ADVANCING A HEALTHIER WISCONSIN CARE TEAM

Crisis Access Response & Engagement Team

DOUGLAS COUNTY, WI

PROCESS REPORT

NOVEMBER 2021

CARETeam
CRISIS ACCESS RESPONSE ENGAGEMENT TEAM
DOUGLAS COUNTY, WI

MCW MEDICAL SCHOOL

ADVANCING A HEALTHIER WISCONSIN ENDOWMENT

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EXECUTIVE SUMMARY

In January 2020, a coalition of groups in Douglas County called the Douglas County Mental Health Coordinated Community Response (CCR) team received an Advancing a Healthier Wisconsin grant to explore, evaluate, and implement community systems change. The group united to launch an effort to enhance coordination and understand their workflows to better support individuals and their families experiencing mental health crises. The group developed a change statement that reads:

> *Transforming Douglas County's behavioral health crisis prevention and response by working actively together using a common vision for crisis response, shared methods of crisis planning and further development of person-centered supports.*

Working with Northspan, the Crisis Access Response & Engagement (CARE) team developed the following practical vision to explain what it wanted to see in place as a result of its actions:

1. Integrated peer support & respite services
2. Coordinated & shared crisis response protocol
3. Developed Superior hospital-based crisis interventions
4. Expanded continuum of treatment and case management
5. Improved coordinated emergency response for individuals in crisis
6. Created supported responses & reduced stigma through community engagement and education

In order to advance this vision and change statement, the group developed two goals:

1. Create systems maps of resources and resource flows
2. Begin to strengthen collaboration among partner organizations

The group conducted extensive key informant interviews to understand how processes worked within organizations. These interviews worked directly with a wide array of organizations that touch mental health processes in Douglas County. Through these interviews, it sought to identify:

1. System process gaps and barriers as a consumer goes through the system,
2. Pressure points in the system, and
3. Opportunities for change

When these interviews were complete, the CARE team brought together these organizations for group process sessions organized by sector. These sectors include:

1. Education
2. First Responders
3. Health Care Behavioral Health
4. Human Services
5. Legal

Once complete, facilitators wrote out processes followed by participants in their own words and transformed them into process map documents. The facilitators solicited feedback from participants on draft process maps and finalized the documents. Additionally, the group held two sessions for consumers to discuss their experiences with mental health networks in Douglas County and their ideas for change.

The work created new connections and provided insights into the interconnections within the processes used by organizations to address mental health crises in Douglas County. It also pulled out issues that inhibit the effectiveness of the current model and provided guidance for systems-level change. With these insights in mind, this report offers six recommendations for changes that can help improve processes in the county:

1. Convene regular service provider meetings to share information across organizations
2. Update and market the list of available resources on **douglascountyresource.com**
3. Place increased emphasis on navigators to help guide consumers through processes
4. Find additional opportunities for first responder collaboration and cross-training
5. Build networks for wraparound services for students
6. Develop pathways for collective policy advocacy

While there are many obstacles to the implementation of improved mental crisis response in Douglas County, this report provides a framework for addressing many of the system's most pressing issues.

OVERVIEW

Individuals facing mental health crises encounter a complex web of organizations that provide valuable supports. These organizations are well-intentioned but often have somewhat different roles in their respective processes, and sometimes struggle to communicate with other organizations or the broader system. Their relationships to one another can be opaque for those who have little experience with them, a problem only exacerbated in the midst of a mental health crisis. As in many places across the country, Douglas County stakeholders are increasingly aware of the interconnected factors that affect mental health and the extent of the services necessary to address certain situations.

Recognizing these challenges, a group called the Behavioral Health Coordinated Community Response Team formed in 2013 and eventually evolved into the Mental Health Coordinated Community Response Team. The group created a website, www.douglascountyresource.com/, as a starting point for collection of resources online. In 2020, a member of the coalition, North Country Independent Living, received a $475,347 Advancing a Healthier Wisconsin grant from the Medical College of Wisconsin. The group was then able to undertake a more comprehensive approach, address changes in the landscape since its initial formation, and bring in more stakeholders who had not participated in the past. It developed the following change statement to guide its efforts:

> *Transforming Douglas County's behavioral health crisis prevention and response by working actively together using a common vision for crisis response, shared methods of crisis planning and further development of person-centered supports.*

The team hired the Northspan Group, Inc. as its facilitator for the response transformation process. Outreach efforts included contacts with nearly 100 individuals whose jobs or volunteer roles touch Douglas County's mental health processes, including 44 who attended process sessions. A complete list of participants is available in Appendix 20.

BACKGROUND INFORMATION

Douglas County sits in the northwest corner of Wisconsin and has a population of 44,295, according to the 2020 Census. Its county seat, Superior, is a regional center, and it shares a Metropolitan Statistical Area with Duluth, Minnesota. While Superior comprises over half of the county's population, it also includes considerable rural areas and smaller communities such as Lake Nebagamon, Poplar, Brule, Solon Springs, Gordon, Oliver, and the Village of Superior. Its population has been relatively stable in recent decades, and its economy centers on manufacturing, outdoor recreation, a service economy based in Superior, and activities related to the Duluth-Superior port.

Like many communities across the nation, Douglas County is taking an increased interest in the local mental health situation, a trend interconnected with social determinants of health, substance abuse challenges, and increasing awareness over the prevalence of mental health difficulties and the importance of reducing stigmas associated with them. As a community that shares a state boundary from the larger Duluth metropolitan area, it faces certain logistical and jurisdictional challenges that other communities of comparable size do not. Its relative isolation from other Wisconsin metropolitan areas accentuates some of these challenges, compelling local stakeholders to seek out unique solutions.

PRACTICAL VISION

Northspan facilitated a virtual session on November 23, 2020 to develop a practical vision for the Crisis Access Response & Engagement (CARE) team. To prepare for the session, Northspan administered a survey of CARE team members that asked five questions, most notably one that sought to understand what participants wanted to see in place in three years as a result of their actions. This survey generated 73 unique ideas, most notably related to themes such as:

- Increase in services/resources/staff/support
- Community support, stigma reduction, de-escalation, and harm reduction
- Improved communication and collaboration
- Peer respite, warm lines, and person-centered efforts

A summary of the survey results is available in Appendix 1.

Twenty-five members of the team attended the session and provided their insights on the outcomes they would like to see coming out of the process. The group developed the following practical vision:

1. Integrated peer support & respite services
2. Coordinated & shared crisis response protocol
3. Developed Superior hospital-based crisis interventions
4. Expanded continuum of treatment and case management
5. Improved coordinated emergency response for individuals in crisis
6. Created supported responses & reduced stigma through community engagement and education

A document containing all ideas that fed into the practical vision is available in Appendix 2.

INTERVIEWS CONDUCTED

In fall 2020, Northspan facilitators worked with members of the AHW committee to develop a series of questions for the key informant interviews. The committee members then conducted nearly 100 interviews across five categories of organizations that interact with persons experiencing mental health crises in Douglas County.

INTERVIEW SUMMARIES

When the interviews were complete, Northspan staff compiled interview results from each of the five groups into five separate summaries. These documents pulled together participant thoughts, identified trends, and provided a framework for shared understanding at the provider process sessions. The summaries are available in this report as Appendices 3-7.

PROVIDER PROCESSES

Sessions

The five provider process sessions were conducted virtually via Zoom over a year-long period in 2020-2021. Each session was scheduled after the completion of the interviews of each organization in each respective category, and 46 individuals participated across the five sessions. Participants received the interview summaries prior to their sessions. In each session, participants shared their own organization's processes related to mental health crises and shared more general feedback on the existing process and their reflections upon it. Reporting on these sessions is divided into three areas: considerations based on participant reflections on the process, examples from other communities, and process map diagrams. Written, step-by-step processes for each of the five provider groups are available as Appendices 8-12.

Considerations

The Considerations section associated with each of the written processes provides broader reflections from participants in the sessions. They include notes on what is working well in the system and what is not, and occasionally outline potential solutions to challenges encountered along the way. Hearing other participants' insights sometimes promoted new awareness of how the system could be improved and form the foundation of many of this report's final recommendations.

Examples from Other Communities

These sections compile best practices known to process session participants. Many were aware of local, statewide, and national initiatives or processes to better support mental health, some of which may be relevant to Douglas County's efforts.

Process Maps

Northspan produced a process map for each of the five provider groups interviewed. The maps show how individuals experiencing mental health crises may be routed through the various systems, showing how different organizations interact with them along the way. The process maps make note of points where decisions must be made, where processes reach decision or delay points, and how individuals move from intake through to determination of needs and eventual actions. These five process maps are available Appendices 13-17.

CONSUMERS

After the completion of the provider process sessions, the CARE team organized two sessions for consumers of mental health services. These sessions aimed to inform the process with consumer perspectives on ideas for change within mental health crisis access response and engagement.

Sessions & Ideas for Change

Northspan facilitated two consumer sessions with groups identified by Certified Peer Support Specialists involved with the CARE team. The first, on October 21, 2021, was with consumers of National Alliance of Mental Illness (NAMI), a national grassroots advocacy organization with a local chapter. The second, on November 3, 2021, was with Family Forum, which is based in Superior and provides early childhood programming. The sessions provide a broad range of feedback, all of which were then grouped into nine categories:

1. Expanding care capacity throughout county
2. Building community through peer support
3. Fostering culture of person-centered, trauma-informed care
4. Collaboration with law enforcement & legal system
5. Increasing access to stable housing & reliable transportation
6. Providing wraparound youth and family support
7. Develop mobile crisis response team
8. Broadening collaboration between organizations
9. Destigmatizing mental health and addiction community-wide

A complete summary of the consumers' insights is available in Appendix 18. A follow-up session with CARE team participants also gave them the opportunity to reflect on the entire process and the consumers' thoughts, and further informed the recommendations. A summary of this session is available in Appendix 19, and a participant resource provider list is available in Appendix 20.

RECOMMENDATIONS

Overall

After compiling information on the processes, Northspan compiled six recommendations for changes that could improve processes for individuals experiencing mental health crises. These recommendations emerged from the insights in the process sessions and are all related to recommendations that emerged from the consumer process ideas for change. The recommendations are:

1. **Convene regular service provider meetings to share information across organizations.** Participants in the human services session expressed a strong willingness to set up regular meetings, with one organization willing to host them regularly. The group does not appear to conflict with any existing groups, though it will require careful coordination to make sure as many organizations as possible have the capacity to attend regularly. The meetings will also need some structure, and perhaps a designated facilitator, to keep them on track and useful for participants.

2. **Update and market the list of available resources on douglascountyresource.com.** See below for a full list of recommendations. Once edits are complete, the CARE team should market the website to make sure all services included in this process are aware of its contents and promote its existence to the broader community to drive traffic to the site.

3. **Place increased emphasis on navigators to help guide consumers through processes.** While improved resource lists will benefit all participants in this process, a human connection can provide the most essential guide through a difficult system. To this end, the creation or elevation of certain individuals as navigators to help consumers through the process emerged as a significant potential force for positive change. This model could take several different structures, and if funding is not available to hire individuals directly for these roles, there are ways to tailor existing roles to better empower service providers to give consumers a consistent point of contact as they obtain necessary resources. A stronger peer support model consistently emerged as an opportunity that could create a vital support network as people work through their challenges.

4. **Find additional opportunities for first responder collaboration and cross-training.** First responders often operate in relative isolation from other groups involved in mental health crisis responses and expressed a willingness to better integrate with the system. Any follow-up knowledge they gain about particular incidents is often incidental (e.g., repeated responses to assist the same individual), and they tend to see consumers only in their moments of worst crisis. While policing has become a subject of national debate and was a concern in the consumer sessions, Douglas County stakeholders are already exploring ways to reduce some of the tensions around a law enforcement presence, particularly through the establishment of a coordinated response specialist in the Superior Police Department. Early reviews of this position were overwhelmingly positive, and opportunities to add such a position in the county sheriff's department to cover rural Douglas County or hire additional coordinated response specialists received strong support. While HIPAA regulations restrict some information-sharing, there is clear room for greater engagement of first responders in future planning for coordinated care.

5. **Build networks for wraparound services for students.** Historically, processes existed to support students after they received care, but these services have dwindled over time, and follow-up from services to schools appears to be a point where care breaks down. Discussions of these shortcomings were among the rawest in the process sessions and showed obvious room for improvement. Integration of schools in the creation of safety plans will help ensure students do not fall through the cracks. Developing these networks will require proactive pushes from both service providers and schools and may require its own taskforce or special initiative to set up a system that works for all stakeholders while maintaining HIPAA rights.

6. **Develop pathways for collective policy advocacy.** The process mapping exercise noted a range of challenges arising from local, state, and federal policies. Some of these policies are far beyond the control of the CARE team and its allies, and a simple lack of resources and capacity plagues many organizations. There are, however, numerous challenges particular to Douglas County, many owing to its status as a border county that shares certain resources with Minnesota while lacking convenient access to other Wisconsin metropolitan areas. The service provider meetings, when established, can provide a regular forum for these discussions and elevate relevant concerns to local or statewide units of government and present proactive solutions. This group could also conduct outreach to other border communities for a collective advocacy push and investigate reimbursement rates in Wisconsin relative to other states.

Website Recommendations (http://douglascountyresource.com/)

Northspan staff reviewed the douglascountyresource.com webpage and developed a series of recommendations to improve the user experience.

GENERAL THOUGHTS

- There's a lot of duplication in the content on the Adults drop down and the Youth & Families drop downs – is there a better way to organize or tag? Instead of having an Adults – Transportation and a Youth & Families – Transportation that have the same information?

- What types of online resources could be listed? Sites that give people a chance to chat with a therapist online?

HOME PAGE

Transforming the phone numbers so someone could click directly on the phone number and be connected

ABOUT

Adding more information about who is in the group, etc.

EMERGENCY/URGENT

- Crisis phone numbers – making them linked out in mobile for easy phone call
- Split into medical & mental health
- A small section on "what to expect when you or someone you care about seeks emergency treatment" (what to bring, what to expect when you arrive – how to make it less of a traumatic experience)

RESOURCES

- Linking out directly to the websites of listed resources

- More information about what specific resources offer – so people don't have to go to each website and have a more general idea if the agency offers what they're looking for
    - Current: Northwest Wisconsin Community Services Agency. Free store, Tax Assistance Program, Senior Center 1118 Tower Ave, Superior, WI 54880. 715-392-5127
    - Suggested: Northwest Wisconsin Community Services Agency: 715-392-5127
        - Free store: donated clothing & household items
        - Judicare: Assists in providing and processing applications for free legal services. Applications are available at all office locations.

- Memory Lane: Support for adults with Alzheimer's
- Tax Assistance Program: free tax preparation assistance
- Crisis: 72-hour food and shelter to homeless individuals & families
- Food & Nutrition support: food pantry, soup kitchen, WIC
- Housing: affordable & transitional housing support

DEFINITIONS

- Lots of opportunity here: http://douglascountyresource.com/definitions/
- Currently set up as "What do these people do?" Consider addition of information such as "When do I need to see this person?" and "How do I find this type of care?"
- Who else could be added – legal/case workers/human services jargon-y titles?
- What related acronyms could be defined here too?

EVENTS

- This would be a great spot to plug NAMI meetings. Currently, they are hidden in the text of the Adult – Mental Health page.

CONTACT US

- Contact form currently not working

APPENDICES ATTACHED

APPENDIX 1

AHW Practical Vision Feedback Summary 11.23.20

CARE Team (Crisis Access Response & Engagement)

Douglas County | November 23, 2020

PRACTICAL VISION FEEDBACK SUMMARY

In preparation for the CARE Team Practical Visioning Workshop held November 23, 2020, partners of Advancing A Healthier Wisconsin were asked to clearly identify the group's hopes & dreams and create ownership of a common vision of the future. Fifteen of the participants responded, and this document presents the results of the feedback.

RESPONDENTS

The feedback questionnaire was distributed via e-mail to targeted members of the behavioral health crisis prevention and response ecosystem in the County. This includes a mix of health care providers, health care support providers, governmental and educational agencies, and first responders.

CRISIS RESPONSE VISONS

The feedback questionnaire consisted of one question asking participants to consider "What do you want to see in place in 3 years as a result of our actions?". Respondents provided 73 ideas as visions of what they hope to see in the future.

Throughout the responses, a few key themes emerged:

- An increase in services, resources, staff and support
    - Respondents noted a current lack of crisis beds and services within the county, with participants naming other communities such as Des Moines (IA) or Washburn County (WI) as aspirational models for a more effective crisis response
- Improved collaboration and communication between stakeholders received twenty mentions, and offered suggestions such as more networking opportunities or an annual conference
- A shift to increase access to peer respite, warm lines and a focus on more person-centered and trauma-informed strategies
- Increased community support and awareness of mental health stigma, resources, and collaboration

Future Vision Keyword or Theme	# of Mentions
Increase in services/resources/staff/support	22
Community support, stigma reduction, de-escalation, harm reduction	21
Improved communication and collaboration	20
Peer respite, warm lines, person-centered	10

APPENDIX 2

AHW Practical Vision Workshop 11.23.20

MCW MEDICAL SCHOOL | ADVANCING A HEALTHIER WISCONSIN ENDOWMENT

CARE Team (Crisis Access Response & Engagement)

Practical Vision Consensus Workshop 11.23.20

CHANGE STATEMENT: Transforming Douglas County's behavioral health crisis prevention and response by working actively together using a common vision for crisis response, shared methods of crisis planning, and further development of person-centered supports.

What do you want to see in place as a result of our actions?
What is our practical vision?

AS A RESULT OF OUR ACTIONS, OUR PRACTICAL VISION IS TO HAVE:

1. Integrated peer support & respite services,
2. Coordinated & shared crisis response protocol,
3. Developed Superior hospital-based crisis interventions,
4. Expanded continuum of treatment & case management,
5. Improved coordinated emergency response for individuals in crisis, and
6. Created supportive responses & reduced stigma through community engagement & education.

