Early Warning System Data Update and New System Response
COVID-19 & Mental Health: A “Perfect Storm”

**INCREASING Risk Factors:**
- Isolation & disconnection
- Loss of natural supports
- **Financial instability / Job loss**
- Relationship stress
- Limited access to healthcare
- Alcohol use (up 60%)
- Feeling hopeless/burdensome
- Access to lethal means (guns, prescription medication, etc.)
- Uncertainty

**DECREASING Protective Factors:**
- Connectedness & **Relationships**
- Access to preventive healthcare
- Social supports
- Sense of purpose/meaningfulness (job or hobby)
- **Resilience / Distress Tolerance**
- Engagement in faith community
- Empowerment
- Healthy Coping Skills
- Routine
Wellbeing has declined significantly
(General Public and Healthcare Professionals)

https://suicidology.org/2020/05/05/ai-healthcare-professionals-mental-health/
During late June, 40% of U.S. adults reported struggling with mental health or substance use.

- Anxiety/Depression Symptoms: 31%
- Trauma/Stressor-Related Disorder Symptoms: 26%
- Started or Increased Substance Use: 13%
- Seriously Considered Suicide: 11%

*Based on a survey of U.S. adults aged ≥18 years during June 24-30, 2020
†In the 30 days prior to survey

For stress and coping strategies: [bit.ly/dailylifecoping](bit.ly/dailylifecoping)
Data Update:
March 13 – July 8, 2020

Calumet (3/13-6/6), Outagamie and Winnebago Counties
Daily calls over time (n = 869)
Shows a 32.8% increase over time

**Significant Date**

**March 13:** Schools out  
**March 17:** Bars/restaurants close  
**March 23:** Safer at Home announced  
**April 7\(^{th}\):** Election  
**April 16\(^{th}\):** Safer at Home Extended  
**May 13:** Safer at Home lifted  
**May 22:** Friday of Memorial Day wkd  
**June 6:** Protests
Percent by Call Type

- Mental Health
- Suicidal Ideation
- Suicide Attempt
- Completed Suicide

Does Not Include:
- Deaths still pending
- Single Motor Vehicle Accidents
- Overdose Deaths
Percent by Day of Week/time of Day
Percent Calls by Gender

- Male: 54%
- Female: 45%
- Transgender F-M: 1%
- Transgender M-f: 0%
- Other: 1%
Percent Calls by Mechanism of Injury

Top 3

1. Poisoning - Rx Drug
2. Sharp Object
3. Firearm

- Poisoning (Rx Drug) 21%
- Sharp Object 20%
- Firearm 14%
- Other/Unknown 23%
- Hanging 7%
- Poisoning (Non-Prescription Drug) 7%
- Fall from Heights 4%
- Jumping in Front of Vehicle 4%
Percent Mechanism of Injury Gender

![Bar chart showing the percentage of different mechanisms of injury among different genders and transgender groups.]
Calls by age group over time

March 23: Safer at Home announced

June 6: Protests
Percent by Primary Triggering Event
(41% had more than one event listed)

Top 3
1. Mental Health
2. Relationship Issues
3. Substance Use
Outagamie and Winnebago Co. Suicides

Bar chart showing suicides by month from March to July for the years 2018, 2019, and 2020.

Line chart showing suicides by month from January to December for the years 2018, 2019, and 2020.
“Deaths of Despair”

• Deaths due to alcohol, drug and suicide often connected to socioeconomic factors
  • On the rise for the last decade
  • Isolation and uncertainty of the pandemic will increase the rate of Deaths of Despair

• Shadow Pandemic of COVID-19
  • Mental Health Crisis
  • Suicide
  • Overdose

• Estimated numbers of these deaths is based on unemployment and economic rate of recovery
Projected Deaths of Despair

Alongside the thousands of deaths from COVID-19, the growing epidemic of “deaths of despair” is increasing due to the pandemic—as many as 75,000 more people will die from drug or alcohol misuse and suicide

(Well Being Trust (WBT) and Robert Graham Center for Policy Studies in Primary Care)

For every 1% increase in unemployment rate, over a year, we would lose 775 more Americans to suicide, 1,200 to overdose and increase by 10,000 those experiencing depression, anxiety and addiction

