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# Wyoming Behavioral Health Programs and Services Needs Assessment

Prepared for the

Wyoming Department of Health, Behavioral Health Division

October 2019

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Western Interstate Commission for Higher Education

Behavioral Health Program

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## Executive Summary

The Wyoming Department of Health, Behavioral Health Division (Division) retained the Western Interstate Commission for Higher Education Behavioral Health Program (WICHE BHP) to conduct a Statewide Needs Assessment as part Wyoming's Mental Health and Substance Abuse Block Grant planning and application process. This assessment of programs and services includes the following:

- An environmental Scan of Wyoming's behavioral health treatment system programs and services, including:
    - review of current state data;
    - data from focus groups with Consumers, Family Members, and Advocates;
    - data from focus groups with Providers across the State of Wyoming; and
    - results of a survey of the existing system with all stakeholders.
- A review of Wyoming behavioral health provider contracts
- A comparison of Wyoming data to similar states (Alaska and South Dakota)

## General Impressions and Recommendations

General Impressions:

- Limited publicly funded resources are spread thin across the state, which includes the 18 contracted providers; 12 that deliver both mental health and substance use disorder treatment, two that provide mental health services only and four that provide only substance use disorder services.
- The Community Mental Health Centers serve all persons regardless of acuity.
- The reporting of evidence-based practices (EBPs) used, including those to serve persons with serious behavioral health disorders to SAMHSA is limited.
- Access to services is hindered by geography and rurality, as people may have to drive for hours to receive services, with some residents preferring to receive services from surrounding states.
- Individuals receiving services and advocates of people receiving services appreciate the caring behavioral health staff as noted during focus groups and in the survey.

Recommendations:

- Consider prioritizing behavioral health services and resources to serve more acutely-ill individuals and individuals with serious behavioral health disorders.
    - Consider working with providers to explore the difference between the SMI and SED populations they describe working with and those reported to SAMHSA.
- The Division, in partnership with contract providers, should revisit performance measure requirements and targets included in provider contracts to ensure that these outcome and workload measures are meaningful, support best practices including integrated community-based placements and services, and reflect current and realistic needs in each region or community.

- The Division should review the requirement that providers submit a LOCUS quarterly for each adult client in a residential placement. The LOCUS requires a significant about of time to complete and clinician time is limited given the workforce challenges experienced by community providers. If the requirement is maintained, the Division should put the data to use and communicate their findings to providers.
- Increase the use of EBPs across the state. While true fidelity may not be feasible, the EBPs may be modified to work in a rural or frontier setting while improving the outcomes and quality of services.
    - This can address the concern raised in the focus groups that there is little standardization of the behavioral health services provided across the state.
    - Consider working with EBP experts or state staff from South Dakota, Colorado, or Nevada to learn about their modifications and the rationale behind them and assess whether Wyoming may be able to adapt the EBPs in a similar fashion.
- Increase the use of tele-health to expand access to the services of behavioral health specialists into all communities as needed.
    - Note: Access to adolescent specialists and psychiatrists are needed throughout the state.
- Consider the feasibility of creating partnerships with the University of Wyoming and community colleges to help recruit behavioral health staff who have ties to Wyoming communities to help reduce turnover and create a more robust flow of staff.
- Develop a state-wide crisis system to help reduce the frequency of people in crisis presenting to the emergency room or jail
    - Crisis services may reduce costs to the system by helping people be served in their community and reducing the need for the costs of their treatment to be absorbed by other systems.
- Consider increasing transition support for people leaving inpatient treatment or incarceration to facilitate their reintegration into the community.
- Resolve Medicaid payment issues - Providers repeatedly reported problems billing Wyoming Medicaid; some providers reported outstanding invoices going back a year. Payment delays are creating problems for providers in terms of cash flow, as well as recruiting and retaining staff.
    - These challenges have reduced provider ability to efficiently bill Medicaid for services and has effectively shifted the burden of funding the Behavioral Health system to Wyoming's General Fund. Not maximizing Medicaid (a federal/state funding model) results in the state General Funds supporting a disproportionate share of the public behavioral health services in Wyoming.

# Introduction and Methodology

The Wyoming Department of Health, Behavioral Health Division (Division) retained the Western Interstate Commission for Higher Education Behavioral Health Program (WICHE BHP) to conduct a Statewide Needs Assessment as part Wyoming's Mental Health and Substance Abuse Block Grant planning and application process. This report is timely as Governor Mark Gordon identified mental health and substance use disorder treatment as priorities for the government as part of his January 9, 2019 State of the State address[1]. In that speech, Governor Gordon specifically identified improving access to mental healthcare for veterans, first-responders and "ultimately for all citizens" as a priority. Additionally, he identified doing more in the "communities to help support those who are struggling with crisis". His speech highlights the need for thoughtful examination of the strengths, gaps, and areas for improvement in the Wyoming public behavioral health system.