MCW MEDICAL SCHOOL | ADVANCING A HEALTHIER WISCONSIN ENDOWMENT

CARE Team (Crisis Access Response & Engagement)

Practical Vision Consensus Workshop 11.23.20

Integrated peer support & respite services	Coordinated & shared crisis response protocol	Developed Superior hospital-based crisis interventions
• Peer driven crisis response services, like respite • 24/7 Peer Run Respite with warm line • Increased Access to Preventative Supports (County /Community) • Crisis respite program (with peer-run respites) • Need more peer involvement everywhere • Support for patients during pandemic • No warm line • 24-7 Mental Health and AODA (alcohol and other drug of abuse) Warmline • Integrated Peer Support at Every Level of Care	• Formal inter-agency crisis protocols • Who & how we respond to a crisis & follow up after crisis • Networking and collaboration across agencies • Care Plans/Reentry Plans for Schools • Maintenance of information • Coordinated information sharing on crisis response • Defining agency roles • Need a person-centered system • Improved Cross-System Communication/ Care • County Wide Crisis Response Plan (see Washburn Co.) • Seamless collaboration of all stakeholders • Involvement of agencies. • Effective crisis response • Ease of information. • Clear Referral Pathways / Networks across sectors • Consistent networking opportunities • Shared interest and energy for new models of crisis response • Improved communication and resource sharing between agencies	• No crisis beds or crisis center (ala Birch Tree) • Crisis services in Emergency Department • Dramatic reduction in people transferred to Duluth during crisis • Adolescent crisis care/hospitalization • Tele Psych services for patients in EDs

MCW MEDICAL SCHOOL | ADVANCING A HEALTHIER WISCONSIN ENDOWMENT

CARE Team (Crisis Access Response & Engagement)

Practical Vision Consensus Workshop 11.23.20

Created supportive responses & reduced stigma through community engagement & education	Improved coordinated emergency response for individuals in crisis	Streamlined initial response & coordinated process
• Need a system that is trauma-informed • Annual convention- trainings • Access to information. • Provider awareness • Community awareness • Main website to access information and education • A community with less stigma towards those with mental health issues. • Homelessness & mental health • Person-center, trauma informed response • Less mental health crises occurring in our community. • Resiliency during pandemic • Parenting support • Those with mental health issues feeling they live in a safe and accepting community that caters to their needs	• Lack of Mental Health services • Lack of mental health resources (physical space & staffing shortages) • No inpatient services in our county • Funding sources identified and secured for crisis programs • Funding-current and searching for new monies • Reduced Outpatient Waiting Lists • AODA resources • Financial admin support (for workers and initiatives) • Opening / Widening Access to Mental health in Rural Communitie • Access to quality care • Additional youth programming (curious what types-related to crisis) • Better access to mental health services in our community. • More therapy options • Placement of behaviorial health patients • Chemical dependency funding and staff demand to implement • MH services in schools • No crisis psychiatry services (Des Moines has a cool service) • Enough well paid staff to meet demand • Rural space access • More case managers • Effective Crisis resources	• Divert from jail & emergency room • Need de-escalation & harm reduction • Less interactions between police and those with mental health issues • Some form of crisis response team or on-the-ground response • No crisis psychiatry services (Des Moines has a cool service) • Supportive (Consumer-Driven) Crisis Response (911/ SPD/ Sheriff/County) • No mobile crisis unit (would be connected with Law enforcement officer)

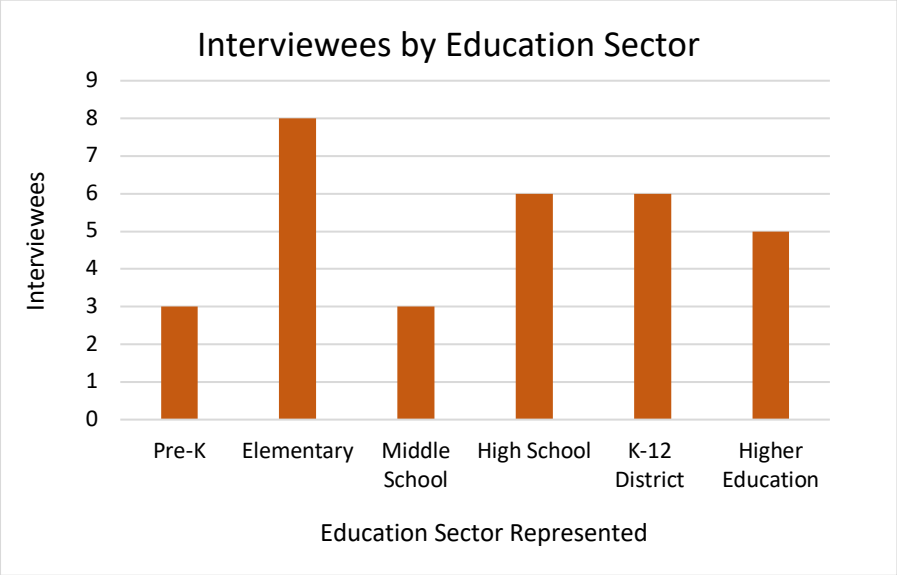
APPENDIX 3

Education Interviews Summary

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
EDUCATION INTERVIEWS SUMMARY

Framing Lens: Change Statement
Transforming Douglas County's behavioral health crisis prevention and response by working actively together using a common vision for crisis response, shared methods of crisis planning, and further development of person-centered supports.

As part of the process to assess Douglas County's behavioral health crisis prevention and response, members of the AHW team interviewed thirty-one individuals representing eight educational institutions throughout the county. The goal of the interviews is to assess each groups' current systems flow, coordination of care, and thoughts regarding changes to current systems.



OVERVIEW
Interviewees were asked to briefly describe their position and population served. In total, there were 31 individuals representing eight educational institutions and/or school districts.

Next, respondents were asked to identify challenge and opportunities within their organizations as related to behavioral health. They were also asked how they measure success within their organizations. A summary of those responses is found in the table below.

Challenges	Opportunities	Measures of success
• Waiting lists for therapy services • Lack of mental health training for teachers • Insurance – lack of and/or out of state • Limited resources for school staff • Family dynamics – parents unwilling or unable to provide care • Transportation • Stigma • Time and connections with social workers	• Additional trainings • Finding ways to reduce barriers (ie $100 for an evaluation as a prerequisite for treatment) • Establishing wraparound care • Better coordination between organizations	• Depends on the student – setting goals for the individual • Students have skills to cope • Getting a parent on board with a treatment plan • Building confidence • Connecting someone to resources

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
EDUCATION INTERVIEWS SUMMARY

CURRENT SYSTEMS FLOW

Participants were next asked about the current systems in place, and how their organization responds to a behavioral health crisis. They were asked to describe their role within the current system, procedures for obtaining releases of information, and barriers for patient access. Responses are summarized and edited for clarity below.

How do folks move through the systems currently in place? What is your role in the system?

- In-school: Student referred to counselor/student support team, usually by a faculty member. If emergency, will call parent for transport to ER or have law enforcement do assessment. If parents are unable to help student, will call county.
- Goal is to have student connected to resources and supervised (whether that be by parent, therpist, or social worker)

Can you describe how you obtain Release of Information (ROIs) and your ROI process? Who would need to authorize? How would it get approved?

- General ROIs for new students transferring in
- Parent consents/signs off
- Nurse handles records
- Student support team handles/updates with intervention information
- Most information stored on file for 3 years
- Coordination with medical providers, social workers, etc.

What are some of the barriers to access that you've seen within your organization for the clients you serve?

- Lack of available resources
- Transportation
- Telehealth - students unable to access telehealth on school issued laptops/iPads
- Waitlists for services
- Patient follow-up/signing up for services on their own
- WI health insurance not accepted in MN
- Parent/family stigma, buy-in, acceptance or ability to understand that child needs help
- Financial ability to receive treatment
- Lack of preventative care services

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
EDUCATION INTERVIEWS SUMMARY

CURRENT COORDINATION OF CARE

Interviewees were asked about the current systems in place that relate to the coordination of patient care between organizations, as well as transitional points where people in need of care can fall through the cracks.

What type of service coordination, information sharing, and teaming happens now?

- Within schools/districts - student support teams, counselors, deans/admins, sometimes teachers
- Schools communicating with Amberwing, Northwest Journeys (when possible)

What supports would you like to have in place to help you in coordinating care/services?

- Homeless shelter for teens
- Eliminating need for parent permission
- Wraparound services
- More education/trainings
- More social workers in schools
- More counselors in schools
- Support for LGBTQ+ students
- Trauma/ACE/Mental Health training for teachers
- Community coordinator
- Proactive and preventative programming for families
- Parent support
- How to offer services before student gets into court system
- Support groups, peer support

Similar responses were recorded when participants were asked about the types of clients that require coordination, information sharing, and teaming as well as transitional points, specifically: *how do people fall through the cracks?* From the perspective of education sector, they collectively hope to see students receive consistent care and want to understand the dynamics behind each student's individual case.

Students without health insurance

- Students may be referred to Amberwing or Miller Dwan by the County, but may not have insurance to receive treatment.
- Wisconsin insurance not accepted at Minesota hospitals/treatment centers

Family Dynamics

- Parents needing help with forms or insurance
- Lack of transportation for student to treatment/programs (parents working/unavailable)
- Stigma "kids being kids," "not a big deal"

Homeless & Transient Populations

- New to community, unable to connect with available resources
- May have had negative experiences with, or mistrust of, current services available leading to reluctance in seeking treatment

Substance Abuse

- No outpatient substance abuse services for minors
- Minors not able to recieve substance abuse treatment until they enter the judicial system

Mental Health Crises

- Lack of communication between school and emergency services
- Access to follow-up care

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
EDUCATION INTERVIEWS SUMMARY

CURRENT COORDINATION OF CARE (CONTINUED)

Those interviewed were also asked about **embedded routines that support coordination of care**. This group largely indicated that most communication and coordinated occurs within the specific school building or district. Many respondents indicated a desire to have more communication across organizations (e.g., county, social workers, psychologists, treatment facilities) to better support students. A common example scenario across multiple responses was that a student could have a mental health emergency over the weekend and return to school on Monday, with the student support teams are unaware that the student experienced a crisis.

Next, they were questioned on types of **client information shared between participating partner organizations** and the process by which information is shared.

Respondents noted that wraparound care, or coordination with county social workers, students, school counselors, and family members is the ideal situation when providing full student support. This group also frequently mentioned perceptions and anecdotes regarding the relationship between education, families, and county staff, which can be tenuous at times.

Interviewers then asked **how clients are involved in the planning of their care/services**.

Interviewees frequently mentioned students' family buy-in and support as critical to receiving treatment. Since most in the group work with minors, parents and guardians are an integral part of the treatment plan. For example, one respondent shared that "depending on provider, some can only make three attempts to reach out to family. Then it's up to the family to reach out. If parents don't know the number, they don't answer."

Examining collaboration between organizations, participants were asked **how they make care decisions as a responding team.**

In this group, many interviewees expressed a desire for better collaboration and communication between organizations, specifically with Douglas County staff and discharge information from either treatment centers or hospital settings. Additionally, participants want to clarify the abilities of what the schools can/cannot do as it relates to mental health treatments. For instance, one respondent stated, "There are differences in language and expectations…We receive recommendations from the medical field but cannot always meet those recommendations in an educational setting."

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
EDUCATION INTERVIEWS SUMMARY

SYSTEMS CHANGE

The final portion of the interview was dedicated to understanding participants' challenges within the current systems, understanding the community dynamics, and naming future goals and hoped-for outcomes from this process.

What are some particular outcomes you are hoping for through this systems change process?

- Opportunities for better collaboration
- Understanding more about available resources and the role each play - how to work with each other best
- Getting everyone together to develop an action plan
- Understanding what sheriff departments, Essentia, Lake Superior Community Health, etc. are doing
- Support
- Accountability
- How to have a system to openly communicate across organizations without breaking confidentiality?

What do you feel are some issues/challenges with the current behavioral health crisis response system in our community that are not the province of a single organization? What are the issues/challenges with the system?

- HIPAA/ROIs - ability to share information across organizations
- Internet/WiFi access
- Parent capacity/availablity to understand system to help child
- Advocacy - *"The people that sit on the Boards, the Mental Health Coalition, Douglas Co., Essentia, need to...talk to people like us...they do a lot of talking and have a nice lunch...they are listening, but not a lot of action."*
- Agencies overwhelmed - staff can recieve more money working in MN
- Low socio-economic area, higher poverty
- Transportation
- Consistency (in organization leadership/staff)
- Rural vs. in-town access to services

What are some existing sources of conflict in the community around the issues you're interested in influencing through this process?

- Changes in hospital procedures affecting school's ability to support students in transition back into school - e.g., not receiving discharge information (used to, but has since stopped)
- Tension between County Health & Human Services Department and parents, professionals, and the community
- Historical trauma and mistrust of government, resources, police, and other agencies as a barrier to obtaining care
- Differences between rural schools & Superior School District (avilablity of services and supports, community dynamics)

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
EDUCATION INTERVIEWS SUMMARY

Interviewees were asked about shared values across organizations in the community as well as general perceptions of what people who live in the community are like. Respondents identified education, well-being of children and families, mental health, and the community coming together when a major event happens as shared values.

.This group reported participation in other work groups and highlighted that relationship-building is the key component to success. Another sentiment noted was that of having a desire to collaborate, but being unsure of who exactly to partner with, as well as a desire to see more actionable items and accountability.

Who should have been there? Whose voices are missing in this process?

Whose voices should be included?

- Students/Student Groups
- Students with disabilities
- Families/Parents
- Hope Squad (Structured, school-based program which trains students to identify struggling peers and refer them to adults)
- Victims
- The individuals in crisis

Whose voices are missing in this process?

- Parents/caregivers
- Grandparents raising grandkids
- Pediatricians/Primary Care
- Prenatal support
- Head Start
- Housing coalitions
- Child care providers
- Youth Service organizations (Boys & Girls Club, YMCA)
- Core business community stakeholders

APPENDIX 4

First Responder Interviews Summary

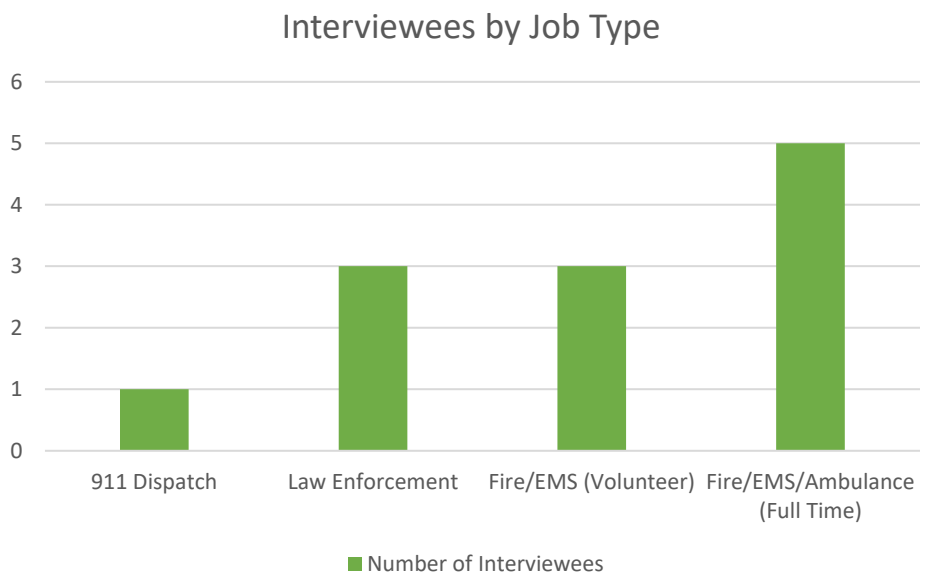
Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
FIRST RESPONDER INTERVIEWS SUMMARY

Framing Lens: Change Statement
Transforming Douglas County's behavioral health crisis prevention and response by working actively together using a common vision for crisis response, shared methods of crisis planning, and further development of person-centered supports.

As part of the process to assess Douglas County's behavioral health crisis prevention and response, members of the AHW team interviewed twelve first responders representing seven organizations throughout the county. The goal of the interviews is to assess each groups' current systems flow, coordination of care, and thoughts regarding changes to current systems.

OVERVIEW
Interviewees were asked to briefly describe their organization and people served. Except for the police department (2 respondents) which serves the City of Superior, all have mutual aid agreements which allow for service throughout Douglas County.

Next, respondents were asked to identify challenge and opportunities within their organizations as related to behavioral health. They were also asked how they measure success within their organizations. A summary of those responses is found in the table below.



Challenges	Opportunities	Measures of success
• COVID • Increase in call volume • Staffing levels • Difficulty accessing resources for patients • Not having the adequate tools to help behavioral health patients long-term • Staff mental health and self-care • EMS required to wait for law enforcement to secure scene safety – delays to response • Compassion fatigue	• Embedding social workers with law enforcement • Relationship building between sheriff's office and Health & Human Services • Mental health crisis line	• "If we don't have administration yelling at us, we're good." • If the patient has a heartbeat when we leave • Sometimes it's just a thank you, that's just huge • **One thing we all use as a measure of success, is that everybody gets to go home**

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
FIRST RESPONDER INTERVIEWS SUMMARY

CURRENT SYSTEMS FLOW

Participants were next asked about the current systems in place, and how their organization responds to a behavioral health crisis. They were asked to describe their role within the current system, procedures for obtaining releases of information, and barriers for patient access. Responses are summarized and edited for clarity below.

How do folks move through the systems currently in place? What is your role in the system?

- As first responders, this group noted they are often the first to arrive. They are responsible for stabilizing the scene and patient, and providing any necessary transport (hospital, jail, etc.) Once the call is resolved, there is not much interaction or follow-up from this group back to the patient.
- ***"911 dispatch triages, gets info, dispatches resources based on algorithm. If mental health or drug related, this triggers a response from police department, Superior fire, and Mayo Clinic Ambulance. 2 officers, 1 engine, 1 ambulance. Lights and sirens. On scene: police department secures scene...come in and assess patient. If they require med care, packaging them and transporting to emergency room."***

Can you describe how you obtain Release of Information (ROIs) and your ROI process? Who would need to authorize? How would it get approved?

- ROI origination for this group would stem from the Public Information Officer, police department, or Emergency Medical Records system (based out of Rochester, MN).
- EMS services rarely have ROI requests, and much of the patient's information is protected by HIPAA. However, they record the call information in the State of Wisconsin database, where it can be accessed by hospital medical directors and other state agencies.

What are some of the barriers to access that you've seen within your organization for the clients you serve?

- Nowhere to take patients if emergency department/inpatient/treatment beds full
- Lack of non-emergency transport options
- Lack of local resources
- Follow-up with patients taken to the emergency department is not required and only occasionally happens voluntarily. First responders unsure if patients are accessing recommended follow up care.
- Stigma around mental illness/mental health
- Aftercare follow-up, long term assistance
- Affordability
- Reactive vs proactive responses to mental health care

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
FIRST RESPONDER INTERVIEWS SUMMARY

CURRENT COORDINATION OF CARE

Interviewees were asked about the current systems in place that relate to the coordination of patient care between organizations, as well as transitional points where people in need of care can fall through the cracks.