<table>
<thead>
<tr>
<th>Year</th>
<th>Slow</th>
<th>Medium</th>
<th>Fast</th>
<th>Slow</th>
<th>Medium</th>
<th>Fast</th>
<th>Slow</th>
<th>Medium</th>
<th>Fast</th>
<th>Slow</th>
<th>Medium</th>
<th>Fast</th>
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<tbody>
<tr>
<td>2020</td>
<td>9,859</td>
<td>9,533</td>
<td>8,343</td>
<td>12,817</td>
<td>12,333</td>
<td>10,846</td>
<td>15,774</td>
<td>14,932</td>
<td>13,349</td>
<td>2021</td>
<td>18,347</td>
<td>16,103</td>
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<tr>
<td>2022</td>
<td>15,879</td>
<td>11,840</td>
<td>5,832</td>
<td>20,642</td>
<td>15,392</td>
<td>7,581</td>
<td>25,406</td>
<td>18,944</td>
<td>9,331</td>
<td>2023</td>
<td>13,410</td>
<td>8,025</td>
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<td>2024</td>
<td>10,394</td>
<td>3,973</td>
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<td>13,512</td>
<td>5,164</td>
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<td>16,630</td>
<td>6,356</td>
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<td>2025</td>
<td>7,651</td>
<td>870</td>
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<tr>
<td>2026</td>
<td>7,103</td>
<td>316</td>
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<td>9,234</td>
<td>411</td>
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<td>11,365</td>
<td>506</td>
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<td>2027</td>
<td>5,732</td>
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<td>2028</td>
<td>4,086</td>
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<td>5,312</td>
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<td>6,538</td>
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<td>2029</td>
<td>3,812</td>
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<tr>
<td>Total</td>
<td>96,273</td>
<td>50,460</td>
<td>27,644</td>
<td>125,155</td>
<td>65,598</td>
<td>35,937</td>
<td>154,037</td>
<td>80,735</td>
<td>44,230</td>
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Types of Recovery: Slow—Same as Great Recession; Medium—Twice as Fast; Fast—Four Times as fast.

WI Unemployment Rate in June 2020: 8.5%
Tri-County EMS Overdose Outcome Data

Data Notes:
2020 is YTD
2019 is full year
2020 is on track to exceed 2019
Where did we leave off...way back in May

• Recognized the opportunity the pandemic presented

• As a larger group looked at the current Systems that respond to suicide/mental health crisis calls

• Developed ideas about ways to innovate within the system and goals for a new system response
4/30/20
Triage MHN
One phone #/Urgent appts
Warm Hand off to MH
Caring Contacts
Safety net for attempters

5/22/20
MHN access the Urgent Appts
Emergency Dept. Process
Dispatch
Postvention

5/5/20
Urgent appt/shared calendar
MHN
Use of technology; VCR’s; Cert.Peer Specialists

6/2020
“Dream” Team
Met weekly
30,000ft view
Ideal System Response

Goals:
• Less “hot potato”
• LE time for police matters not MH crisis
• Humane consumer experience; less transactional
• Fewer Ch.51’s
• Educate partners about each other’s roles and responsibilities
• Filling the “access blackhole” MHN
“Dream” Team

Sara Kohlbeck  
Assistant Director  
Comprehensive Injury Center  
PhD Student | Institute for Health and Equity  
Medical College of Wisconsin  
**Dr. Stephen Hargarten**  
Associate Dean – Office of Global Health  
Professor of Emergency Medicine  
Medical College of Wisconsin  
**David Drewek**  
Executive Director  
Sherman Consulting  
N.E.W Mental Health Connection  
Board Member

Ignacio Enriquez  
Behavioral Health Officer  
Appleton Police Dept.  
**Paula Verrett**  
Iris Place Program Director  
NAMI Fox Valley  
**Wendy Magas**  
Project Coordinator HTM  
N.E.W Mental Health Connection  
**Jennifer Seefeldt**  
Victim Crisis Responder  
Survivor of Suicide Loss  
**Amanda Stuck**  
State Representative  
Survivor of Loss

Kathy Flores  
Director of the Room to Be Safe LGBTQ Program  
Diverse & Resilient  
Statewide Anti-Violence Program Director  
**Sarah Dearing**  
Crisis Supervisor  
Outagamie County Mental Health  
**Josh Hopkins**  
Behavioral Health Officer  
Outagamie County Sheriff’s Office  
**Sarah Bassing-Sutton**  
Community Suicide Prevention Coor.  
N.E.W. Mental Health Connection
"We need alternatives to policing for community issues. Many LGBTQ, Black, Indigenous and other People of Color fear police being called for their mental health issues because they know this may exacerbate an already complicated crisis of mental health. So many individuals will suffer in silence with an issue rather than involve the criminal justice system. This leads to higher rates of suicide in these marginalized communities. If we want true healing in our community, we would treat mental health crisis with the respect and dignity it deserves with a team of mental health workers trained in trauma who have the time and ability to sit with people in crisis and offer help and healing. Police officers are meant to address crime, not community issues like mental health."