## DESCRIPTION OF REGIONS

The Division identified five regions of the state: Basin, Central, Northeast, Southeast, and Western. The counties included in each region were identified by the state. During the stakeholder survey discussed later, respondents were asked to identify in which region they reside so, survey findings may be provided by region. The county breakout is:

- Basin Region - Counties: Park, Big Horn, Washakie, Hot Springs
- Northeast Region - Counties: Sheridan, Johnson, Campbell, Crook, Weston
- West Region - Counties: Teton, Sublette, Lincoln, Uinta, Sweetwater
- Central Region - Counties: Natrona, Converse, Niobrara, Fremont
- Southeast Region - Counties: Carbon, Albany, Laramie, Platte, Goshen

During the stakeholder survey, respondents were asked to identify in which region they reside so, survey findings may be provided by region.

## SURVEY DEVELOPMENT AND DATA COLLECTION

A variety of methods were used to inform this project. We began by creating an online survey instrument, using SurveyMonkey Software, to assess the behavioral health needs and experiences across five regions of Wyoming. These regions were identified by the Division and included the Basin, Central, Northeast, Southeast, and Western regions. We created the initial framework for the survey and then developed it through an iterative process working with staff from the Division. The survey included questions about participant demographics as well as participant perspectives on underserved populations, strengths, weaknesses, barriers, and gaps in the behavioral health system for both their region and statewide, and their perception/experience of resources available to support the behavioral health system regionally and statewide. The questions were both quantitative and qualitative in nature, allowing participants ample room to comment or provide additional information on any items

[1] Governor Mark Gordon's State of the State Address to the 65th Wyoming Legislature on January 9, 2019 https://governor.wyo.gov/media/news-releases/state-of-state-2019

they desired.

The survey link was distributed by staff at the Division. Consumers, behavioral health providers, family members, state agency employees, and advocates were all invited to participate. The survey was also publicized in *Laramie Live*, a Wyoming newspaper, on Wyoming Public Radio, and through WICHE BHP's and the Wyoming Department of Health's Twitter accounts. The survey went live on April 24, 2019 and remained active until June 7, 2019.

Following the data collection phase, we downloaded all data from SurveyMonkey into Microsoft Excel for initial analyses. To begin, qualitative and quantitative data was separated. Qualitative data was analyzed and coded for themes. As themes were identified from the data, they were also assessed for frequency by counting the number of participants who had identified that theme. Regional questions were assessed using only participants from that region, while statewide questions used all participant responses, regardless of region. Following the initial identification of themes, the data was read again in order to condense and combine similar themes and to understand which themes were standing out in relation to others.

Statewide quantitative data was analyzed using Microsoft Excel. Graphs were also created using this program. To analyze regional responses, Stata Statistical Software was used[2]. Simple descriptive statistics were run to determine responses by region. This data was then entered back into Excel to produce graphs.

**Data limitations**

The survey data collected for this study has several potential limitations. First, individuals responding to the survey may have been those with overly negative or overly positive experiences within the system. In other words, individuals who had an average experience in the Wyoming Behavioral Health system may not have taken the time to complete the survey. Further, despite attempts to reach as many facets of the community as possible, individuals with severe mental health concerns and/or those currently receiving treatment, may not have accessed the survey to provide their feedback. Finally, completing this survey required the ability to 1) read English and 2) have access to a computer with internet access. These requirements may have resulted in the inability of certain Wyoming subpopulations to provide their input.

## FOCUS GROUP QUESTIONS

Another method used to inform the project were focus groups, which were conducted with consumers and advocates of the public behavioral health system in Wyoming. (The focus group questions are provided in Appendix A.) These focus groups were conducted on June 11, 2019. We held a focus group at the inaugural Pathways to Wellness Consumer and Advocate Conference in Casper Wyoming. We met with approximately 34 consumers to listen to their feedback about what is working and where there are gaps and room for improvement in the public behavioral health system. A second focus group was held with the Behavioral Health Advisory Council at the conclusion of the conference. With this second group, similar questions were asked and again the group was able to provide

feedback on what is working and where there are gaps and room for improvement in the public behavioral health system.

Additionally, we held focus groups with two providers from each of the five regions identified by the Division (Basin, Central, Northeast, Southeast, and Western). These focus groups were conducted via Zoom during the month of June 2019. Providers were given the chance to give feedback on what is working and where they see room for improvement of the public behavioral health system in Wyoming.

