

Community Stakeholder Input Report and Summary

The project team interviewed over 30 individuals representing various community organizations and agencies that serve or interact with individuals with mental health, substance abuse and/or developmental disabilities issues about their experiences serving this population and interacting with the Human Service Center staff and programs. These stakeholders represented school personnel, law enforcement, representatives of the legal system and private service providers. Their comments and suggestions are identified in two primary categories:

- First, as strengths or positive aspects of HSC programs specifically or the overall system of services that exists in the community.
- Secondly, as issues of concern or ideas for improving NCHC programs specifically or in the context of the overall system of services that exists in the community.

It should be noted that the “community” referred to in this section and the stakeholders interviewed primarily reflect the services and populations served in Oneida County. However, some of the stakeholders commented on services and issues that impact the other two counties (Vilas and Forest) as well.

In order to receive candid feedback and suggestions, the individuals interviewed were assured that their comments would not be shared with others in a way that would identify the source of the information. This type of assurance is common and accepted practice in studies of this nature.

Input from School Personnel

The project team interviewed six representatives from the following five public school districts serving Oneida County students. They were asked about their experiences working with students and families experiencing MH/SA and DD issues:

- Arbor Vitae-Woodruff School District
- Minocqua-Hazelhurst-Lake Tomahawk School District
- Lakeland Union High School District
- Rhinelander School District
- Three Lakes School District

Strengths/Positive Aspects

- MH/SA service array and capacity
 - Crisis line works well – timely response is provided.
 - Crisis worker/screener now comes to the school, which is much better than over the phone evaluation.
 - Options Treatment Program for is great for addressing kids’ MH/SA needs – would like to see it be a longer program.

- DD service array and capacity
 - Good services provided in Birth to Three program – prepares kids well for entering school.
 - Good transition planning and referrals between Birth to Three program and the schools – good flow of information between Headwaters and the schools.
 - Headwaters does most of the exit testing for kids entering school, which is better since Headwaters staff knows the children.
- Role of HSC
 - Grant-funded Child and Adolescent Access Process Project through Ministry Health Services is a positive project to bring about better identification of service needs and inter-agency collaboration. HSC participates in this effort.
 - Schools have good relationship with Birth to Three program administered by Headwaters under contract with HSC. Most were not aware that the Headwaters program is funded by HSC. Headwaters, not HSC, is the “face” of the program.

Issues of Concern and Improvement Ideas

- MH/SA service array and capacity
 - Schools are seeing younger kids with behavioral and substance abuse issues and families with long histories of mental health and substance abuse problems.
 - Children needing services are placed on a waiting list and are not able to obtain services in a timely fashion.
 - Access to mental health services is lacking – tough to get appointments for psychiatry and therapy services.
 - For most significantly impaired kids, it’s very difficult to get them into treatment, find a funding stream and keep them in treatment.
 - Few resources for children and most are based in Rhinelander (some MH providers have a one year wait list).
 - Shortage of AODA counselors in the area.
 - No aftercare plan for kids coming out of treatment facilities.
 - Schools are also faced with resource constraints and increasing service needs.
- DD service array and capacity
 - Lack of resources in the community (e.g., no ARC program, limited housing for adults with disabilities, lack of transportation).
 - Some students could have moved onto adult programming but schools have kept kids longer due to lack of services – this limits independence of those 18 and older.
- Role of HSC
 - HSC doesn’t have a “presence” in the community.
 - HSC is not an active participant at key meetings and efforts to improve interagency coordination and address service needs.
 - HSC doesn’t market itself and what they have to offer – doesn’t do outreach.
 - HSC system is complicated – need for more outreach and education about what is available and how to access services.

