates to law enforcement officers, there are a number of known risk factors for suicide. According to the National Alliance on Mental Illness (NAMI), some of the risks for the general population include, but are not limited to:

- Gender
- Age
- History of trauma

weakness. This needs to change. "Perpetuating the culture of silence and denial around officers' mental health needs is unacceptable."[1]

What is the Department of Justice Doing to Help?

The Department of Justice, through the Bureau of Training and Standards, develops the curriculum taught within the basic law enforcement officer training academies in Wisconsin. In an effort to enhance and ensure officer physical and mental wellbeing starting at the academy level, in 2016, the basic law enforcement curriculum was updated to include training on officer wellness and physical fitness.

In addition, a Physical Readiness requirement was added. Applicants must pass a Physical Readiness Test to be eligible to enter into the academy. Throughout the academy students take part in formal physical fitness training sessions (generally twice a week) as a class, and it is recommended they take part in physical fitness training on their own time at least three times a week. At the end of the academy, students complete the same Physical Readiness Test they took prior to the start of academy to determine if they meet the minimum levels of physical readiness necessary to perform the essential physical tasks of a Wisconsin law enforcement officer safely and effectively. The exit standards for the Physical Readiness Test are 10% higher than the entrance standards.

Academy students complete a four-hour block of training on Wellness and a four-hour block of training on Suicide Prevention. The training on wellness focuses on living a healthy lifestyle, stress management techniques, healthy choices in diet and exercise, alcohol and drug use, maintaining healthy relationships, and maintaining financial stability throughout an officers' career.

The training students receive on suicide prevention comes from a program called QPR which stands for Question, Persuade, Refer. QPR training focuses on identifying the signs and symptoms of someone in crisis; knowing how to ask someone if they are thinking about committing suicide; persuading a suicidal person to get help; and referring a suicidal person to resources that can help.

During the suicide prevention course, students also learn about the risk factors for suicide as they relate to law enforcement. They learn the clues or warning signs which indicate suicidal behavior may likely

key findings of their survey is that peer support is viewed as the most helpful of treatments by 73% of respondents.[7]

The purpose of peer support team training sponsored by the DOJ is to provide a core group of law enforcement peers who are trained to provide support, information, and employee assistance program referral to other law enforcement officers and their family members.

The Department of Justice would like to offer peer support training in four additional regions of the state to assist with the development of five regional peer support teams, as well as provide peer support training for the Wisconsin State Patrol and Department of Natural Resources.

Regional peer support programs are important to assist smaller agencies in the state that may be unable to support an in-house peer support program. There are 573 law enforcement employers in Wisconsin, and approximately 55% employ nine or fewer law enforcement officers.

What More is Needed?

Additional funding is needed to support officer wellness programs through the Wisconsin Department of Justice.

Legislative privacy protections are needed for officers who seek support through peer support programs. HIPAA, the Health Insurance Portability and Accountability Act of 1996, protects personal health information from public disclosure, and it applies to doctors, psychologists, clinics, pharmacies, etc., but it does not apply to peer support programs. Some states have started to enact legislation, so that officers can utilize peer support services without fear of disclosure of private health information.[1] Similar legislation could be considered for Wisconsin.

Thank You

Thank you for providing me with the opportunity to testify today. If you have any future questions or comments, I may be reached at (608) 267-2781 or vikedg@doj.state.wi.us.