What type of service coordination, information sharing, and teaming happens now?

- Informal debriefing and information sharing within organizations – ie shift changes, post call
- Law enforcement sharing/coordinating with CASDA regarding domestic violence calls
- Law enforcement sharing information with HHS or CPS when relevant
- Monthly meetings with fire departments in Douglas County, Sheriff's Office, Emergency Management Department, EMS, Douglas County 911, Mayo Ambulance
- Ambulance shares patient care report with receiving facility, any other sharing would require ROI signed by patient

What supports would you like to have in place to help you in coordinating care/services?

- Support for "frequent fliers"
- More resources for county social workers, increase in social work staff
- Education and training in mental health for volunteer staff
- More tools in toolbox for handling mental health calls for 911 dispatchers
- Support for witnesses of trauma, family members
- Respite
- Training in CIT (for law enforcement)
- Community Paramedic Program
- Support/follow up for patients who don't quite need to go to the hospital, but still need help
- 24-hour crisis lines
- Better connections/relationship building with staff members at mental health resource centers (better referrals for those needing help)

Similar responses were recorded when participants were asked about the types of clients that require coordination, information sharing, and teaming as well as transitional points, specifically: *how do people fall through the cracks?* From the perspective of first responders, they collectively hope to see patients receive follow-up care.

Frequent Fliers

"Dispatchers notice elderly that call over and over and over…could be 7 different officers [responding], so no one notices that that person has been visited that many times. Don't know how to bring that to anyone's attention. It's only if someone specifically goes in to look and says "Holy [expletive], look how often we've been there"

Hoarding/Unsafe Living Conditons

"I've responded to calls before, bad living conditions, this person needs extra help at home, could be mental health issue they don't know, individual themselves doesn't know. We make reports to HHS, sheriff's dept. Once we make report to DHS it's in their court to follow up with. Most of the time they can't really do anything about it."

Homeless & Transient Populations

"Nobody's checking on them, how can you? Don't know where to look for them. Transient people [in] winter they find their way south, summer she's back in town."

Chronic Substance Abuse

"Sometimes they don't want the ambulance, but they feel so horrible they want some support. Those who want to quit [drug use] but are in the gap between that decision and getting treatment. They're teleg -raphing they're not safe, but they don't meet requirements for medical transport."

Mental Health Crises

"Small amount of services we as law enforcement have - family, hospital, or alone...and we'll be back later, are our only 3 options."

Those interviewed were also asked about **embedded routines that support coordination of care**, which this group did not report beyond stabilizing the patient and situation, providing acute care, and transfers to hospitals and referrals other social services. One participant lamented, "You can refer this stuff, but what can you do as an individual responder?"

Next, they were questioned on types of **client information shared between participating partner organizations** and the process by which information is shared.

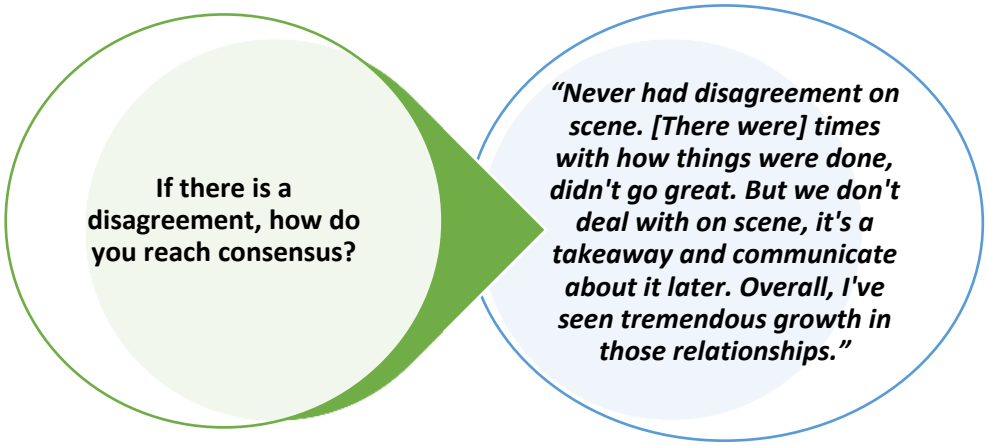
With public entities, certain information is subject to open records laws. The county-wide records system stores names, addresses, call code, phone number, computer-aided dispatch (CAD) notes, and are sent to mobile phones for police officers. Marcy's Law requires advance notification and waiver. Information regarding juveniles is redacted, or otherwise written to be unidentifiable.

Beyond the county recording system, one responder commented, "If it doesn't happen on scene, there is not info sharing."

Interviewers then asked **how clients are involved in the planning of their care/services**. When working on an individual level, responders noted that the goal it to allow freedom for the patient to make their own decision. Often, they'll try to work with family members to encourage support and care. One interviewee summed it up succinctly, noting, "It's called assault and battery if you do something to a patient and they don't want you to."

At the community level, responders described the county-level local emergency planning committee, which meets annually at a minimum, but most often quarterly.

Examining collaboration between organizations, participants were asked **how they make care decisions as a responding team.** Frequent answers included referrals to the sheriff, or some other type of assistance, such as social workers that can get the patient connected to someone. A key part is encouraging patients to seek the care they need once they are transferred out of the care of first responders.



Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
FIRST RESPONDER INTERVIEWS SUMMARY

SYSTEMS CHANGE

The final portion of the interview was dedicated to understanding participants' challenges within the current systems, understanding the community dynamics, and naming future goals and hopeful outcomes from this process.

What are some particular outcomes you are hoping for through this systems change process?

- ***"Moments that stand out, calls where I actually felt like I saved someone's life. That does not happen very often. Then I found out later that conversations had a lot more impact that I thought. We never really know the impact of what we do."***
- Legislative changes making it easier to implement assistance
- More resources for help/support: 24 hour line or social worker, support for patient family members and caregivers, dementia patient support
- Reduction in ER transports, understand the different levels of care and what we can offer/assist with before it gets to a physical altercation, getting people actual medical help rather than only interacting with first responders
- Ability to know medical information before responding (e.g., does this person have schizophrenia), more diversions from criminal justice system, mental health court system like drug court
- Peer groups for first responders

What do you feel are some issues/challenges with the current behavioral health crisis response system in our community that are not the province of a single organization? What are the issues/challenges with the system?

- Involvement of HHS/CPS right away, kids getting taken into custody
- Lack of funding
- First responder mental health and burnout (especially for volunteer EMS)
- Police dept. says "take to hospital" and ambulance says "take them to detox"
- Getting frequent fliers the help they need - EMS can make suggestions to ER provider or wherever they are being transported, but then it's up to the ER
- Delegating authority and collaboration between organizations
- Patient bed capacity

What are some existing sources of conflict in the community around the issues you're interested in influencing through this process?

- ***"Law enforcement is looking at things through a different lens. They are there to secure the scene and perceiving the person as a threat…have cases where law enforcement is being more verbally aggressive and there's a trickledown effect. When we [EMS] arrived, the person was unnerved, but then law enforcement arrives and it escalates or gets worse. When it gets to that point, it's hard to walk it back."***
- Lack of fuding for volunteer EMS services, equipment & training
- Crossover on Narcan administration and understanding patient safety
- Working to respect people's dignity
- Lack of education about what's actually needed
- ***"Volunteer responders are put in the same class as the Lions Club, Elks Club, etc., good orgs, but they aren't the same. People don't call them when a child is choking or there is an emergency. People get confused that a Volunteer Fire and EMS may have social aspect, but they're not a social or civic organization."***

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
FIRST RESPONDER INTERVIEWS SUMMARY

When asked what sort of compromises, decisions, or outcomes that were less than ideal that had been reached in the past, respondents noted disparities between training requirements and practical applications to routine work.

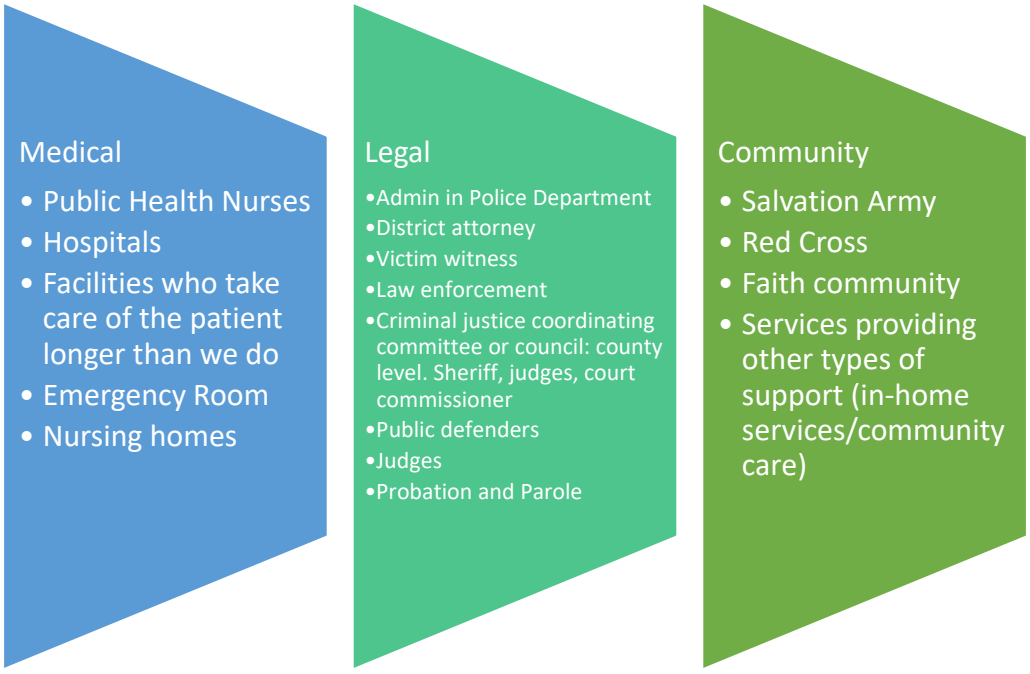
- County health dept. wants to be involved in approval process - they're footing the bill if no insurance
- Law enforcement: on Emergency Department report, strong expectation of 2-3 witnesses – many times that's not the case.
- Don't want to burn people out doing all the non-critical training for "low volume, high consequence" events that you'll never experience
- There is a disconnect between what the school is training students on and what responders are responding to, especially in rural communities.
- ***"…all these different requirements to do our jobs, but it is also a volunteer position."***

Interviewees were asked about shared values across organizations in the community as well as general perceptions of what people that live in the community are like. They described a mix of deep compassion for the community they serve as well as acknowledgements that the work is challenging.

- Rural community mix of rural and urban, families and friends/hometown kind of feel, but physically distant.
- ***"It takes a village and [I] think everyone would like to see everyone doing better, but it's sometimes hard"***
- ***"There is not the drive to be there to help your neighbor or friends. There isn't value put on being a volunteer and being a part of community."***
- ***"Douglas Co. is a big county/group, but they do care about each other."***
- Time and money are crucial and, people don't have time to volunteer
- ***"Made of caring and generous ppl that want to do the right thing. Empathy is provided. Intentions are good. Even if doesn't work out."***

Finally, participants were asked if, in the past, there were situations where the right people were not there. Responses mentioned underutilized non-profits and private organizations, and an overreliance on city and county personnel, which respondents felt limited their scope and ability to help.

Who should have been there? Whose voices are missing in this process?



APPENDIX 5

Health Care Behavioral Health Interviews Summary

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
HEALTH CARE / BEHAVIORAL HEALTH INTERVIEWS SUMMARY

Framing Lens: Change Statement
Transforming Douglas County's behavioral health crisis prevention and response by working actively together using a common vision for crisis response, shared methods of crisis planning, and further development of person-centered supports.

As part of the process to assess Douglas County's behavioral health crisis prevention and response, members of the AHW team interviewed twenty-six individuals representing thirteen health care institutions throughout the county. The goal of the interviews is to assess each group's current systems flow, coordination of care, and thoughts regarding changes to current systems.

OVERVIEW
Interviewees were asked to briefly describe their position and population served. In total, there were 26 individuals representing 13 different organizations within the healthcare industry. Organizations ranged from emergency department staff at local hospitals to outpatient treatment providers serving a range of clientele from children and families to elderly patients.

Hospital	**Non-Profit**	**Inpatient/Outpatient**	**Counseling Center**
• 3 organizations • 14 interviewees	•4 organizations •5 interviewees	• 4 organizations • 5 inteviewees	• 2 organizations • 2 interviewees

Next, respondents were asked to identify challenges and opportunities within their organizations as related to behavioral health. They were also asked how they measure success within their organizations. A summary of those responses is found in the table below.

Challenges	**Opportunities**	**Measures of success**
• COVID • Increased demand for services • Long waiting lists • Low availability of after-hours/overnight services • Lack of insurance • Challenging to hire staff	• Peer support • Access to after-hours care • Increased collaboration between agencies	• Greater quality of life, relationships • Pre- and post-tests and metrics for clinical side • Patient gets to next level of care they need • Discharge that's planned and termination of services, and next steps for clients • Talking about success, celebrating the success stories

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
HEALTH CARE / BEHAVIORAL HEALTH INTERVIEWS SUMMARY

CURRENT SYSTEMS FLOW

Participants were next asked about the current systems in place and how their organization responds to a behavioral health crisis. They were asked to describe their role within the current system, procedures for obtaining releases of information, and barriers for patient access. Responses are summarized and edited for clarity below.

How do folks move through the systems currently in place? What is your role in the system?

- Identify risk level, ask if they have suicide plan
- High risk: consider having provider call 911, consult with on-call psychiatrist or refer for therapy, encourage social support.
- Moderate risk: try to get evaluation with psychiatrist. Figure out stressors and risk factors. Document assessment and clinical decision and treatment plan, coordinate follow up

Can you describe how you obtain Release of Information (ROIs) and your ROI process? Who would need to authorize? How would it get approved?

- *"Different places are different."*
- Most organizations have a general ROI that they will have patients sign upon intake
- Patients often decide who they are comfortable releasing information to (parents, school, therapists, etc.)
- For crisis situations, an ROI is not required to act

What are some of the barriers to access that you've seen within your organization for the clients you serve?

- Wisconsin insurance
- Lack of after hours services. Without evening and weekend services, people revert to coming to the ER
- Financial challenges
- No access to methadone with high rates of opioid addiction
- Mistrust and distrust - feeling that the system is working against an individual
- Technology
- *"In crises you don't have time to navigate oll of the barriers."*

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
HEALTH CARE / BEHAVIORAL HEALTH INTERVIEWS SUMMARY

CURRENT COORDINATION OF CARE

Interviewees were asked about the current systems in place that relate to the coordination of patient care between organizations, as well as transitional points where people in need of care can fall through the cracks.

What type of service coordination, information sharing, and teaming happens now?	What supports would you like to have in place to help you in coordinating care/services?
• More coordination seen on the substance abuse side with Treatment Court team for Drug Court • Coordination with Inclusa, Community Care of WI when clients are shared • Monthly peer meetings with guest speaker on a topic of interest followed by a business meeting. Purpose of meetings is to provide education, information, networking, and peer support.	• Case manager for mental health in community • Social worker embedded with police • Geriatric focused providers • Targeted case management, wraparound care • Crisis line for Douglas County • Peer support, opportunities to create a community and make sure it is safe • Providers who treat eating disorders, trauma using Eye Movement Desensitization and Reprocessing (EMDR), and other specialists

Similar responses were recorded when participants were asked about the types of clients that require coordination, information sharing, and teaming as well as transitional points, specifically: *how do people fall through the cracks?*

Referral Loops & Handoffs

- Providers want to be able to provide warm handoffs, but resources may not be there
- Clients frustrated trying to reach someone and giving up
- Long waiting lists

Transistioning out of care/treatment/programs

- "They go from micromanaged [care] to expected to stay sober with no support."
- Lack of follow up care/treatement plans or client has to set up their own

Wisconsin vs. Minnesota

- Disparities in care/services available between MN & WI
- Methadone treatments not available in Wisconsin
- 24 hour line/crisis respite not available in Wisconisin

Tipping Points

- How to help those who are struggling before experiencing a crisis
- Preventative care

Housing

- Lack of supportive housing in the community
- Safe, affordable
- Sobriety requirements can be a barrier

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
HEALTH CARE / BEHAVIORAL HEALTH INTERVIEWS SUMMARY

CURRENT COORDINATION OF CARE (CONTINUED)

Interviewers then asked **how clients are involved in the planning of their care/services**. Participants described varying levels of involvement from plans designed solely by a case manager to clients developing their own lists of goals. This group highlighted a shared value in providing person-centered care.

SYSTEMS CHANGE

The final portion of the interview was dedicated to understanding participants' challenges within the current systems, understanding the community dynamics, and naming future goals and hoped-for outcomes from this process.

What are some particular outcomes you are hoping for through this systems change process?

- *"It would be helpful to have a referral/call center similar to what Essentia has"*
- Referral/connection line like 211
- Local crisis team
- Social worker embedded with Superior Police
- *"Provide more comprehensive, accessible, cost-effective, holistic preventive and reactive services to as many people as possible."*

What do you feel are some issues/challenges with the current behavioral health crisis response system in our community that are not the province of a single organization? What are the issues/challenges with the system?

- Staff capacity at provider organizations
- Understanding the role each organization plays in the system for better patient outcomes
- Mistrust/distrust between consumers and providers and/or between provider organizations
- *"Patients are sometimes waiting for 48+ hrs and then going 150 - 250 miles away for inpatient care."*

What are some existing sources of conflict in the community around the issues you're interested in influencing through this process?

- Tensions between Douglas County and other organizations
- Tensions between organziations due to differences of opinion on harm reduction and abstention
- More networking or information-sharing opportunities between provider organizations would help to allieviate tensions and confusion about available services
- Insurance coverage/reimbursement issues
- *"Perception is that some agencies will not provide services to specific races or even socioeconomic status."*

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
HEALTH CARE / BEHAVIORAL HEALTH INTERVIEWS SUMMARY

Interviewees were asked about **shared values** across organizations in the community as well as general perceptions of what people who live in the community are like. Participants in this group described the established stigma around mental health, and the importance of continuing to break that down. As with other groups, the health care cohort mentioned the small-town, community feel found in Douglas County and that people generally want to help and care about each other.