- Need for satellite office(s) for HSC to cut drive time to services in Rhinelander and improve the visibility of HSC in the community.
- School personnel make referrals to HSC but reported minimal interaction with HSC.
- Lack of leadership and continuing turmoil within HSC has led to staff turnover and dissatisfaction which impacts how effective HSC can be.
- HSC can't change the environment of high substance abuse and mental health issues (e.g., rural and tourist nature of the area contribute to the ready availability of alcohol).
- HSC is not an agency that is involved with other agencies for collaboration and service coordination.
- Doesn't do a good job with interagency collaboration – very fragmented system with lots of turf issues.
- Coordination between HSC and Oneida County DSS regarding the payment of mental health services is a problem.
- General/other
 - Problem isn't so much a communication issue as it is a resource issue (i.e., people know about the services, they just aren't available).
 - Area could benefit from a restorative justice approach to juvenile justice and implement a teen court program.
 - Would like to see more focus on prevention programming (e.g., establishment of a community center as a place for teens to go outside of Rhinelander).
 - Doesn't support the building of a juvenile detention center in Oneida County – would be a drain on resources.

Input from Law Enforcement Agencies and the Legal Community

The project team interviewed six representatives from the following five agencies who work with individuals experiencing MH/SA issues in Oneida County:

- Oneida County Corporation Counsel
- Oneida County Sheriff's Department (Patrol and Jail Divisions)
- Rhinelander Police Department
- Wisconsin Department of Corrections – Community Corrections Office in Rhinelander
- Wisconsin State Public Defender's Office in Rhinelander

Strengths/Positive Aspects

- Twice yearly meetings of tri-county law enforcement, county corporation counsels and hospital staff are good.
- Officers rarely override recommendation of MH screeners.
- Typically call HSC for suggestions on MH/SA training for officers.
- Koinonia provides good services.
- Management and case workers at Koinonia are helpful and good to work with.
- Length of Koinonia program is good – shorter programs aren't as effective.
- Women's treatment outreach project is a good model.
- Intensive Supervision Program for multiple OWI offenders works better than in other counties because the referral to ISP occurs at the outset of the case.

Issues of Concern/Improvement Ideas

- MH service process delays
 - Need an on-call person to handle administrative questions about emergency detention process when other HSC managers or staff is not available. Should be a go-to person to call.
 - Lack of timely response from screeners – law enforcement may be waiting up to 2 hours for a screener to call them – this is a huge drain on law enforcement resources.
 - Medical clearance time for hospital has improved, but is still slow – takes up to 90 minutes for the hospital emergency room to clear an individual for admission to the hospital inpatient unit.

- MH service array and capacity
 - Most of the evaluations (up to 80%) by the emergency screeners are completed over the phone rather than in person.
 - Current practice of no face-to-face evaluations for MH crises in the jail with 15-minute checks by jail personnel is staff intensive and risky.
 - St. Mary's Hospital inpatient unit is full up to 1/3 of the time.
 - Labor and cost-intensive for law enforcement to transport individual (using 2 officer transport) to Winnebago or to other facilities outside the tri-county area.
 - Back-up inpatient facilities if St. Mary's is full include Norwood in Marshfield, Aspirus and NCHC in Wausau, Bellin in Green Bay, Winnebago in Oshkosh and Mendota in Madison – it would be good if these could be prioritized to minimize transport time for law enforcement.
 - Need to reduce number of out-of-town transports for emergency detention.
 - Waiting list for MH/SA outpatient providers for individuals on a 90-day settlement agreement – may not see a psychiatrist until day 80.
 - Need better coordination between MH services provided inside and outside the jail setting. (e.g., it is difficult when jail inmates with MH issues get cut off from their MH provider while in jail, and it is not helpful when outside MH providers prescribe medications, without regard to cost, that the individual can't afford to continue).
 - Training of law enforcement in MH issues is sporadic and limited due to cost concerns.
 - No integration of MH/SA issues at a time when mood disorders are increasing rapidly in the population.

- Substance Abuse service array and capacity
 - Lack of aftercare treatment for AODA.
 - Lack of transitional housing and halfway houses as a step-down from Koinonia. Better if those recovering from substance abuse issues could establish some independence from their old lifestyle.
 - Need AODA service option for individuals between an outpatient and inpatient level of service for about 2-3 days per week.
 - Use placement at Koinonia as an incentive for OWI individuals to shorten jail time, if judges agree and individuals make upfront payment for residential treatment program at Koinonia.
 - Payment policy at Koinonia restricts needed access to services for some.