Kathy Flores

“The creation of an ideal system is so critical because it forces us to acknowledge head-on that this is not "someone else's problem." This is a problem that impacts everyone, in different ways and in differing intensity. It is no longer a secret or taboo to acknowledge that mental illness and substance abuse are problems in our community, but many still do not know where to begin. The work of the Dream Team has allowed us the opportunity to find that informed and unbiased starting point that will guide our future selves in normalizing mental illness and reducing the rate of suicide."

David Drewek
“The reason this work is so important to me is because I have gone through the trauma of four suicide attempts and been through repeated hospitalizations. I am passionate about helping others overcome the experiences and circumstances that lead to suicide. I dream of a community that responds with kindness and compassion when a neighbor is in distress!”

Paula Verrett

“I have greatly enjoyed working on the next model for caring for people in crisis. It is with particular enjoyment with this diverse, dedicated group of individuals on the dream team and with Sarah’s unwavering, steadfast leadership. I have seen the evolution of systems of crisis/emergency caring evolve over the past four decades (that’s how old I am) and I am excited that this group and the larger group can make a significant contribution to the next level of caring for people and families in crisis.”

Dr. Steven Hargarten
Being a survivor of suicide and working directly with families affected by suicide I have a firsthand view of how devastating this is for a family and how hard it is to process your grief. When dealing with families I often hear how the resources were not readily available for their loved one or they had to wait weeks to receive professional help and more times than not these individuals don’t have the strength to wait weeks. **Time is critical in these sensitive moments.** A secure and well thought out process is going to give people the hope and support that they need. Consistent and clear directives need to be put into place so help is readily available for those going through an emotional crisis or for those that are left behind. This plan is a piece of the puzzle that has waited long enough to be put together, the amount of completed suicides and welfare checks is growing and the time is now for all these missing pieces to come together so we can deliver clear and consistent care to our communities. My brother didn’t have the support he needed to live and I believe my family would have benefitted from services the Dream team has outlined, during and after his suicide death as we were left alone to navigate this complicated journey.
## Inputs

<table>
<thead>
<tr>
<th>NEW Mental Health Connection</th>
<th>Operational Team</th>
<th>Law enforcement agencies</th>
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<tbody>
<tr>
<td>&quot;Dream Team&quot;</td>
<td>Medical College of Wisconsin</td>
<td>County crisis centers</td>
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<tr>
<td>County dispatch/EMS VCRs</td>
<td>Certified Peer Specialists</td>
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<td>Emergency department staff</td>
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<td>Mental Health Navigator</td>
<td>Emergency department staff</td>
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<td>County Coroners</td>
<td>Mental Health Navigator</td>
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<td>Funding (from AHW as well as other organizations)</td>
<td>County Coroners</td>
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<td>Time</td>
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## Activities

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<thead>
<tr>
<th>Strategy meetings</th>
<th>Development of ideal system response</th>
<th>Implementation meetings</th>
<th>Pilot Evaluation</th>
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## Participation

<table>
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<tr>
<th>Dream Team</th>
<th>Dream Team</th>
<th>NEW Mental Health Connection Pilot site(s)</th>
<th>Operational Team County crisis County dispatch/EMS VCRs Certified Peer Specialists Law enforcement County Coroners Mental Health Navigator Emergency department staff</th>
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## Outputs - Activities

| Increased competence of community agencies to respond to suicidal crises | Increased competence of all involved agencies in providing a safe, least restrictive response to suicidal crises | Increased awareness of available mental health resources, including open appointments and available mental health beds | Improved communication between law enforcement, county crisis, and peer specialists after a suicide occur |

## Outcomes - Short

- **Increased involvement of community agencies in response to suicidal crises**
- **Decreased involvement of law enforcement in response to suicidal crises**
- **Increased use of available mental health resources, as allocated by the MHN**
- **More collaborative deployment of resources to loved ones after a suicide death**
- **Mitigation of negative impacts on loved ones and the community after a suicide death**

## Outcomes - Long

- **Non-punitive, culturally humble response to suicidal crises**
- **Increased trust in crisis response among community members**
- **More rapid access to immediate mental health services for individuals in crisis**
- **Mitigation of negative impacts on loved ones and the community after a suicide death**
Ideal System Response—“First Responders”

**Person in Crisis**

**Call 911**
- **Tiered Response**
  - **Suicide Crisis**

**Mental Health Crisis Assessment**

**Tier 1:** Not a safety issue to self or others; “Behavior” issue
- **In Person**
- **LE and MH Prof**

**Tier 2:** Suicide Plan/no access to means/Prior Attempts
- **In Person**
- **Peer Specialist/specially trained VCR’s** assess and manage safety planning
- **MHN for urgent appt**
- **Address Lethal Means**