When asked about **participation in other work groups** and their **effectiveness,** interviewees reported a general feeling that more meetings do not always magically translate into more resources. Responses indicated that having more accountability and task-oriented items for those involved will keep momentum moving toward achieving desired goals. They emphasized the importance of grassroots efforts and involvement, and that top-down efforts often meet resistance.

Whose voices should be included? Whose voices are missing in this process?

Whose voices should be included?

- Clients
- Families
- Faith communities
- Schools and homeschooling groups
- Different socioeconomic groups
- Native communities

Whose voices are missing in this process?

- Patients
- Therapists/Providers
- Different populations, cultures, and identities
- Non-English or multilingual speakers/agencies (Health surveys available only in English will not reach these speakers)
- Kid perspective - not just parents
- Private businesses

APPENDIX 6

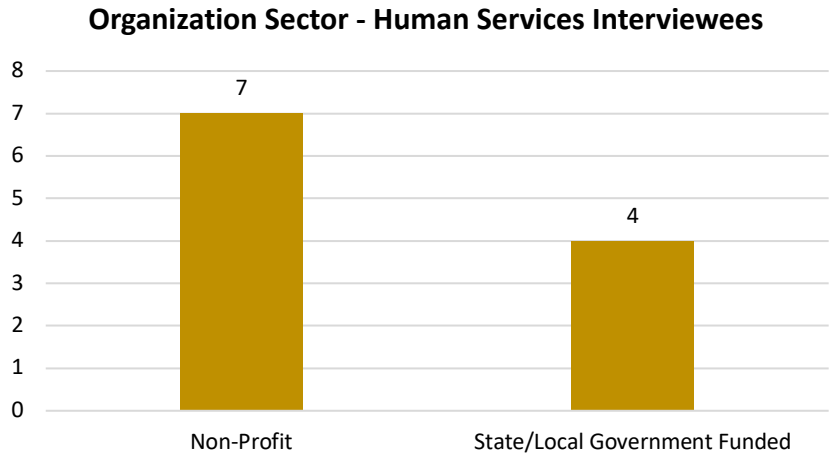
Human Services Interviews Summary

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
HUMAN SERVICES INTERVIEWS SUMMARY

Framing Lens: Change Statement
Transforming Douglas County's behavioral health crisis prevention and response by working actively together using a common vision for crisis response, shared methods of crisis planning, and further development of person-centered supports.

As part of the process to assess Douglas County's behavioral health crisis prevention and response, members of the AHW team interviewed thirty-one individuals representing eight educational institutions throughout the county. The goal of the interviews is to assess each group's current systems flow, coordination of care, and thoughts regarding changes to current systems.

OVERVIEW
Interviewees were asked to briefly describe their position and population served. In total, there were 18 individuals representing eleven different human services organizations. Most organizations represented are non-profits, although 4 are either wholly funded by, or represent, county or state government. Organizations represented in this group provide a range of services, from supporting adults with disabilities or mental illness to creating independent living plans to facilitating support during crises.



Next, respondents were asked to identify challenges and opportunities within their organizations as related to behavioral health. They were also asked how they measure success within their organizations. A summary of those responses is found in the table below.

Challenges	Opportunities	Measures of success
• First responders - lack of trauma-informed training • Insurance • Changes in technology - phone calls vs texting; Facebook vs. TikTok or YouTube to reach youth • Police response to and/or lack of awareness of mental health, dementia, autism • Services are voluntary - follow through • Long term mental health care • Shelter space • Available resources - wait lists	• Virtual meetings help with large territory served • Long-term care • Additional staff • Preventative care	• ***"Needing us less"*** • Seeing individuals gain autonomy, independence • Depends on the individual and their goals • Connecting someone to the right services • ***"If somebody relapsed there was a time I'd see as failure, now I see that they pulled it off for 10 months."***

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team

HUMAN SERVICES INTERVIEWS SUMMARY

CURRENT SYSTEMS FLOW

Participants were next asked about the current systems in place and how their organization responds to a behavioral health crisis. They were asked to describe their role within the current system, procedures for obtaining releases of information, and barriers for patient access. Responses are summarized and edited for clarity below.

How do folks move through the systems currently in place? What is your role in the system?

- Enter through referrals - self, school, law enforcement, etc.
- Assessment - is this an emergency situation? If yes, connecting with emergency services; if no, assessing clients' needs and setting goals to achieve them. Can range from needing a bus pass to creating and executing a plan to live independently.
- Advocacy - "client tells us when they want help being their voice"

Can you describe how you obtain Release of Information (ROIs) and your ROI process? Who would need to authorize? How would it get approved?

- In this group, many of the organizations have their own ROIs for the client to sign. Participants noted that these are often stored in a locked cabinet/file system on site, as well as electronically with limited access for staff.
- HMIS: Homeless Management and Information System. Database for anybody who works with persons experiencing homelessness. We need consent and release to enter info into it.

What are some of the barriers to access that you've seen within your organization for the clients you serve?

- Waiting lists
- Accessing services
- Lack of trauma informed care for first responders (example: "someone goes in to report sexual assault, they [the police] are not trauma informed, make the person feel uncomfortable.)
- Unaccompanied youth, parents not signing off on mental health care
- Lack of transportation
- Lack of internet access
- Financial and insurance barriers
- Not sure where to start
- Low insurance reimbursement rate for providers when compared to MN

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
HUMAN SERVICES INTERVIEWS SUMMARY

CURRENT COORDINATION OF CARE

Interviewees were asked about the current systems in place that relate to the coordination of patient care between organizations, as well as transitional points where people in need of care can fall through the cracks.

What type of service coordination, information sharing, and teaming happens now?

- Formal coordination often occurs within organziations through staff meetings, debriefs, or other procedures.
- Externally, coordination takes a more informal or crisis response route.
- *"Many aspects to safety planning. Emotional, spiritual, community safety. The more resources you can connect with, more successful."*

What supports would you like to have in place to help you in coordinating care/services?

- Depends on client and what they want - family can be really involved and positive or a hindrance.
- Asking the individual who they would turn to and connecting them to those people/resources
- *"Finding manpower and money."*
- A county coordinator
- More mental health providers for youth
- Transitional housing program
- Detox center in Superior
- *"When there are new programs, making sure everybody in the County knows about it."*

Similar responses were recorded when participants were asked about the types of clients that require coordination, information sharing, and teaming as well as transitional points, specifically: *how do people fall through the cracks?* This group noted the difficulties in wanting to provide the correct referrals, but also highlighted the challenges in providing services to individuals with varying levels of needs with limited resources.

Referral Loops & Handoffs

- Client continues to be referred to different agencies, gets frustrated and stops seeking care
- *"We have declined some warm handoff relationships, because we resist warm handoff to a voicemail."*

Change in Circumstances

- People switching organizations for care
- Losing health insurance
- People moving into the community and not sure where to access help

Marginalized Groups

- Black, Indigenous population
- LGBTQ2S+
- People with disabilities
- Lack of representation on committees

Youth

- Lack of parental support for treatment
- Living in poverty
- Homeless
- Runaways

Shelter/Housing

- Need for longer term shelter/housing options
- *"Can't go from homlessness, joblessness to a home, job, daycare, etc. in 30 days."*

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
HUMAN SERVICES INTERVIEWS SUMMARY

CURRENT COORDINATION OF CARE (CONTINUED)

Those interviewed were also asked about **embedded routines that support coordination of care**. Only one group reported having these embedded routines, which include face to face meetings quarterly. Next, they were questioned on types of **client information shared between participating partner organizations** and the process by which information is shared. This group will share information when needed (and possible) between organizations. Typically, this includes an ROIs or a handoff between organizations. Interviewers then asked **how clients are involved in the planning of their care/services**. With the Human Services group, the care plans are designed with the individual. Much of the planning requires listening to the client and understanding what their short- and long-term needs and goals are.

SYSTEMS CHANGE

The final portion of the interview was dedicated to understanding participants' challenges within the current systems, understanding the community dynamics, and naming future goals and hoped-for outcomes from this process.

What are some particular outcomes you are hoping for through this systems change process?

- An immediate response team; crisis services available 24 hours
- County-wide crisis plan to help with communication flow
- Better teaming between organizations and Adult Protective Services
- Deeper understanding of what services each provides/can provide
- Greater investment in prevention - legislators and funding decision makers listening to providers and data for what is needed to provide better, more effective care

What do you feel are some issues/challenges with the current behavioral health crisis response system in our community that are not the province of a single organization? What are the issues/challenges with the system?

- Finding, keeping, and sustaining money and programs
- Keeping qualified professionals in Wisconsin/Douglas County
- Comprehensive community services
- Legislation and policies
- Lack of services for youth - from full mental health to just having a space where youth want to hang out
- Fragmented and complicated health care system
- Needing referrals to receive certain services
- *"How people connect into the system; for example, mobile crisis. If a parent is struggling with their kid and calls law enforcement, it's going to trigger a check...there isn't a way across systems to have the respect to ask "What's the right response?" or "What do you they really need?" so there aren't unintended consequences."*

What are some existing sources of conflict in the community around the issues you're interested in influencing through this process?

- Lack of funding, lack of resources
- Youth wanting to have a voice on local coalitions, but meetings are often held during school days/times; often transportation barriers
- Relationships with county
- *"Tension within the system...but territory in general comes from not understanding the other entity's goal, and it's usually tied to funding"*

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
HUMAN SERVICES INTERVIEWS SUMMARY

Interviewees were asked about **shared values** across organizations in the community as well as general perceptions of what people who live in the community are like.

On the organizational level, participants highlighted trauma informed care, focus on the individual, and mutual respect as shared values. Within the community, this group reiterated that people generally want to help, but may be unsure how to best handle someone having a mental health crisis. In some responses, it was noted that self-reliance culture runs deep, with one response detailing *"social circles are small and tight and committed. Inherently people keep to themselves."*

When asked about **participation in other work groups** and their **effectiveness,** interviewees reported involvement with work groups across sectors. They noted that more accountability and clearly defined action steps are critical to the success of completing the particular group's goals.

Who should have been there? Whose voices are missing in this process?

Whose voices should be included?

- **Clients**
- **Youth**

Whose voices are missing in this process?

- **Clients/Individuals who have lived experience**
- **Youth**
- **Caregivers**
- **Vulnerable populations (for example, those involved in the Community Support Program)**
- **City Council/Mayor**
- **"*Whoever makes the decision about the money*"**
- **Consumers/Community members**
- **NorthLakes Community Clinic (Federally Qualified Health Center, operates 14 clinics throughout NW WI, provides services to all regardless of insurance status and ability to pay)**
- **Lake Superior Community Health Center**
- **Adult Services**
- **Public Health**

APPENDIX 7

Legal Interviews Summary

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
LEGAL INTERVIEWS SUMMARY

Framing Lens: Change Statement
Transforming Douglas County's behavioral health crisis prevention and response by working actively together using a common vision for crisis response, shared methods of crisis planning, and further development of person-centered supports.

As part of the process to assess Douglas County's behavioral health crisis prevention and response, members of the AHW team interviewed six individuals representing four organizations in the legal sector. The goal of the interviews is to assess each group's current systems flow, coordination of care, and thoughts regarding changes to current systems.

OVERVIEW
Group members interviewed from the legal sector include staff from the Douglas County District Attorney's office, probation and parole offices, and victim/witness coordinator. Logistically, these offices are part of the State of Wisconsin Department of Corrections, serve county-wide, and work closely with the local police, sheriff, and Wisconsin State Patrol.

Challenges	Opportunities	Measures of success
• Indigent or financially unstable • Undiagnosed mental health issues • Individuals unable to receive care – long waiting lists, cannot travel to Duluth, cost • Patient follow-through • Establishing trust • Interactions reactionary rather than preventative • Services are available, but not in Douglas County, often traveling to Eau Claire for residential treatment	• Working with individuals 1:1 regarding their charges, pleas, sentencing • Creation of a mental health court similar in intent to treatment court • Getting court system to view and adopt other options if they are available (other than jail or probation) • *"There are some Probation & Parole offices in larger communities that host different entities that come in to provide assistance. For example: Every Tuesday someone comes in that can assist people with applying for BadgerCare. Wednesday it's housing options. Thursday it something else. To have the resources here and that could come to us, then we could help connect people to get clients set up."*	• *"Successful if [we] ensure the victim's rights and defendant's rights are vindicated."* • Reducing victimization in the community • Successful completion of probation without further recidivism or victimization

CURRENT SYSTEMS FLOW
Participants were next asked about the current systems in place and how their organization responds to a behavioral health crisis. They were asked to describe their role within the current system, procedures for obtaining releases of information, and barriers for patient access. Responses are summarized and edited for clarity below.

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
LEGAL INTERVIEWS SUMMARY

How do folks move through the systems currently in place? What is your role in the system?

- Inital interactions start after a crime committed. First appearance either by arrest or summons.
- Attorney's office(s) interact with both victims and offenders. If possible, schedule pre-trial assessment or counseling.
- Once court complete, individiual's case moves to probation offices. Assess for risk of recidivism, work to provide referaals and assign to a case agent, who designs plan based on needs and recidivism risk.
- Once individual is done with probation, they can take a voluntary exit survey. Probation staff noted: *"[the] Intake process very heavy on involvement, end they do survey and discharge, [there is] no formal process."*

Can you describe how you obtain Release of Information (ROIs) and your ROI process? Who would need to authorize? How would it get approved?

- Victims have right to know and right to privacy under Marcy's Law, but ultimately criminal cases are public record.
- Every person signs ROI at onset for probation cases - DAs, public defenders, and service providers while on supervision
- Clients can refuse and withdraw at any point

What are some of the barriers to access that you've seen within your organization for the clients you serve?

- Money - for example, pre-trial assessments have to be paid by the individual
- Access to mental health professionals and resources (long waiting lists)
- Transportation
- Housing
- Employment with convictions
- Those who are found not guilty by insanity (NGI) are superivised by DHS and DOC - not allowed to travel out of state, must receive all services in Wisconsin

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
LEGAL INTERVIEWS SUMMARY

CURRENT COORDINATION OF CARE

Interviewees were asked about the current systems in place that relate to the coordination of patient care between organizations, as well as transitional points where people in need of care can fall through the cracks.

What type of service coordination, information sharing, and teaming happens now?	What supports would you like to have in place to help you in coordinating care/services?
• Those that are found not guilty due to insanity (NGI) - coordination with DHS "textbook" well-established regulations • Complex - in Wisconsin there are contracts that different regions have with different providers • *"We don't know what happens until it's already over with."*	• Information - if there's a genuine mental health issue to determine convict or not, probation or not • Mental health court • *"It would be nice to know what services Douglas County Health & Human Services can to provide to us vs. what they cannot provide to us"* • Support for mental health providers as well • *"[There's a] lot more coordinating on drug court team, meet every week, with judge, DA, sheriffs, cops, treatment providers"*

Similar responses were recorded when participants were asked about the types of clients that require coordination, information sharing, and teaming as well as transitional points, specifically: *how do people fall through the cracks?*

- Homeless population
- Transitioning out of supervision
- Those unable to recieve mental health care in timely manner
- Lack of access to technology

CURRENT COORDINATION OF CARE (CONTINUED)

Those interviewed were also asked about **embedded routines that support coordination of care**. This group did not report any embedded routines. Next, they were questioned on types of **client information shared between participating partner organizations** and the process by which information is shared. This group shares information when needed (and when possible) between organizations. Typically, this includes communications with the police, defense attorneys, alcohol and other drug addiction (AODA) treatment staff, and social workers.

Advancing Healthy Wisconsin CARE (Crisis Access Response & Engagement) Team
LEGAL INTERVIEWS SUMMARY

SYSTEMS CHANGE

The final portion of the interview was dedicated to understanding participants' challenges within the current systems, understanding the community dynamics, and naming future goals and hoped-for outcomes from this process.

What do you feel are some issues/challenges with the current behavioral health crisis response system in our community that are not the province of a single organization?

What are the issues/challenges with the system?

- Law enforcement responding to crisis: *"The police presence is a little extreme. We need a softer way/approach"*
- What's realistic? For example, hearing "why can't the judge sentence them to treatment?" Have to explain that judges cannot order treatment, but can order probation and they [probation office] will work with them on accessing treatment.

From your perspective, are there shared values that cut across various organizations in the community?

- *"Not everyone wants the most severe punishment, segments of the community are very understanding. They want accountability."*
- Balance between holding individuals accountable for their actions, but also wanting to see them receive help.

When asked about **participation in other work groups** and their **effectiveness** this group reported being a part of various community work groups ranging from establishing drug-free educational programming for elementary schoolers to community events to safe disposal of old medications.

Who should have been there? Whose voices are missing in this process?

Whose voices should be included?

- Probation & parole
- Judges

Whose voices are missing in this process?