- Role of HSC
 - HSC needs to provide better information about what community service options exist for individuals with MH/SA needs.
 - Don't know what services are available – feels everything is bare bones due to budget problems.
 - Law enforcement has minimal interaction with HSC management to discuss process, approach or concerns – most discussions take place with hospital staff.
 - Law enforcement is unaware of HSC contacts in mental health area.
 - Didn't know that HSC just established its own AODA outpatient clinic with two AODA counselors.
 - Didn't know that screeners were mobile and could go out on calls to do a face-to-face evaluation for emergency detentions.
 - Jail would consider HSC for MH service provision but don't know if HSC has the necessary staff capacity.

Input from Private Service Providers

The project team interviewed 26 individuals or representatives of 22 private service providers under contract with HSC to serve individuals with mental health/substance abuse and/or developmental disabilities in the tri-county area.

Strengths/Positive Aspects

- Business relationship with HSC
 - Work with lots of other counties and HSC doesn't micromanage the provider relationship like some other counties do.
 - Work with lots of other counties and has had problems, but not with HSC – contracts are not too thick or complicated.
 - Unlike other some counties, HSC is good about paying on time.
 - Interactions with HSC are good – they can talk with each other and work out issues.
 - Contract area and monthly billing works smoothly – never needed to contact anyone at HSC regarding problems.
 - No complaints with contracting or billing.
 - Administrative level interaction with DD area has improved in past five years and Human Services Board has been supportive.
 - HSC Executive Director and managers are good to work with.
 - Billing staff is good to work with.
- Case management and services
 - Communication has been very good, open and professional – when provider calls, the case manager is well informed about the consumer and is willing to share relevant information.
 - HSC case manager has been responsive and good to work with.
 - Child psychiatrist is very good to work with.

- Better communication, relationship building and trust between HSC and provider regarding emergency detention process.
- Good working relationship and things work well at the service planning level with residential provider.
- Of several county contracts, contract with HSC is provider's best. Most contact, through DD case manager, has been very good – good communication and responsiveness, always on top of paperwork, work collaboratively and effective in watching the wait list. Never had an administrative problem with the contract that the case manager couldn't resolve.
- Good communication with most DD case managers.
- HSC nursing staff is good to work with.

Issues of Concern/Improvement Ideas

- Business relationship with HSC
 - A number of other entities provider works will allow them to bill electronically and receive direct deposit for payments – not HSC.
 - Would appreciate if HSC used email and electronic format for documents instead of relying on phone or regular mail communication.
 - Cost constraints of HSC make them less likely to contract for higher-cost services that consumers may need.
 - Suggest eliminating the requirement that providers can only mail invoices after the 1st of the month.
 - HSC top management was discourteous, adversarial and unprofessional.
 - HSC doesn't establish a track record of positive working relationships with providers that can help when there are problems that need to be resolved.
 - Lack of problem solving approach by HSC top management – more blaming and finger pointing. Top management has negatively influenced perspective of county boards and Human Services Board.
 - Top management at HSC is unresponsive and unapproachable – calls aren't returned, no follow-up. Concerned that consumer grievances aren't followed up on.
 - Relationship with HSC is unpredictable – never know where things stand.
 - Mixed business interaction with HSC – some goes well but lots of energy is put into processing data and paperwork for providers. Could HSC centralize some of the paperwork and administrative tasks?
 - Deal with many other counties and the relationship with HSC is the most difficult.
 - Need better and more timely communication from HSC.
 - Communication needs to improve with HSC.
 - It would be good to get a response within a week – it would be nice to get a call saying how long it will take for HSC to get back to them.
 - Knows HSC staff is busy, but it is difficult getting responses to phone calls.
 - HSC managers appear overwhelmed - difficult to get a response.
 - Lack of response from HSC top management – phone calls aren't returned.
 - HSC could cut redundancy and processing time of filling out duplicate paperwork on clients. HSC likely re-writes or re-enters this same information.