**Tier 3:** Weapon/Attempt in progress/intox Danger and safety issues
- **In Person**
- **LE/ MH Prof and/or Peer Specialist**
- **Address Lethal Means**

**Guiding Principles**
- Compassionate Care
- Least Restrictive
- Living Well and Safely
- Equity
- Competent/Skilled/Support
- Zero Suicide Safe Care

**Caring Contacts**
- *Day after by the provider who the consumer has been scheduled with*

**Tier 1:** Vague Ideation/no prior attempts/no plan
- *Referral to Warmline (Iris Pl)*
- *Crisis Phone Call*
- *MHN urgent appt*
- *Safety Plan*
Ideal System Response: Emergency Department

Person CHOSES (informed consent) to go inpatient (voluntarily) and arrives at the Emergency Department.

ROI signed for ED staff to inform Primary Care of SA and current Mental Health Prof.

Person is immediately brought back to a MENTAL HEALTH ED “exam” room and is joined by a Certified Peer Specialist who is employed by the Hospital.

Contracted Mental Health providers or someone from Beh Health unit is paged to ED and speaks with the individual to professionally assess and assist in decision making about options for care.

Person is offered Iris Place (peer run respite).

Non-Law Enfor. Transportation provided to Facility with available bed.

Voluntarily inpatient hospital care; MHN is contacted regarding available inpatient beds.

MHN is contacted for an Urgent appt.

Guiding Principles
- Compassionate Care
- Least Restrictive
- Living Well and Safely
- Equity
- Competent/Skilled/Support
- Zero Suicide Safe Care

Ideal: MOBILE CRISIS
- LPN, Cert. Peer Specialist/VCR and SW travel to ED’s for assmt and consult
- Assmt would be accepted by admitting facility; shared via EMR

Protocol
- Medical clearance concurrent with admission intv.
- Standardized inpt admission paperwork
- Peer Specialist accompany on transport if by LE
- “Fast Track” to inpt; ThedaCare Psych Urgent walk in
- Technology to provide consult to ED Dr.
Ideal System Response: Completed Suicide

- Completed Suicide/ Sudden Death
  - Family/neighbor Support/Chaplin

Victim Crisis Responder (VCR)/ (Certified Peer Specialist)
Survivor Support (contact within 24hrs of event)

Law Enforcement/ EMS/ Firefighter/Coroner (able to focus on death investigation)

- Safety Planning
- Resources-professional and support groups/ (Language on how to talk about a suicide/ guilt associated/ self-care)
- MHN if need for urgent appt.
- Funeral Home/ Grief network
- Therapist/County Crisis/ Primary Care Dr.
- Suicide Prevention Agency
- School/ Employer

Guiding Principles
- Compassionate Care
- Least Restrictive
- Living Well and Safely
- Equity
- Competent/Skilled/Support
- Zero Suicide Safe Care

Suicide Investigation Form
What comes next?

• Quarterly updates from the projects within Project Zero

• Be patient, not all projects will move at the same pace – speed is determined by readiness, capacity and funding (and COVID-19)

• “Dream” Into Reality Teams! - How do we define these???? What is the structure for the Implementation phase???- (DIRT teams 😊)

• The “Dream” Team will serve as the implementation Steering Committee
Youth Mental Health & COVID-19

Children thrive when they are safe and protected, when family and community connections are stable and nurturing, and when their basic needs are met.

The coronavirus pandemic and the unprecedented measures to contain its spread are disrupting nearly every aspect of children’s lives: their health, development, learning, behavior, their families’ economic security, their protection from violence and abuse, and their mental health.

The COVID-19 pandemic may worsen existing mental health problems and lead to more cases among children and adolescents because of the unique combination of the public health crisis, social isolation, and economic recession.

(Golberstein E, Wen H, Miller BF. Coronavirus Disease 2019 (COVID-19) and Mental Health for Children and Adolescents. JAMA Pediatr. Published online April 14, 2020.)
Youth & Adult Adjustment Over Time in Crisis

(The arc of recovery is long for all, unending for some)

A = baseline functioning
B = event
C = vulnerable state
D = usual coping mechanisms fail
E = helplessness, hopelessness
F = improved functioning

G = continued impairment
H = return to baseline
I = post-traumatic growth
Q & A / Thank you

Sarah Bassing-Sutton
sarah@newmentalhealthconnection.com
920-420-4903

Sara Kohlbeck
skohlbeck@mcw.edu

Beth Clay
beth@newmentalhealthconnection.com
920-202-0117

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