- Superior Police Department - Pathways to Hope program
- Treatment Court

APPENDIX 8

Education Processes

EDUCATION PROCESSES

PRE-K (FAMILY FORUM)

1. Intake process begins
   a. Caregiver/parent reaches out for assistance regarding a child
   b. Designated advocate for family (teacher, caregiver, etc.) reports and converse with manager if comprehensive team is necessary
2. Family-focused meeting scheduled with administrative staff
3. Meeting formulates an action plan with internal or external referrals
4. Staff works to bridge any remaining gaps, including those related to:
5. Accessing resources
   a. Insurance issues
   b. Mental health consultant on the administrative team in Douglas County (Child Development Project)

SECONDARY EDUCATION

1. Conduct behavioral and mental health risk review processes in high school for those known to be struggling and keep up with them using a team of counselors, social worker, psychologist, and administration
2. Superior High School 9th grade team teachers come together to develop lists of kids, do pre-planning, and continue with risk review for grades 10-12
3. Maintain a list of resources in county and nearby areas such as Duluth, and work to get around gaps and build a safety net
4. Intake process begins via a variety of paths:
   a. Student self-identifies; typically someone staff knows or has worked with in past, or has friends who do
   b. Outreach from student's family
   c. Staff referrals to counselors, either directly or via a form
   d. Hope Squad, a Superior High School student-run suicide prevention group
   e. Counselors may refer to social worker, especially if they do not have a working relationship with the student
   f. Administration, if they have a situation they've identified or in response to disciplinary concerns

5. Identify level of crisis. If immediate:
   a. Provide evaluation
   b. Inform family
   c. Call 911 or other emergency contact

6. Conduct base evaluation assessment of student

7. Reach out to family
   a. If family cannot be contacted immediately, liaison officer may be included to bring parent and/or take child to Miller Dwan

8. Determine if there have been services provided in the past, and if so, where

9. Identify resources for the student and develop behavior and safety plans, if necessary

10. Work with family in making calls for resources

11. Schedule parent meetings for follow-ups (does not always happen)

PRIMARY EDUCATION

1. Process largely follows that for higher grades
   a. Intake less likely to be self-referral and more driven by staff
   b. Usually fewer immediate resources in the school (e.g., no social worker)

2. Develop a safety plan once child has returned to school

HIGHER EDUCATION (NORTHWOOD TECHNICAL COLLEGE)

1. Intake process begins
   a. Student self-identifies
   b. Individuals submit form online if chance of self-harm or harm to others in near future, but not an immediate emergency. Forms referred from Vice President of Student Affairs to Dean of Students to a team including counselor and Dean of Students. Others, including a nurse, can be included depending on the situation.
   c. Instructors or staff refer students to counselors

2. Counselors review referrals from instructors and route them to the most appropriate counselor on the student's home campus (Superior, Ashland, Rice Lake, or New Richmond)

3. Reach out to student
   a. By phone
   b. Email or text follow-up as necessary

4. Meet with student to determine needs and locate resources
   a. Preferably in-person
   b. Phone or Zoom conversations also options

5. Provide necessary resources
   a. Share resource directory (both internal and external resources)
   b. Assistance with scheduling appointments, as appropriate
   c. Call 911, if necessary

UNIVERSITY OF WISCONSIN EXTENSION

1. Not a service provider; connects families to resources
2. Provides education, empowers families, brainstorms on resources, and help them problem-solve.
3. Makes calls if necessary
4. Follows up by asking if the family was able to access care and identify barriers if not successful
5. Offers temporary tools to help while students are on waiting lists for longer-term support

OTHER CONSIDERATIONS

- Internal Gaps
- Resources for pre-K support, with no respite care available.
- School district administration attempting to create memoranda of understanding (MOUs) with outside agencies to reduce barriers to service provision in schools.
- High schools also often lack the necessary personnel, though interns have helped.

EXTERNAL GAPS

- Transportation, especially to services such as Amberwing in Duluth or from rural areas to services in the Twin Ports, has been a barrier. A Duluth-based agency had offered transportation for day treatment in the past and was helpful.
- Waits for connections to services can be many weeks or months.
- Douglas County does not have any substance abuse services our outpatient treatment for minors, and families encounter insurance issues with services in Duluth. Some get sent as far away as North Dakota.
- State-level issue of reimbursements for medical services in Wisconsin, which are less generous than Minnesota's and therefore not cost-effective.

FOLLOW-UP AND WRAPAROUND SERVICES

- The system often breaks when students return from crises. Students get referred out and go to receive care, but there is often no process for safety plans upon return.
- Restoration of wraparound services and bringing supporting agencies to the table with schools would be a significant outcome of this process. The group acknowledges there are HIPAA barriers but does not believe they cannot be overcome.
- Miller Dwan used to have a wraparound person who was at discharge meetings; now, no releases of information after admission to a mental health unit. Amberwing does provide this.

- Little follow-up from county, especially during Covid. Previous experiences with county wraparound and assigned social worker to provide resources was very effective, but this no longer exists.
- Other counties' crisis lines consult with schools and help create safety plans.
- Teachers would like to be included as a stakeholder in wraparound efforts.

ADDITIONAL COMMENTS

- Internal processes work relatively well, and awareness has increased over the years.
- Need customer feedback on the process.

APPENDIX 9

First Responder Processes

FIRST RESPONDER PROCESSES

DOUGLAS COUNTY DISPATCH

1. Dispatch receives call from an individual, family member, a witness, or first responders already on a scene.
2. Dispatch assesses the situation to determine appropriate response, including the who, what, where, when, and why of the situation.
3. If there is a statement of threat or there may be weapons, dispatch contacts the police department for a response.
4. If there is no statement of threat, dispatch contacts the fire department/Emergency Medical Services (EMS) or ambulance. Whichever organization can respond to the situation first will do so.
5. Dispatch may be brought back into the process if initial responders require additional support, in which case the process begins anew. This is not uncommon, as situations are not always clear from the initial call and may change rapidly.

LAW ENFORCEMENT (SUPERIOR POLICE DEPARTMENT, DOUGLAS COUNTY SHERRIFF)

1. Law enforcement sent to scene by dispatch.
2. Law enforcement arrives on scene and gathers information to determine issues.
3. Law enforcement may decide to transport the individual to detox, the hospital, or jail.
   a. If the individual is cooperative, law enforcement may transport the individual to detox or the hospital, as appropriate.
   b. If the individual is not cooperative, law enforcement follows Chapter 51 protocols to take without consent and complete necessary paperwork.
   c. If no transportation is necessary, law enforcement provides resources. The process can end here.
4. Law enforcement may provide testimony in court in the event of further legal action.

FIRE DEPARTMENT/EMERGENCY MEDICAL SERVICES
(EMS; Superior Fire Department, Volunteer Fire Departments, Douglas County EMS)

1. Fire department/EMS sent to scene by dispatch.

2. Fire department/EMS arrives on scene and determines if information provided to dispatch matches the scene.
   a. If there is a statement of threat, fire department/EMS calls dispatch to request law enforcement presence and stage until scene is safe.
   b. If the situation requires an ambulance for transportation, fire department/EMS contacts dispatch to request ambulance.
3. Fire department/EMS provides treatment.
4. Fire department/EMS shares information with any other responders who are on the scene to develop a more complete understanding of the situation.
5. Fire department/EMS involvement ends when situation is resolved or passed on to law enforcement or ambulance.

AMBULANCE (MAYO AMBULANCE)

1. Ambulance sent to scene by dispatch.
2. Ambulance arrives on scene and determines if information provided to dispatch matches the scene.
   a. If there is a statement of threat, ambulance calls dispatch to request law enforcement presence and stage until scene is safe.
3. Ambulance shares information with any other responders who are on the scene to develop a more complete understanding of the situation.
4. Ambulance may contact dispatch to request additional support from fire department/EMS or another ambulance if necessary.
5. Ambulance provides treatment.
   a. Take individual's vital signs.
   b. If the individual is suicidal, restraints may be necessary.
6. Ambulance determines whether transportation is necessary.
   a. If transportation is necessary, ambulance may transport the individual to detox or the hospital, as appropriate.
   b. If transportation is not necessary, ambulance involvement ends.

OTHER CONSIDERATIONS

- If the situation does not pose an immediate threat but living conditions could create a recurring threat, agencies may call in the Department of Health and Human Services or other support services.
- A critical incident stress management team can debrief members and provide support to first responders when necessary.
- When possible given Health Insurance Portability and Accountability Act (HIPAA) regulations, individuals within the process welcome follow-up to understand how situations were resolved and explore opportunities for improvement.
- Additional opportunities for training across agencies can help improve communication and are welcome.
- Proposed coordinated response specialist within the Superior Police Department could further enhance this process.
- Lack of capacity within the local system creates challenges, including trips by ambulances to distant hospitals to find available beds.
- Lack of common radio channels creates additional communication challenges.

APPENDIX 10

Health Care Behavioral Health Processes

HEALTH CARE BEHAVIORAL HEALTH PROCESSES

HUMAN DEVELOPMENT CENTER (HDC) CRISIS LINE

1. Crisis line receives calls from a variety of sources concerned about a mental health issue
   a. Self-identification
   b. Individuals concerned about friend or family member
2. Crisis line attempts to gather as much information as possible, though some individuals are unwilling to share much
3. Crisis line seeks to de-escalate current problem until individual can see therapist as scheduled or be connected with a resource
   a. Crisis line staff monitor local resources and openings in an attempt to provide referrals that will not require several months of waiting
4. Crisis line writes up narrative on the conversation
5. If the crisis line cannot determine whether the individual will be safe by the end of the call, crisis line will have police conduct a welfare check
6. For acute situations, situation may escalate to a Chapter 51 (emergency detention) process, in which the police department will determine if someone is dangerous to oneself or others and proceed to a 72-hour hold

HOSPITAL

1. Patient arrives at hospital in one of several ways
   a. Walk-ins
   b. Brought by concerned friend or family member
   c. Brought by EMS
   d. Brought by police
2. Nurse provides triage determines if individual is safe
   a. If not safe, a 1-to-1 sitter stays with the person
3. Psychological consultation services (PCS) screening completed via telehealth at the Superior hospital
4. Emergency Department provider and nurse determine if the individual will go to inpatient psychology or resources in the community
5. Case management and social work team does legwork to create a placement plan
6. Process ends with placement in an inpatient behavioral health unit or with discharge to community, with or without resources

DAY TREATMENT FACILITY (CHILDREN)

1. Organization receives referrals from a variety of sources, either via email or form on website
    a. Amberwing
    b. Miller Dwan
    c. Therapists
    d. Social Workers
    e. Parents/Caregivers
    f. Schools
    g. HDC case managers
    h. Web search
    j. Word of mouth
2. Conduct intake meeting with parents and complete necessary paperwork
3. Connect with individuals who have worked with the client in the past, including schools and social workers, if applicable
4. Initial assessment conducted by licensed therapist
5. Assess individual's insurance situation; if insurance will not cover services (usually because the insurance company determines not enough services have been used yet), connect the family with individual therapy, hospitals, school interventions, and medical treatment that will provide those services
6. Individuals go through a Monday-Friday, 6- to-9-month program
7. Develop safety plan prior to discharge ("graduation")
8. Individuals graduate from the program

OTHER CONSIDERATIONS

- Regional and national shortage of ER beds and resulting staffing shortages; challenge is not local.
- Due to a lack of local mental health facilities, patients can be sent considerable distances for care if Miller Dwan is on divert (not taking patients); Ashland has some capacity, but Eau Claire is often the closest place they can be sent.
- Support within the system is strong, but placement outside it is a barrier.
- After day treatment programs end, it becomes harder for individuals to access resources.
- If parents/family members are not on board or lack their own resources, returning to these environments after treatment can exacerbate problems.
- Essentia Health Fargo's ER stays are significantly shorter than in the Duluth area.

- Miller Dwan used to have an adult access center; perception was that the process was smoother before it closed
- Patients with no history of violence or complicating factors are easier to place; those who do can stay in the ER for long periods, where little to no therapy or medication change happens. Those who need help the most wait the longest.
- Historically, the presence of state hospitals lessened some of the burden; now, there are more dangerous patients in adult treatment.
- High burnout rate for staff.

APPENDIX 11

Human Services Processes

HUMAN SERVICES PROCESSES

GENERAL NON-PROFIT PROCESS

1. Agency receives referral
   a. Nursing homes
   b. Community providers
   c. Word of mouth
   d. Hospitals
   e. General advertising of services

2. Agency provides welcome to customer
   a. Create a welcoming environment
   b. Explain role of agency
   c. Explain confidentiality

3. Conduct discovery and gather information
   a. Most commonly via phone, though some organizations use text and email, and others will come to homes or meet in a safe, neutral location
   b. If there is a perceived risk to safety, proceed to step 4
   c. If there is no perceived risk to safety, proceed to step 5

4. Risk to safety: Contact relevant
   a. Call 911
   b. Crisis hotline

5. Identify intent of call and what the customer hopes to gain from the interaction

6. Present options, resources, and supports that align with needs
   a. Assistance for people with disabilities gaining independence such as budgeting, organization, time management, and bus training (North Country Independent Living, or NCIL)
   b. Loans of assistive technology (NCIL)
   c. Transition services into or out of hospital or residential facility (NCIL)
   d. Long-term care (Aging & Disability Resource Center, or ADRC; Inclusa)
   e. Pre- and post-crisis work, including development of Wellness Recovery Action Plan (WRAP) and getting into systems such as housing, divorce, etc. (National Alliance on Mental Illness, or NAMI)
   f. NAMI support groups and education
   g. Adult Protective Services (Douglas County)
   h. Support for individuals affected by sexual assault or domestic violence (Center Against Sexual and Domestic Abuse, or CASDA)

i. Medicaid (Great Rivers)
j. Transportation
k. Food crises
l. Short-term or long-term supportive housing (can be a several-year process)
i. Harbor House
ii. Solid Rock
iii. Grace Place
iv. Steve O'Neil

7. Explain pros and cons of different options
8. Develop an action plan
9. Implement plan
a. Assess whether individual can follow up on own or requires assistance
b. Provide advocacy for individuals who don't know how to navigate the system or are anxious
c. Otherwise, attempt to hold individual accountable

10. As consumer proceeds through plan, determine whether appropriate care was provided or if further follow-up is necessary
a. If plan is implemented successfully, continue to check in as necessary
b. If plan is not implemented successfully or additional interventions are necessary, return to step 3 or step 6, as appropriate, to explore other potential solutions

NORTHERN WATER PARISH NURSES

1. Agency receives referral
a. Self-referral
b. Parish nurses receive direct referral
2. Refer to relevant emergency services if necessary
3. Follow up directly via phone, giving clear times and expectations for follow-up
4. Determine if parish nurses are able to provide direct assistance
a. Advice
b. Access to services
c. Transitional care
d. Understanding of what recovery looks like
5. If able to provide direct assistance, connect with relevant parish nurse
a. Parish to which the individual belongs
b. Parish nurse for the individual's neighborhood
c. Parish nurses with specific expertise relevant to the individual's needs
6. If unable to provide direct assistance, connect with relevant partner agency
7. Provide individual with information on who will be following up, and connect with the referral afterward to make sure the connection happened

SOCIETY OF ST. VINCENT DE PAUL

1. Person in need calls the office number. Voicemails are transcribed daily; all work is volunteer
   a. Frequent Birch Tree referrals; people don't want to go to the hospital
2. Return call to individual, several times if necessary to work through crisis.
3. Gather information on the person, including story, situation, and needs
4. Set up a plan with immediate, short-term, and long-term steps
5. Set up a visit (preferably a home visit, or in a neutral public space) and determine whether the
6. In severe cases, call crisis hotline for a welfare check by police
7. If the caller is well-known, stay on the line with them to work through situation
8. Provide connections to longer-term resources
9. No formal release process
10. On a case-by-case basis, can provide assistance for shelter, including hotel stays (when possible)

UNITED WAY OF WISCONSIN

1. Individual calls or texts 24/7 211 hotline or specific 10-digit numbers that feed into it.
   a. In some counties, this is the front door to the county crisis line, but not in Douglas County
2. Conduct standard assessments that are focused on the individual; keep people on the line and engaged
3. If the individual requires immediate intervention, refer to the relevant contact:
   a. Potential triage
   b. Warm handoff to 911
   c. Suicide lifeline if suicidal but no immediate danger
4. If the individual does not require immediate intervention, provide referral to resources on a continuum
5. Educate individual on need for referral for inpatient treatment
6. Create an action plan and provide advocacy as necessary
7. If in crisis, automatic engagement of supervisor; documented and reported
8. Some situations will trigger follow-up
9. Provide hand-offs and referrals to recovery coaches

HARBOR HOUSE

1. Receive referrals from other agencies
2. Meet people where they are to understand situation
3. Map out services the individual/family is already receiving to avoid repetition
4. Coordinate and provide referrals as necessary
5. If eligible, work through process for admission, acknowledging that it may not happen immediately and may require time and several calls
6. Provide housing at shelter sites
   a. Short-term shelter (usually 30 days; longer during Covid-19)
   b. 2-year transitional living building for 7 families (3 for treatment court participants)
   c. Permanent supportive housing for 5 families
7. Individual/family moves out
   a. May or may not have permanent housing lined up
   b. Successes rate can be unclear
   c. If relevant, connect with Society of St. Vincent de Paul for hotel stay assistance

DOUGLAS COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

Civil Commitment Intake Process

1. Social worker available for intake during regular business hours, both for calls and walk-ins
   a. County also maintains contract for 24-hour crisis line
2. Social worker provides in-time case management, provides referrals, and guides next steps
3. Civil commitments arrive through third-party petition or detention (statute-driven, not voluntary) via one of several channels:
   a. Law enforcement
   b. Medical staff
   c. Counseling
   d. Family and friends
   e. Witnesses
4. Law enforcement performs welfare check to determine if individual meets criteria for custody
5. 3-party petition brings parties together to refer and generate petition
6. Petition reviewed by counsel who determines whether to proceed; county receives approximately 8-10 requests per month and moves forward on 2-3.
   a. If a determination to proceed, process follows that of an emergency detention
   b. If no determination to proceed, process ends
   c. If co-occurring case or a physical concern is present, candidates for guardianship may become Adult Protection cases

Emergency Detention Process

1. Individual hospitalized and evaluated for risk to self and others, and for temporary incompetence due to cognitive status

2. Must establish probable cause that commitment may need to occur within 72 hours and that the individual is a candidate for treatment
   a. Coach hospital if the situation meets the description
   b. Pull records and conduct research
   c. Collect testimony
   d. Set up where the individual will be sent
   e. Draft documents

3. Individual is served

4. Court date set

5. Staff testifies in court
   a. If no probable cause, process stops
   b. If probable cause is declared, individual is transported to facility

6. Hospital conducts two evaluations

7. Final hearing

8. Case management varies in levels of restrictiveness; sets up necessary pieces and safety nets

9. Court order establishes treatment conditions

10. Inform individual of treatment conditions

11. Facilitate home visits (similar to Adult Protective Services visits)

12. Staff looks for clues as to whether the individual is safe and whether they are able to move to a less restrictive pattern

13. Provide necessities
   a. Establishing housing (potentially in one of 3 houses the County rents from Harbor House)
   b. Establishing primary care
   c. Arranging for financial benefits

14. Work with natural supports for post-commitment safety net and long-term stability

15. 30 days before expiration, review the case for possible extension

16. Review hearing occurs

17. If granted extension, return to Step 1

18. If no extension, individual is discharged

19. Several weeks later, follow up with individual and make any necessary appointments or connections

OTHER CONSIDERATIONS

Information-Sharing Systems

- The group knows people relatively well and has a strong referral network
- Communication between organizations could be better, especially when things have changed
- Smaller nonprofits' scopes or limitations are not always well-known
- Society of St. Vincent de Paul is willing to host regular meetings of service providers – strong agreement among the group that these would be valuable and not perceived as a conflict with the Anti-Poverty Action Coalition (APAC), though some concerns about capacity to attend these meetings