- HSC sometimes wants provider to provide services and not pay for them (e.g., lack of reimbursement for residential provider when consumer stays home ill and doesn't go to day program).
- Lack of timely service authorizations for contracted mental health services since the MH Services Administrator left.
- Lack of timely service authorization for DD services.
- Payment of bills is sometimes delayed over minor amounts. Entire monthly bill is held up when just the issue in dispute could be targeted.
- Contracts are signed late.
- Contracts don't spell out HSC program expectations and outcomes.
- HSC could be more direct in communicating service expectations and any performance issues.
- Need for HSC to put in place consistent and sound business practices.
- Providers who ask questions of HSC fear retribution – that their business relationship will be negatively impacted.
- MH/SA service array and capacity
 - Need for MH treatment, residential and inpatient services for adolescents.
 - Long waiting lists at Northwoods Guidance Center are a problem in making referrals.
 - Need for consistent and continuous child psychiatric services – community has lost many psychiatrists over the past years.
 - Good if area could recruit another child psychiatrist.
 - Need for substitute care and treatment foster homes for kids.
 - Younger adults (age 18 – 22) have limited support.
 - Lack adequate diversion resources for MH – Crisis bed program at Koinonia uses an AODA model that doesn't know what to do with individuals in MH crisis.
 - Move of crisis stabilization bed to Koinonia was not wise; staff in previous group home (Community House) were better qualified and trained to deal with individuals in crisis.
 - Crisis bed program doesn't always have the appropriate staff to handle referrals.
 - Good services offered at Koinonia.
 - Counties are getting good value for AODA services.
 - Need more outreach, prevention and an established AODA counseling service in Vilas and Forest counties. Outreach to the schools has decreased.
 - Lack of nurse resources. Shortage of nurse practitioner positions in the area. Need adequate nursing support for community mental health services and need to use nurses appropriately – shouldn't be used for clerical work or to perform other tasks that less skilled positions could perform. Need a MH nurse at Koinonia.
 - Interaction between St. Mary's and HSC isn't always effective. Consider contracting with other providers more responsive to the needs of HSC.
 - Psychiatrists are set in their ways and not always helpful to finding solutions to systemic issues.
 - Not enough prevention/early intervention for AODA – AODA models tend to deal with people who have crashed.
 - Biggest gaps for AODA consumers are lack of housing and transportation.

- Service integration
 - Lack integration of MH/SA services (e.g., drinking may be masking depression and there is a need to treat both).
 - No organizational integration of MH/SA services – need one organizational unit that can be run as a dually certified outpatient center that can see clients with co-occurring disorders back to back.
 - MH/SA services are not at all integrated – the two areas don't communicate.
 - MH/SA are not well coordinated at HSC – no systemic integration of services.
 - Seeing more individuals with co-occurring disorders. No integrated treatment.
 - Co-occurring disorders are more difficult to treat. Services are fragmented.
 - Individuals with co-occurring disorders are often referred back and forth between MH and AODA units.
 - Need for a more coordinated approach to AODA work – who is doing what and what options exist for individuals on a waiting list for outpatient counseling. There is no coordinated service planning between HSC and provider agencies regarding waiting list status.
 - Need for coordinated care for kids – MH/SA care is not integrated. Ministry Health is leading discussions on Coordinated Service Teams for kids. HSC should be the driver for coordinated care and be allowed to coordinate other service providers.

- Service delivery approach
 - Failure to continue wraparound approach funded through the federal Northwoods Alliance for Children and Families (NACF) grant to prevent out-of-home placements in several northern Wisconsin counties.
 - Two-year degree law enforcement officers shouldn't have authority to detain someone in an emergency crisis situation.
 - No centralized intake process. Entry point to outpatient program is not clear. Individuals leave hospital/MH inpatient and get put on a waiting list for services.
 - Concerned about number of crisis screenings that are done over the phone rather than in person.
 - Quality of contracted MH outpatient providers (Community Mental Health, Price Decker, Transitions) is good.
 - Don't understand why HSC created its own AODA outpatient clinic when there are other available qualified providers.
 - Concerned that HSC outpatient clinic, Northwoods Guidance Center (NGC), will close.
 - NGC clinic is a good model because it integrates therapy and psychiatry services in one organization and at one location; better collaboration for the consumer.
 - Fully merge NGC into HSC operations – NGC still operated as a stand-alone in many ways.
 - Use of teleconferencing equipment for psychiatric services can also provide opportunity for other mental health services (e.g., people won't have to drive 100 miles to participate in service planning activities).
 - Need to return to Rhinelander Model that combated the stigma of mental illness by linking mental health consumers with individuals who were mentors and leaders in the community.

- Need to have a mental health system that consumers can trust – need better advocacy for most vulnerable individuals.
- Mental health providers need to do more groups for cost efficiency.
- Need to review approach to how MH/SA services are delivered and integrate best practices/evidence-based practices.
- Lack of medical leadership and integrated treatment approach to mental health services.

- DD service array and capacity
 - DD case managers aren't as visible in meeting with consumers due to caseload.
 - Difficult to get in touch with case manager.
 - Provider staff completes tasks that should be the responsibility of case managers.
 - Some displeasure among families with availability of resources to young children (0 –3) with developmental disabilities and those that have reached 18.

- Management of HSC
 - Difficult to know what the HSC budget is or what is driving the budget deficits – “shifting sands”, lack of transparency, etc. HSC blames budget overruns on high costs at state mental health institutes, but most of these are appropriate placements.
 - Concerned about mismanagement of funds by HSC.
 - Work ethic and productivity concerns at HSC – lights go out at 4:30.
 - Union issues present a problem in being responsive to consumers (e.g., staff can't shut off the lights at 4:30 when people are in crisis).
 - Barriers to improvement and more effective service delivery are union issues related to evening and weekend coverage and job duty restrictions.
 - It seems HSC is disorganized and fragmented and that AODA area needs to check with Executive Director on every issue.
 - DD area needs to check with Executive Director on issues, which causes delays. Program manager is capable of making decision if given the authority to do so.
 - Lack of communication and team approach of HSC top management.
 - HSC top management doesn't consult or coordinate with staff or providers when planning for services, which fails to tap into the experience of these individuals. Impression that HSC top management doesn't want to include different perspectives.
 - Need effective agency management.
 - Management style is “closed” not open. Issues are not explained or dealt with openly.
 - Top-down management style at HSC.
 - Need new management of agency.
 - Top management doesn't have good rapport with consumers and doesn't explain service cuts or other program changes.
 - HSC lacks infrastructure and tools to appropriately manage the agency's limited resources.
 - Leadership behaviors at HSC are stumbling block for more effective interagency relations. There is a chaotic undertone at HSC marked by blaming and mistrust.
 - Lack of follow-up by top management (“says one thing, but then doesn't follow through”).
 - Majority of management time is spent in crisis management, which causes planning and new initiatives to suffer.

- HSC gets rolling on an initiative and then nothing happens. There is no one at HSC to hand things off to; lack good clerical help.
- IT infrastructure could be improved through better communication (better use of email and voicemail) and implementation of electronic medical records that are tied to billing; data collection is a nightmare at HSC.
- Lots of good staff at HSC but working environment is not healthy – it's a dysfunctional environment marked by distrust, backbiting, micromanagement, high staff turnover and low morale.
- Hostile atmosphere and work environment between HSC staff and administration. Non-collaborative, non-supportive and confrontational management style. Huge turnover of staff. Agency has no common vision and focus.
- Scary environment at HSC – line staff need more encouragement.
- Previous HSC administrations had more collaborative relationship with provider and there was a genuine effort to support services; now relationship is adversarial and HSC is focused on reducing, restricting and eliminating services.
- HSC could contract out additional services to save money.
- Two AODA coordinators are not necessary.
- Koinonia is very mission-driven.