Existing Gaps

- Lack of person power to meet high need
- Consideration of spillover effects of mental health challenges, e.g., the burden of care placed on children to care for families when a parent/guardian is coping with them
- Most services are adult-oriented; connection to schools missing
- People sometimes get bounced around between organizations – could benefit from navigators who mentor, advocate, and help walk people through the process
- Few dual diagnosis facilities for alcohol and drug concerns
- Covid restrictions and new resources (though often very welcome) have made the system harder to navigate
- Finding and training volunteers has been challenging during the pandemic (especially those who are not as comfortable with technology)
- Important to make things more sustainable, and not dependent on a few people
- Duluth Greater Downtown Council social worker and Wausau full-service building as examples of encouraging models elsewhere

APPENDIX 12

Legal Processes

DEPARTMENT OF CORRECTIONS (DOC) PROBATION AND PAROLE

1. Individuals arrive in probation and parole offices through court system and sentencing process or when coming out of a facility for extended supervision or parole

2. Determine if the need is acute
   a. If the individual (or outreach from the individual's family or others near the individual) shows an acute threat of self-harm or harm to others, call for a welfare check and potential hospital and mental health hold, subsequent mental health evaluation, and referral to counselor or therapist

   b. If there is no acute threat, refer to local resources, work with DOC psychologist to set up evaluations, and obtain necessary releases to discuss treatment with other agencies or entities

3. Conduct a risk assessment to determine risk to reoffend and criminogenic needs
   a. If from court system, supplement assessment with relevant criminal complaints, police reports, prior history, and any past supervision

   b. If from prison, review the institution's evaluations and assessments

4. Over the course of several meetings, develop a global picture of the individual and determine how to proceed

5. Individual goes through intake and is assigned an agent of record

6. Regularity of meetings is variable, depending on the risk level; could be weekly or once every several months

7. DOC conducts check-in meetings and assesses the situation

8. Check in to ensure patients are completing follow-up appointments

DOUGLAS COUNTY DISTRICT ATTORNEY'S OFFICE

1. Crime committed and investigated by law enforcement

2. Craft an appropriate sentence or resolution that recognizes individual's mental health or Alcohol and Other Drug Abuse (AODA) situation

3. DA may reach obtain additional collateral information from family members, with a diagnosis, or observe compliance with bail conditions

4. Perform a weekly evaluation and provide some resources pre-plea if possible

5. Develop a sentence that holds the individual accountable but also provides services

6. If appropriate, make a plea offer to the court that makes a recommendation for a probationary sentence

7. Process ends in one of three outcomes:
   a. Payment of a fine
   b. Entering a deferred agreement (essentially, unsupervised probation with conditions such as getting an assessment and following recommendations)
   c. Probation
   d. Jail
   e. Prison

DA OFFICE VICTIM/WITNESS COORDINATOR

1. Read police reports
2. Reach out to victims to inform them of the court process and their rights at each stage
3. Victims may self-report mental health, trauma, or addiction issues
4. Discussion may lead coordinator to provide referrals or a list; referrals must remain vague, such as to the Douglas County Resource webpage
5. If immediate services are unavailable, identify stopgaps and connect with advocates who can identify the best provider for the individual (e.g., send violence, sexual assault, and child abuse victims to CASDA)
6. Involvement can end at any point; victim participation is voluntary

NOT GUILTY BY INSANITY (NGI) CASES

- Very rare; difficult legal standard to meet
- In NGI cases, additional resources are available through staff at the Wisconsin Department of Human Services (DHS) and Lutheran Social services
- Broader support network for people not living independently, including Lake Superior Community Health, the Human Development Center, and Inclusa
- With DHS involvement, placement anywhere in the state becomes an option, opening up many more resources
- Team of resources meets to ensure the individual's needs are met
- Process works well and usually provides services much more efficiently than in non-NGI cases (which are the vast majority of cases), including wraparound services that are otherwise often missing

EXAMPLES FROM OTHER COMMUNITIES

- Eau Claire County has implemented evidence-based decision making (EBDM) to determine bail risk and level of need through a Department of Justice grant. In current system, can't obtain this information until after a plea, and reliant on past record and seriousness of the case, which is an inefficient way to determine flight risk.

- A pre-plea/disposition assessment tool exists, but no one is available to use it. Bayfield County's treatment court coordinator is also a criminal justice coordinator and can complete the assessments, but Douglas County's is not.

- Duluth has a specialty mental health court for people with chronic mental health and criminal issues, which allows for greater focus and wraparound services. Lack of personnel would make this more challenging in Douglas County.

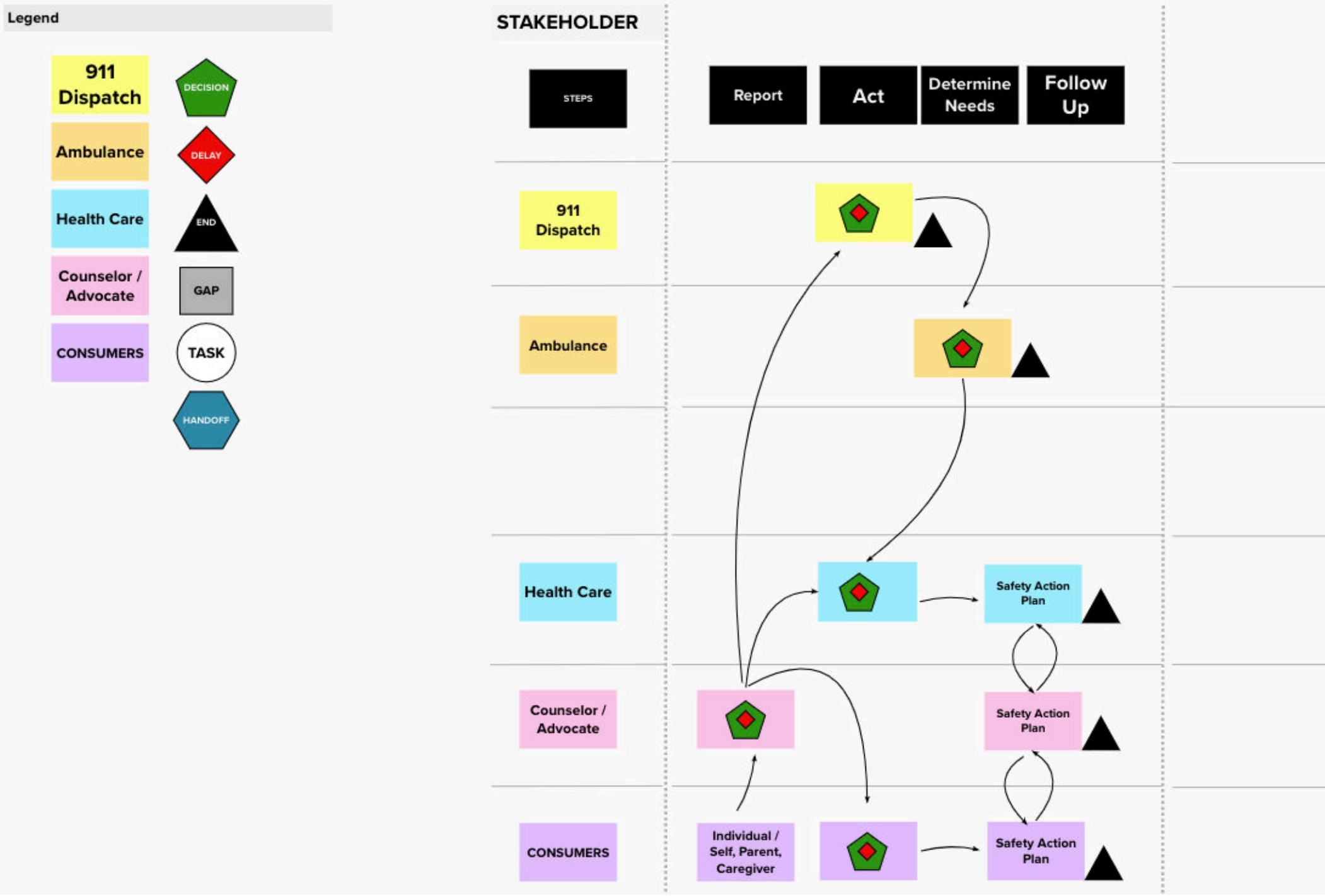
OTHER CONSIDERATIONS

- Could use a more thorough/updated list of available resources for victims to minimize their research work.
- Similarly, the DA office would benefit from greater understanding of available resources pre-plea.
- Most solutions to the challenges are likely long-term and will require training, and can benefit from emulating successful models elsewhere (e.g., Eau Claire County).
- The criminal justice system is not ideal for facilitating treatment; staff in this area are not trained or certified mental health counselors and are just performing triage until individuals can attend their appointments, which may be months later.
- In some situations where the legal system cannot obtain a Chapter 51 hold due to statute limitations, it puts people through the criminal process, sending individuals to jail because there is nowhere else to them.
- Criminal issues and mental health issues can blur together; too often, situations are clearly problematic, but must wait until something tragic happens to intervene. Diversion of more people from these situations would be a positive outcome.
- Occasional communication breakdowns with nonprofit services, but not systemic issues; need to maintain the correct contact information.

APPENDIX 13

Education Process Map

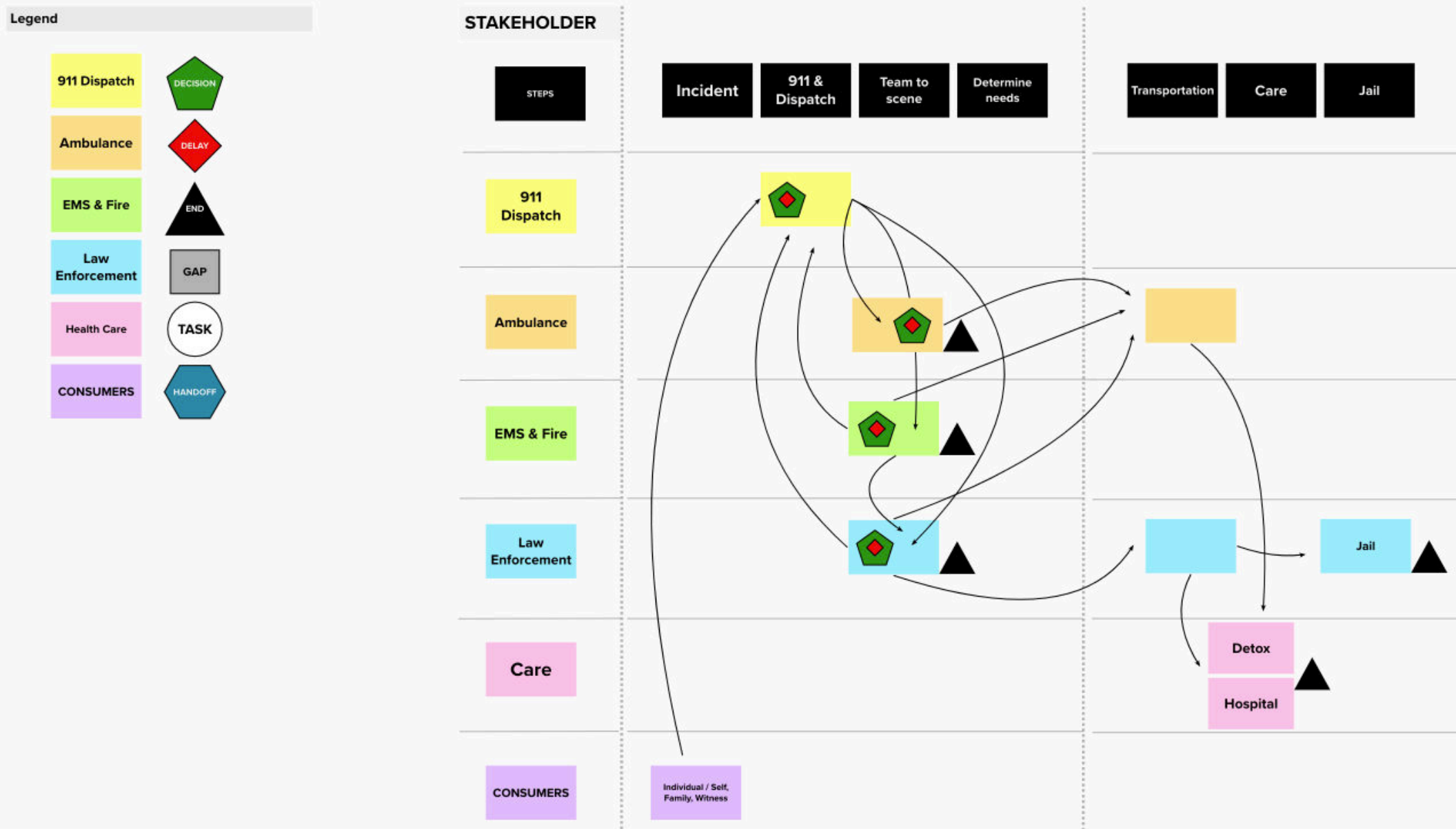
Education CARE Team (Crisis Access Response & Engagement) PROCESS



APPENDIX 14

First Responder Process Map

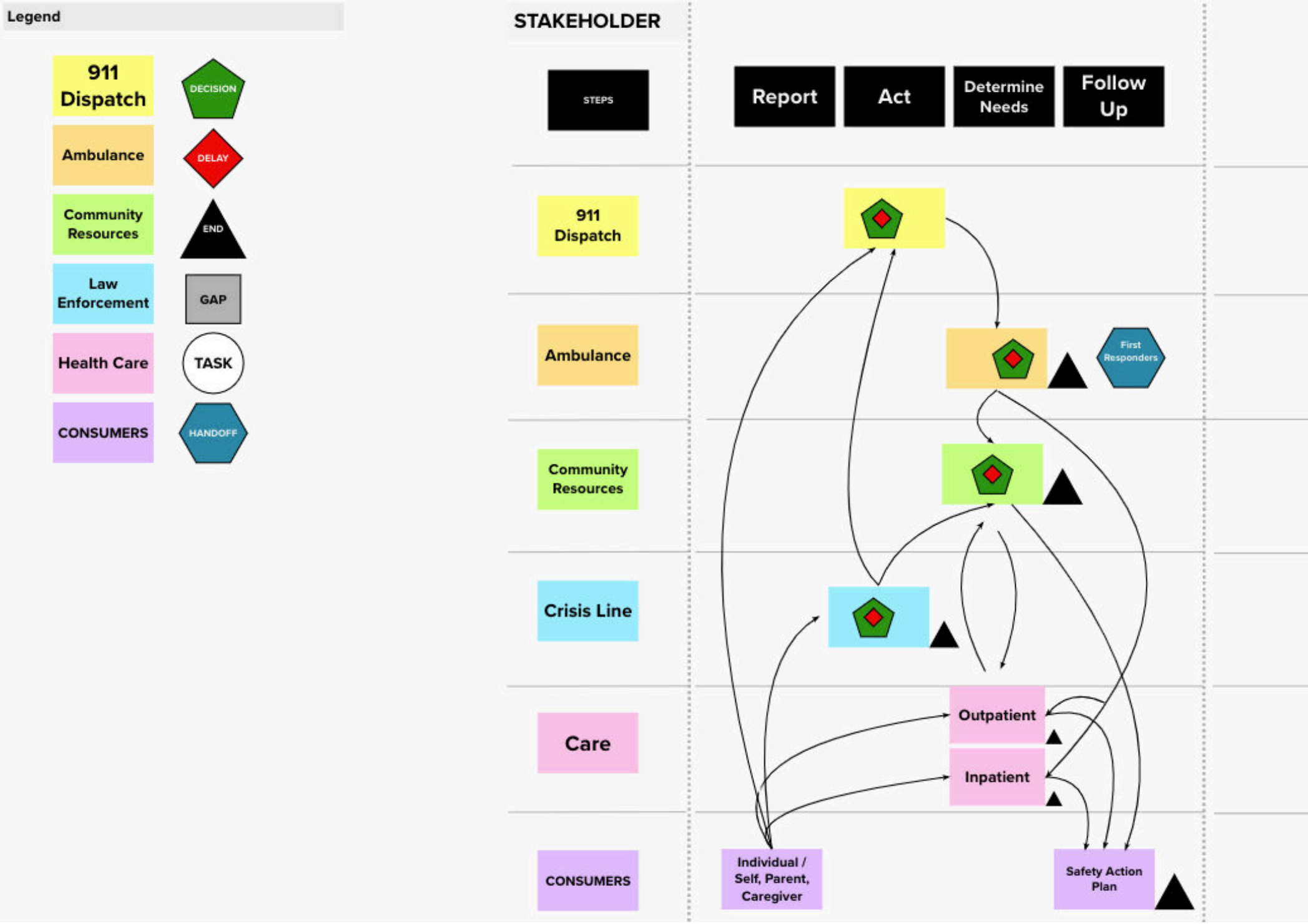
First Responders CARE Team (Crisis Access Response & Engagement) PROCESS