- Governance of HSC
 - HS Board could use an overhaul to get more knowledgeable individuals on the Board (e.g., someone suggested having a bake sale to address funding problems).
 - Some on HS Board are uninformed and look only at the dollars. HSC top management needs to better inform the Board and focus not only on the money.
 - HS Board is making decisions about provider contracts without any knowledge about the agency or services being provided.
 - Tri-county system doesn't work well. Everything is done by the Human Services Board and county boards don't have a good understanding of the services. Human Services Board isn't well informed about the services and rubberstamps everything.
 - Tri-county system has furthered cooperative, collaborative services that have benefitted all three counties, Forest and Vilas have benefitted from having broader array of services provided by a larger entity and Oneida has seen economic benefits from having HSC operations in Rhineland, with most employees living in Oneida County. Oneida has also benefitted from affiliation with Forest and Vilas, designated as lower income counties, when pursuing state grants and aid.
 - Responsibility for lack of communication between county boards and HSC management also rests with county board supervisors on the HS Board who should be bringing information back to their respective county boards. HS Board has become progressively uninvolved in HSC operations. Members don't ask questions or provide direction to HSC.
 - Forest County as the smallest contributor has a disproportionate influence on the HS Board compared to the other two larger counties. Oneida County should take its rightful seat on the Board.

- Role of HSC
 - HSC does not take a visible role in community discussions about service planning. It appears that budget issues, staff turnover and crisis management approach have distracted from broader HSC role in the community.
 - HSC doesn't have identity in the community; it's invisible. People don't have any idea what services HSC provides unless they have had direct contact with the agency.
 - Invitations to HSC to participate in meetings with other providers to address issues of common interest go unanswered.
 - Providers in area meet, but without HSC – not a player in community discussions, even though HSC is such an important part of the service delivery system. Could be more effective as a tri-county community if HSC could be pulled into discussions.
 - HSC doesn't counter negative image in the community – no outreach, liaison or marketing efforts. HSC isn't well known, except for negative publicity, and staff morale is low.
 - Tri-county system could work well with appropriate leadership. At one time, HSC was seen as a model with a systems approach to services. Now it is not visible in the community.
 - HSC is not visible in Madison as it used to be.
 - 51 system should be more collaborative (e.g., have more consumer involvement; everyone should be working together to deliver services in a rural area); 51 system resources do not belong to any one person (“my money, my program, my budget”) but are public resources.
- Relationship with Department of Social Services
 - Relationships between HSC and Oneida County Department of Social Services, as well as other county social services departments in Forest and Vilas are fragmented – difficult to determine roles and funding for shared clients. Need better communication around respective roles of each.
 - Oneida County DSS doesn't work well with HSC to address children's service needs.
 - Oneida County DSS stopped working with HSC due to frustration and lack of response.
 - Hard to coordinate two separate agencies (HSC and DSS) and it is confusing for consumers.
 - Should combine HSC and Oneida County DSS under one umbrella and leverage strengths and mitigates weaknesses of each. For example, DSS is seen as very organized with clear communication channels and defined roles, but is resistant to change, rigid and has a philosophy of providing minimal care. HSC is willing to be creative, apply for grants and think more globally, but has systemic problems with internal instability, management style, and lack of communication and organization.
 - HSC and DSS have very different management styles.
 - Human services agencies should be combined in Oneida County.
 - If HSC and DSS are combined, new leadership is necessary.
- General/other
 - Difficult to maintain qualified direct care workforce – provider has lost staff to retail positions that offer benefits.

- Oneida County gets burden of service needs since folks move to Rhinelander to access services.
- Family Care will allow services to flourish in tri-county area – care management organization under Family Care will be a better service entity than either HSC or DSS.

Summary of Key Findings from Community Stakeholder Input

Given the diversity of the individuals interviewed for this project, the perspectives and comments that were shared with the project team were also diverse. There were many different perspectives offered, including positive comments about HSC and the services provided. However in terms of potential improvement, probably the single most common concern from those who expressed concerns was the need for better and more timely communication between HSC, other service providers and community agencies about HSC operations and services as well as issues of mutual interest.

In addition to the management and governance issues raised by various individuals, stakeholder concerns typically focused on services that HSC is not providing or roles that it is not playing in the community. Concerns that were expressed included:

- Lack of a visible role and presence that HSC, as the public 51 system, plays in the community and broader discussion about service planning.
- Lack of timely access to mental health services, especially for children.
- Need to deal more effectively with individuals who are dually diagnosed with mental health and substance abuse and the lack of integrated services.
- Limited preventative and transitional AODA services in the community given the significant needs in this area.
- Difficulty accessing services throughout the broad geographic area served by HSC.