APPENDIX 15

Health Care Behavioral Health Process Map

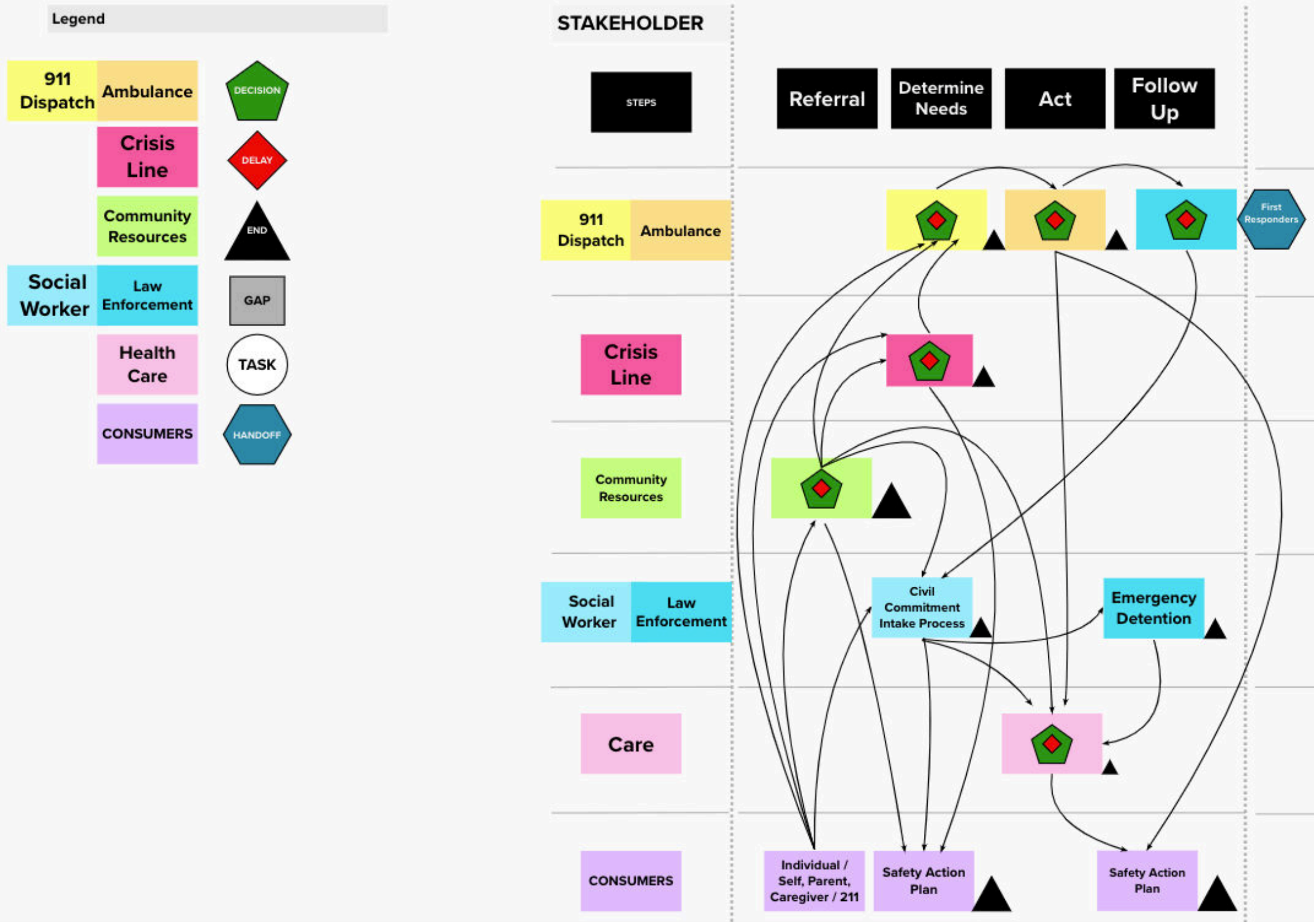
Health Care Behavioral Health CARE Team (Crisis Access Response & Engagement) PROCESS



APPENDIX 16

Human Services Process Map

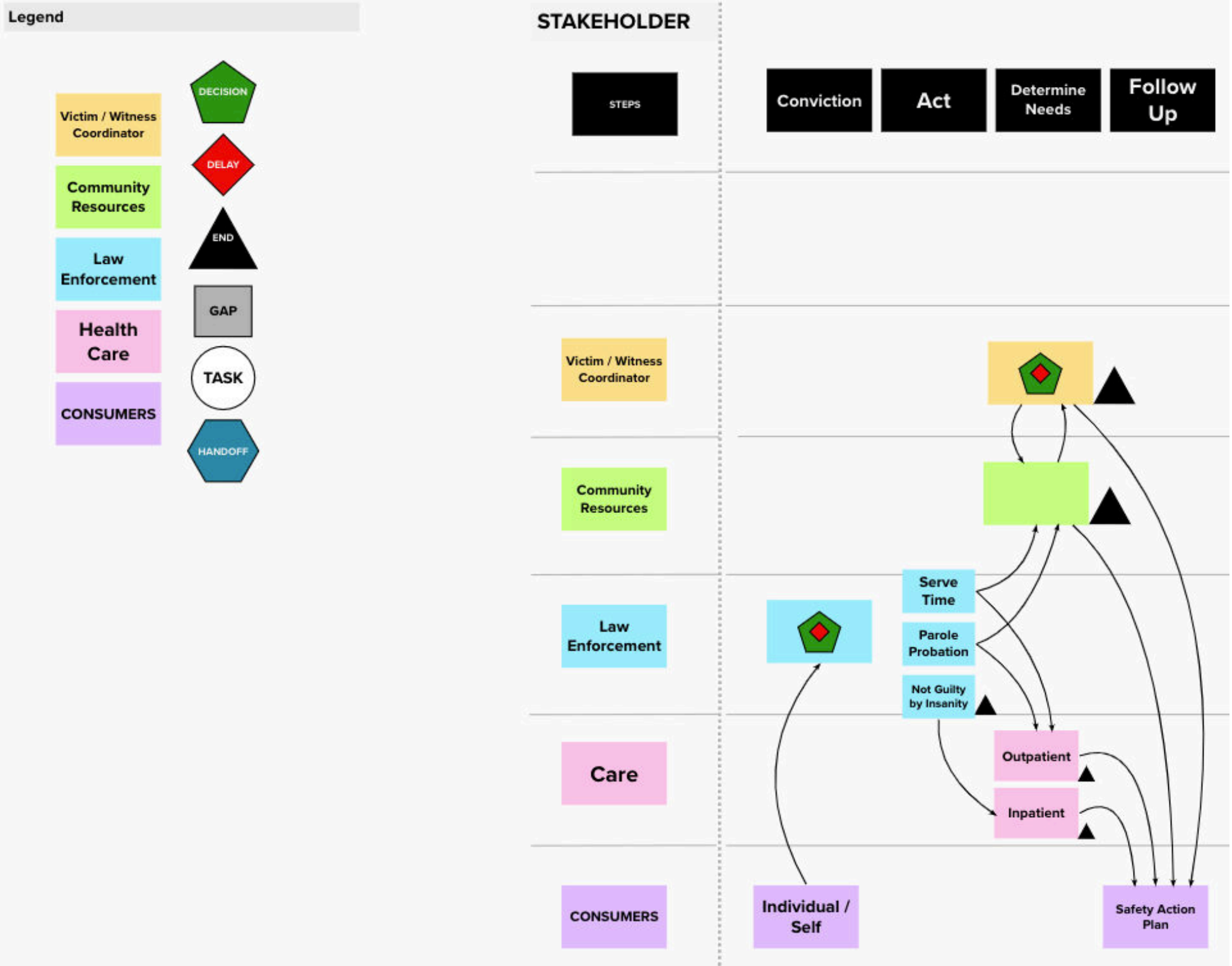
Human Services CARE Team (Crisis Access Response & Engagement) PROCESS



APPENDIX 17

Legal Process Map

Legal CARE Team (Crisis Access Response & Engagement) PROCESS



APPENDIX 18

AHW Consumer Process Ideas for Change 10.21.21 and 11.03.21

MCW MEDICAL SCHOOL | ADVANCING A HEALTHIER WISCONSIN ENDOWMENT

CARE Team (Crisis Access Response & Engagement)

Consumer Process Ideas for Change 10.21.21 & 11.03.21

RATIONAL AIM: By the end of this session, we will have a grasp on gaps and barriers to mental health crisis access response & engagement.

EXPERIENTIAL AIM: We will gain ideas for change.

CONSUMER PROCESS IDEAS FOR CHANGE:

- Expanding Care Capacity throughout County
- Building Community Through Peer Support
- Fostering Culture of Person Centered, Trauma Informed Care
- Collaboration with Law Enforcement & Legal System
- Increasing Access to Stable Housing & Reliable Transportation
- Providing Wraparound Youth & Family Support
- Develop Mobile Crisis Response Team
- Broadening Collaboration Between Organizations
- Destigmatizing Mental Health and Addiction Community-wide

MCW MEDICAL SCHOOL | ADVANCING A HEALTHIER WISCONSIN ENDOWMENT

CARE Team (Crisis Access Response & Engagement)

Consumer Process Ideas for Change 10.21.21 & 11.03.21

Expanding Care Capacity throughout County

- Respite care
- respite for caregivers and direct service professionals
- Mental health hotline
- A true DBT program – teaches you coping skills
- Services with better staff retention, less turnover
- 24-hour resource drop in center
- Beds and availability here here here
- Inpatient treatment in Douglas County
- Inpatient with detox in superior
- less turnover in mental health providers, continuity of care is important
- Making sure services available to everyone
- Marking sure crisis response is available in every community
- Wait time reduction
- More funding for human services to do case management
- mental health crisis shelter, thinking of parents and children
- Therapy and counseling for families that easier to get into
- outreach in schools/more help for school counselors
- specifically more counselors that specialize in trauma for younger kids

Building Community Through Peer Support

- non-faith based recovery support meetings
- Access to volunteering options
- Community based life skill classes available to all
- Access to peer support
- More jobs for peer specialist to assist fellow peers
- More social events for peers that is dry & mental health friendly
- Recreational sober activities
- Sobriety support partners – opportunities for peer connections
- A peer run respite
- A warmline – won't call police, answered by peers
- Peer specialists in CASDA, Harbor House, etc

Fostering Culture of Person Centered, Trauma Informed Care

- Crisis response that's person centered
- Releasing people from jail with shoes and coats in the winter
- More compassion and understanding
- Person centered care in the ER
- Providers that listen
- trauma informed practices
- Handle With Care program in all counties
- Handle with Care program in Douglas County
- Mandatory trauma informed courses for those specifically working w/ children and families.
- Peer specialist in ER – have one in Ashland

MCW MEDICAL SCHOOL | ADVANCING A HEALTHIER WISCONSIN ENDOWMENT

CARE Team (Crisis Access Response & Engagement)

Consumer Process Ideas for Change 10.21.21 & 11.03.21

Collaboration with Law Enforcement & Legal System	Increasing Access to Stable Housing & Reliable Transportation	Providing Wraparound Youth & Family Support	Develop Mobile Crisis Response Team
• Legal aid options for free or low cost • NAMI "in our own voice" sessions for law enforcement • Peer specialists in jails & drug court • A law enforcement advisory council • AIM Court – assistance to incarcerated mothers • Different sex offender registry for crimes which don't involve minors • Mental health court • mandatory mh evalutaions when receiving addiction services • More stringent screen and accountability in community services	• non-emergency medical care transport • Transportation access • More transitional housing options - ability to stay 24 hours/day • Less time after felony convictions to get into housing • Opportunities to house people with a felony record • Programs that help felons obtain and retain stable employment & housing • Transitional supports, and permanent housing for Mental Health & SUD	• Pre and postnatal mental health specific services • NAMI programs in the schools • more adolescent support groups • mandatory mental health evaluations with CPS cases • Program to foster pets while in jail • Rebuilding relationships with children	• mobile mental health advocates • Mobile crisis response team with a peer • Peer specialist working with police • mh advocates or professionals be available during police encounters • mobile mental Heath advocates, especially working with the police

MCW MEDICAL SCHOOL | ADVANCING A HEALTHIER WISCONSIN ENDOWMENT

CARE Team (Crisis Access Response & Engagement)

Consumer Process Ideas for Change 10.21.21 & 11.03.21

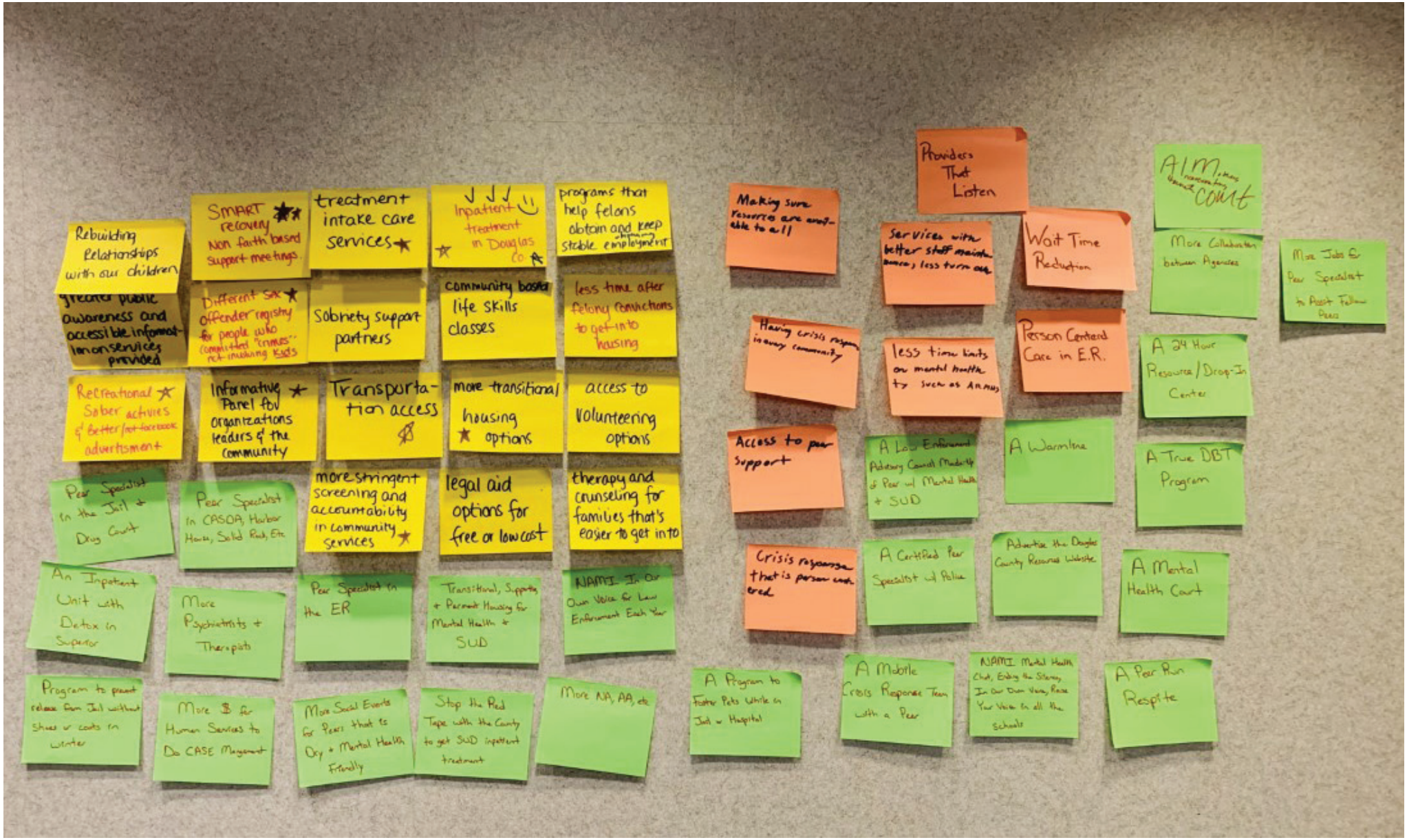
Broadening Collaboration Between Organizations	Destigmatizing Mental Health and Addiction Community-wide	Marketing Available Resources Broadly	Reducing Insurance Barriers for Mental Health Care
• Treatment intake care services • More collaboration between agencies • Collaborative comprehensive services team servicing the same family across providers • wraparound services for children	• Changing the stigma about drug addiction • Community support is key • Mental health days • Mental Health not a taboo - negative stigma	• Advertise the Douglas County resource website • Greater awareness and accessible information about available community services • Informative panel for organizations, leaders and the community	• MN taking WI insurance for treatment • more access for mh services with state insurance • Stop the red tape with the country to get SUD inpatient treatment

MCW MEDICAL SCHOOL | ADVANCING A HEALTHIER WISCONSIN ENDOWMENT

CARE Team (Crisis Access Response & Engagement)

Consumer Process Ideas for Change 10.21.21

NAMI WALL OF IDEAS

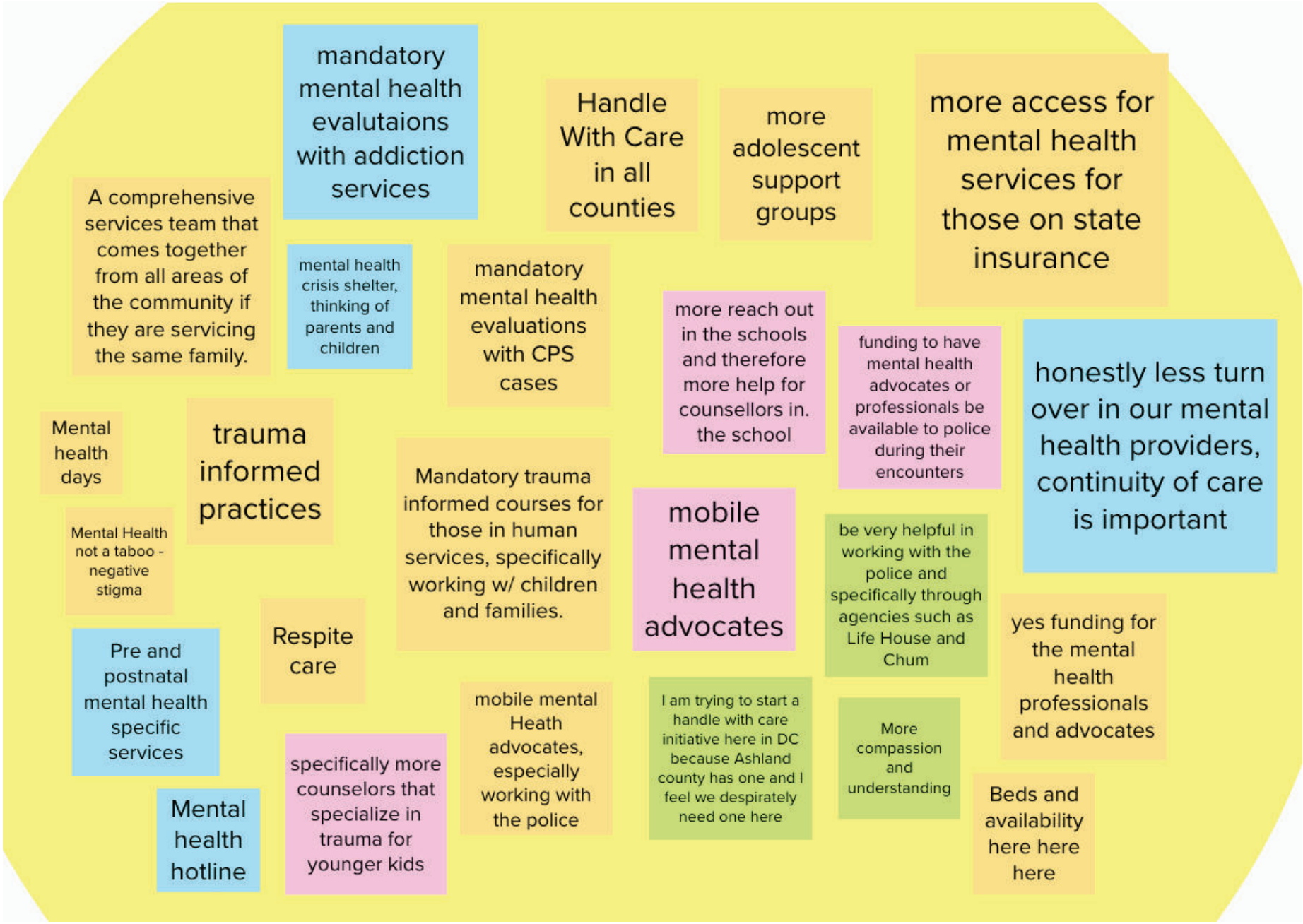


MCW MEDICAL SCHOOL | ADVANCING A HEALTHIER WISCONSIN ENDOWMENT

CARE Team (Crisis Access Response & Engagement)

Consumer Process Ideas for Change 11.03.21

FAMILY FORUM WALL OF IDEAS



APPENDIX 19

AHW Final Group Workshop 11.18.21

CARE Team (Crisis Access Response & Engagement)
Final Workshop | November 17, 2021

In this session, all CARE team members were invited to provide feedback on the provider group process documents and reflect on what they learned throughout the process.

AGENDA | NOVEMBER 17 2021 | 9:00AM – 11:00AM

Open Zoom space at 8:45AM

9:00AM	Welcome & Zooming In
9:05AM	Introductions
9:15AM	Cooperative Study
9:35AM	Small Group Discussion
9:55AM	Full Group Report Out
10:25AM	Review Consumer Process Ideas for Change
10:35AM	Full Group Discussion
10:50AM	Full Group Reflection
11:00AM	Next Steps & Adjourn

GROUP REACTIONS TO THE PROCESS DOCUMENTS

First Responders

Working well:

- Hired an outreach worker who is doing transformative work
- Better person-centered approach with follow-up
- Officers going through CIT training and homeless encampment training
- Police department responsive to requests

Not working well:

- Follow-up phone calls – officers may not call back when agencies ask about outcomes
- Networking – need more; outreach worker is on this

Ideas for improvement:

- Outreach worker doing well; funding for more would be great

Human Services

Working well:

- Whole system has a committed, caring group that is passionate about its work

Not working well:

- People not knowing how to navigate system
- People get referred places to learn services aren't available or get bounced around between agencies
- Miscommunication

Ideas for improvement:

- Comprehensive community services (CCS)
- Peer respite center

Education

Working well:

- Doing best they can with resources they have, even when it's not enough
- Have increased awareness of people they work with on a daily basis
- Proactive preventative measures helping

Not working well:

- Lack of services for mental health
- Awareness no longer the bigger crisis; now, it's access to services.
- Training for educators would help.
- Insurance, transportation, getting parents on board for minors can all be lacking

Ideas for improvement:

- Clearer referral and aftercare process – not sure where students should be referred to, and can be so far out that they're stuck
- When receiving care, getting this information back so they're aware of next steps
- Proactive preventative upstream approaches as early as possible

Legal

Working well:

- Communication between District Attorney's office, police department, sheriff, probation all great; good working relationship
- Agents are adaptable in dealing with difficult situations (e.g., undiagnosed) - they do a good job with what's available
- Not Guilty by Insanity work: lots of available resources, use Department of Social Services and Lutheran Social Services and it's stellar
- Coordinated response specialist fantastic

Not working well:

- Long waitlists
- Limited access
- Services now often virtual, which can be a barrier
- Transportation and housing
- Mental health and stability necessary first and foremost, not criminogenic factors

Ideas for improvement:

- Accessibility to services
- Mental health court would be fantastic, but needs financial support and bodies

Health Care Behavioral Health

Working well:

- Addition of partial hospitalization program – intensive service helping quite a few people. Lots happening and it seems to go well.

Not working well:

- Don't have a handle on how many people are out there not getting services
- Duluth-based services don't always have great contacts in Douglas County or knowing where to go
- Reimbursement for services in Wisconsin a challenge
- Availability of both inpatient and outpatient services; people don't want to go to Eau Claire or Winnebago, especially for children
- Opportunity for peer respite houses and safe places to stay with triage to make sure patients are at right level of care.

Ideas for improvement:

- More coordinated communication with police department in Superior – why do patients end up in the Emergency Department?
- Smoothing out Chapter 51 process
- Need legislative pressure to look at reimbursement rate to attract more providers in the Superior area
- Peer respite home as opportunity for additional resources – more doable than some of the other dreams

GROUP REFLECTION ON THE FIVE PROCESSES

- No significant surprises – most of the stakeholders are in the same boat
- We need more services, period. Inexcusable to have year-long waiting periods.
- Accessibility and quality of service are now the keys.
- Rural communities – how can we get something like Superior outreach worker in sheriff's department/rural parts of county
- Was unfamiliar with peer respite work – perspectives broadened by this
- Lack of technology to assess the services that do exist
- It comes down to legislative action, but this is challenging – need fiscal carrot for people to come here. Feels beyond us. Consistent issue; response from legislature is "yes, we know but there's nothing we can do about it." Mild success a few years ago.
- Minnesota invests state money into Medicaid; Wisconsin does not. Need to investigate how Wisconsin compares and what is being reimbursed here.
- Douglas Co does have more resources than other border communities, but see Duluth successes and can fail to stack up, seemingly
- Our providers are great
- Need to keep pushing upstream (not just reactive services) - science has shown what is effective. In crisis is not the best time to receive care - "can't teach people to swim when they're drowning"
- Don't see break in crisis surge with kids anytime soon. Look at the challenge in a different way? Not necessarily sure what it is, but need to target it.
- State budgets are tighter, and prevention is the first thing cut – have to focus on statutes. Three successful programs have been cut. There has to be a change in how things are paid for.

REFLECTIONS ON CONSUMER PROCESS IDEAS FOR CHANGE

- More sober events
- Ownership is important – how do we encourage this? Services with peer specialists, empower people to be decision-makers in what happens
- Peer support for treatment court; utilizing graduates to mentor new entrants
  Non-faith-based support and recovery meetings
- How do we sustain many of the ideas; inpatient AODA, detox/inpatient setting, programming, etc.? Need to focus on those ideas that individual organizations may be able to support without a fiscal burden
- Not much surprising but good reminders
- Support youth, crisis response, collaborating with schools/communities - has worked very well elsewhere
- Support regarding trauma for younger kids
- Support Mental health evaluations along with alcohol and other drug abuse treatment

FULL GROUP REFLECTION

Change for Immediate Results

- First responders/law enforcement group: success of coordinated response specialist – expand this role countywide, have a first point of contact, identify people who need help.
- Identify people who had problems and guide them where they need to go. Early identification, early intervention, and funnel people to services immediately.
- See these people certified as peer specialists – they know how to navigate systems. Expand this program.

Changes for Long-Term Results

- More intervention in schools – more therapists, skill-building, positive support curriculum into schools. Amberwing and Hermantown partnership as model.
- Wraparound program with youth
- Having the resources so we don't have a 6-month waits for them
- Addressing the legislative piece, as hard as it would be

Concluding Thoughts

- Access and youth services are crucial – and remember the rural communities, not just Superior
- Keep bringing as many voices and perspectives to the table as possible.
- Chrissy Barnard is on the governor's mental health council – can Douglas County find other partners facing similar challenges and collaborate?
- Covid toll on kids and what was lost – having activities that are social, get people together, give them a place to go
- Peer-run respite that is all-encompassing; warm line for drop-ins – has worked well elsewhere

APPENDIX 20

Participant Resource Provider List

PARTICIPANT RESOURCE PROVIDER LIST

PROVIDER TYPE	ORGANIZATION(S)	PARTICIPANT	EMAIL
Education	Superior School District - Dean of Superior High School	Barb Matlack	barbara.matlack@superior.k12.wi.us
Education	Maple-Northwestern School District, Middle School	Erika Kaufman	ekaufman@nw-tigers.org
Education	Solon Springs School District	Jessie Golburg	jgolburg@solonk12.net
Education	Maple-Northwestern School District, Middle & Elementary Schools	Kara Hietala	khietala@nw-tigers.org
Education	University of WI - Superior	Randy Barker	rbarker@uwsuper.edu
Education	Solon Springs School District	Russ Nelson	rnelson@solonk12.net
Education	Family Forum	Allison Naeyaert	AllisonN@familyforum.org
Education	Solon Springs School District	Amanda Linden	alinden@solonk12.net
Education	Superior School District - Great Lakes Elementary School	Becky Nickila	rebecca.nickila@superior.k12.wi.us
Education	Maple-Northwestern School District, High School	Breena Kroll	bkroll@nw-tigers.org
Education	Superior School District - Dean of Superior High School	Bryan Denninger	bryan.denninger@superior.k12.wi.us
Education	Superior School District - Bryant Elementary School	Carrie Hennessey	carrie.hennessey@superior.k12.wi.us
Education	Solon Springs School District	Christine Nordness	cnordness@solonk12.net
Education	WITC-WI Indianhead Technical College	Dede Maki	dede.maki@witc.edu
Education	Superior School District - Northern Lights	Erin Schilling	erin.schilling@superior.k12.wi.us
Education	University of WI Extension	Evelyn Flesvig	eflesvig@uwsuper.edu
Education	Superior School District - High School Counselors	Heidi Sigfrids	heidi.sigfrids@superior.k12.wi.us
Education	Solon Springs School District	Holly Jones	hjones@solonk12.net
Education	Superior School District - HS Social Worker	Jane Larson	jane.larson@superior.k12.wi.us
Education	Family Forum	Jeanne Myer	JeanneM@familyforum.org
Education	Family Forum	Joan Keeler-Pellman	JoanK@familyforum.org
Education	Superior School District - Dean of Superior Middle School	Jody Geissler	jody.geissler@superior.k12.wi.us

PROVIDER TYPE	ORGANIZATION(S)	PARTICIPANT	EMAIL
Education	WITC-WI Indianhead Technical College	Kent Lundahl	kent.lundahl@witc.edu
Education	Superior School District - Northern Lights	Kryssi Plasch	kryssi.plasch@superior.k12.wi.us
Education	Maple-Northwestern School District, Iron River Elementary	Molly Stonesifer	mstonesifer@nw-tigers.org
Education	Northwood's School District	Natasha Kildow	natasha_kildow@northwoodk12wi.com
Education	Superior School District - Great Lakes Elementary School	Niki Whittet	niki.whittet@superior.k12.wi.us
Education	Superior School District - 4 Corners Elementary School	Rachael Larson	rachael.larson@superior.k12.wi.us
Education	Superior School District - Special Education	Tara Gonyer	tara.gonyer@superior.k12.wi.us
Education	Superior School District - Great Lakes Elementary School	Terri Bronson	terri.bronson@superior.k12.wi.us
Education	Superior School District - High School Counselors	Tiffany Mattson	tiffany.mattson@superior.k12.wi.us
Education	University of WI Extension	Tracy Henegar	Tracy.Henegar@wisc.edu
Education	Superior School District - High School Counselors	Wendy Nelson	wendy.nelson@superior.k12.wi.us
First Responders	Superior Police Department	Brad Jago	jagob@ci.superior.wi.us
First Responders	Dougals County Emergency Management	Adam Olson	olsonak@ci.superior.wi.us
First Responders	Mayo Ambulance	Belissa Ho	Ho.Belissa@mayo.edu
First Responders	911 Dispatch/Communications Center	Dani Miller	millerd@ci.superior.wi.us
First Responders	Vacationland Fire/Emergency Medical Services (EMS) Association + Town of Superior & Oliver Fire Departments	Darryl Feigle	dfiegle@yahoo.com
First Responders	Mayo Ambulance	Greg Hanson	hanson.greg7@mayo.edu
First Responders	Superior Fire Department	Howie Huber	Huberh@ci.superior.wi.us
First Responders	Brule Fire/Emergency Medical Services (EMS) Department	Keith Kesler	khkbrule@yahoo.com
First Responders	Superior Fire Department	Lindzi Campbell	lindzi.campbell@gmail.com
First Responders	Douglas County Sheriff's Department	Mac Ohm	ohmm@ci.superior.wi.us

PROVIDER TYPE	ORGANIZATION(S)	PARTICIPANT	EMAIL
First Responders	Superior Police Department	Nick Alexander	alexandern@ci.superior.wi.us
First Responders	Lakeside/EMS Fire Department	Nova Nordrum	nnordrum@gmail.com
First Responders	Superior Police Department - Coordinated Response Specialist	Jen Stank	stankj@ci.superior.wi.us
Health Care Behavioral Health	Essentia Health St. Mary's Duluth ER BH	Katie Bauman	Katie.Bauman@EssentiaHealth.org
Health Care Behavioral Health	Amberwing	Lori Thrun	lori.thrun@essentiahealth.org
Health Care Behavioral Health	Essentia Health St. Mary's Duluth ER	Sharon Lepak	Sharon.Lepak@EssentiaHealth.org
Health Care Behavioral Health	Human Development Center (HDC)	Steve Engelson	steve.engleson@hdchrc.org
Health Care Behavioral Health	Lake Superior Community Health	Aaron Pust	apust@lschc.org
Health Care Behavioral Health	Essentia Health St. Mary's Hospital Superior	Adrienne Radovich	Adrienne.Radovich@EssentiaHealth.org
Health Care Behavioral Health	Essentia Health St. Mary's Duluth ER	Andrew Gallagher	Andrew.Gallagher@EssentiaHealth.org
Health Care Behavioral Health	Essentia Health St. Mary's Duluth ER BH	Anna Maher	Anna.Maher@EssentiaHealth.org
Health Care Behavioral Health	Northwest Journey	Anne Wollan	AnneW@nwcgc.com
Health Care Behavioral Health	Mariner Clinic	Beth Lundgren	Beth.Lundgren@slhduluth.com
Health Care Behavioral Health	Clear Harbor Counseling	Betsy Byler	betsy@clearharborcounseling.com
Health Care Behavioral Health	Superior Treatment Center	Brandon Zacher-Hunter	brandon.hunter@superiortreatmentcenter.org
Health Care Behavioral Health	Tradewinds	Carole Smith	
Health Care Behavioral Health	Twin Ports VA	Charleen Balcer Rowekamp	Charleen.BalcerRowekamp@va.gov
Health Care Behavioral Health	Creative Counseling Group (CGC)	Donald Mattson	donald@ccgcounseling.com
Health Care Behavioral Health	Essentia Health St. Mary's Hospital Superior	Dr. Bob Zotti	Robert.Zotti@essentiahealth.org
Health Care Behavioral Health	Northwest Journey	Gina Perfetti	Ginap@nwcgc.com
Health Care Behavioral Health	Essentia Health St. Mary's Hospital Superior	Kim Pearson	Kim.Pearson@EssentiaHealth.org
Health Care Behavioral Health	Lake Superior Community Health	Kristie Hills	Khills@lschc.org

PROVIDER TYPE	ORGANIZATION(S)	PARTICIPANT	EMAIL
Health Care Behavioral Health	Essentia Health St. Mary's Duluth BH	Kurt Radke	Kurt.Radke@EssentiaHealth.org
Health Care Behavioral Health	Tradewinds	Robin Kulaszewicz	robin@tradewindsresidence.com
Health Care Behavioral Health	Twin Ports VA	Ryan Burkhart	Ryan.Burkhart@va.gov
Health Care Behavioral Health	Mariner Clinic	Sarah Honemann	Sarah.Honemann@slhduluth.com
Human Services	NCIL (North Country Independent Living)	Angie Musolf	angiem@northcountryil.org
Human Services	NAMI (National Alliance on Mental Illness)	Chrissy Barnard	Chrissy@northcountryil.org
Human Services	Douglas County Health & Human Services	Dave Longsdorf	dave.longsdorf@douglascountywi.org
Human Services	NCIL (North Country Independent Living)	Liz Gilbertson	liz@northcountryil.org
Human Services	St. Vincent de Paul	Lynn Brice	lynnbrice@gmail.com
Human Services	Miller Dwan Foundation	Joan Oswald	
Human Services	Miller Dwan Foundation	Kerry Johnson	
Human Services	Miller Dwan Foundation	Traci Marciniak	
Human Services	Inclusa	Angie Blegen	Angela.Blegen@inclusa.org
Human Services	United Way/211	Charlene Mouille	cmouille@unitedwaywi.org
Human Services	ADRC (Aging & Disability Resource Center)	Chelesa Thompson	Chelsea.thompson@douglascountywi.org
Human Services	Harbor House Crisis Shelter	Chelsea Branley	chelsea.b@harborhousecs.org
Human Services	Harbor House	Danielle Ranta	danielle.r@harborhousecs.org
Human Services	CASDA (Center Against Sexual & Domestic Abuse)	Denise Seldon	Denise@casda.org
Human Services	ADRC (Aging & Disability Resource Center)	Erika Johnson	Erika.Johnson@douglascountywi.org
Human Services	Northern Water Parish Nurses	Jan Stevensons	nurse@nwpnm.org
Human Services	NAMI (National Alliance on Mental Illness)	Jessie Huber	peace4lovebthankful@gmail.com
Human Services	CASDA (Center Against Sexual & Domestic Abuse)	Kelly Burger	Kelly@casda.org

PROVIDER TYPE	ORGANIZATION(S)	PARTICIPANT	EMAIL
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Human Services	Inclusa	Kristen Waklee	kristen.waklee@inclusa.org
Human Services	Northern Water Parish Nurses	Lyndi Sakuray	nurse@nwpnm.org
Human Services	St. Vincent de Paul	Lynn Tracy	ltracy27@yahoo.com
Human Services	TMG (The Management Group)/Iris Consultant	Nancianne Nardi	NLNardi@tmgwisconsin.com
Human Services	Boys & Girls Club - Superior	Stephanie Carlson	
Human Services	HDC (Human Development Center) - Project Reach Out	Tanya Nelson	tanya.nelson@hdchrc.org
Human Services	ADRC Intern	Tanya Plachta	
Human Services	Boys & Girls Club - Superior	Tim Stratioti	Tstratioti@bgcnorth.org
Legal	Probation & Parole	Aaron Lenmark	aaron.lenmark@wisconsin.gov
Legal	Victim Wittness	Martina Tendrup	Martina.Tendrup@da.wi.gov
Legal	District Attorney's Office	Mark Fruehauf	Mark.Fruehauf@da.wi.gov
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Legal	Probation & Parole	Samantha Anderson	samantha.anderson@wisconsin.gov
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