# Environmental Scan of Wyoming's Behavioral Health Treatment Programs and Services

## Review of Current Treatment Contract Documents to Inform Program and Service Requirements

### Methodology

WICHE BHP reviewed the Division's administrative rules related to contracting, along with three sample contracts provided by the Division (Southwest, Yellowstone and Pathfinder). WICHE reviewed similar provider service contracts from the two other states used for comparative purposes in this study – Alaska and South Dakota. In addition, WICHE BHP drew upon experience reviewing contracts in other states for other projects, including Colorado and Hawaii. WICHE BHP also reviewed comments made by mental health and substance use providers about contracts during the interviews conducted as part of this study.

### Administrative Rules and Contracting Process

The Division's administrative rules require providers to apply for a contract. Along with other application requirements, the rules require that the applicant submit a "service delivery plan." This plan must include the amount of funding requested for each service, "program goals and objectives" and "the needs in the region and how the program proposes to meet those needs…"[2]

### Overview of Contract Requirements

Like provider contracts in other states, the Division's contract is structured to include payment terms, general and special provisions, along with "boilerplate" requirements often common to all state contracts, including insurance requirements, termination provisions, and other legal conditions. Like other states, the Division uses contract "attachments" to outline the "statement of work" to be provided by the contractor, along with other requirements not included in the boilerplate sections.

[2] Wyoming Administrative Rules, Department of Health, Behavioral Health – Personnel and Program Quality, ch. 5 5, Section 2(A)(ix)

These attachment documents also include a service definitions and reporting guidance document that delineates required and optional outpatient services to be provided.

Wyoming structures most of its contracts to include a "base payment" amount and a "service payment" amount. The base payment amount is typically 30 percent of the total outpatient services contract amount, and is designated for administration, data collection and reporting, and maintaining accreditation. The remaining payment amount is 70 percent for services. The funding source for these contracts is state general fund and federal block grant funds, and the funding from these contracts are not to be used for services billable to Medicaid or to other insurers.

The base payment amount is paid monthly assuming the contractor fulfills all administrative requirements, for example, copies of audits and tax documents and verification of accreditation for mental health and substance use disorder service provision. The service payment is paid monthly based upon service hours reported as "state paid" by the contractor in WCIS. Differential rates are applied to state paid hours for priority populations services and state paid general populations services. Priority population state paid hours are paid at the rate of $120 per hour irrespective of service type delivered and at the rate of $87 per hour for services delivered to the general population. If the contractor is unable to provide enough state paid service hours to generate a quarter's worth of total capped payment, the contractor may request an exception payment for extenuating circumstances.

### PERFORMANCE REQUIREMENTS AND TARGETS

The statement of work requires contractors to meet performance-based contracting requirements, including:

- demonstrating an average wait time of five days or less for adult clients with a serious mental illness (SMI) and the same for SUD clients (outpatient services only); and
- demonstrating an average improvement of functioning upon treatment completion and discharge of five points or more as measured by the Daily Living Activities (DLA) Functional Assessment tool and translated into a Global Assessment of Functioning (GAF) score, for of adult clients with SMI and clients with SUD.

The contracts also include specific targets negotiated individually with each provider related to SMI and SUD clients, including:

- increasing the percentage of outpatient clients with SMI unemployed at admission who are employed at interim or discharge;
- increasing the percentage of adult outpatient clients with SMI homeless at admission who are not homeless at interim or discharge;
- maintaining the percentage of outpatient clients with a methamphetamine use disorder who have a discharge status of treatment complete to fifty-five percent (55%) or higher; and
- maintaining the percentage of outpatient clients with an opioid use disorder who have a discharge status of treatment complete to fifty-five percent (55%) or higher.

The contracts also identify utilization rate targets for contracted residential placements. Additionally, utilization rates for performance requirements for programs within a treatment facility

are identified in contracts

- 85% utilization rate for mental health community living programs, and SUD residential programs
- 35% utilization rate for social detoxification and mental health crisis stabilization

The contract language states that "failure to comply" with the statement of work may require the contractor to submit a corrective action plan. The contract also gives the Division the authority to withhold all or part of payments to the contractor.

### LEVEL OF CARE ASSESSMENT REQUIREMENT

The contracts require providers to utilize the Level of Care Utilization System (LOCUS) tool to determine the needed level of care for all persons upon admission, at interim updates that occur once a quarter or more frequently as necessary, and at discharge from community housing. The LOCUS was developed by the American Association of Community Psychiatrists as a tool to provide mental health clinicians and service providers with a systematic approach to the assessment and determination of the service and support needs of individuals with mental health challenges. The LOCUS provides for six levels, ranging from the least intense (recovery maintenance, such as seeing a case manager once a month and having access to a 24-hour crisis line if needed) to the most intense (medically managed residential services include hospital inpatient care.)

Providers are required to report LOCUS data using the Management Information System (MIS). When asked how LOCUS data is currently being used, Division staff indicate the LOCUS data will be used to evaluate if clients are entering levels of care that match their assessed level and to help identify regional gaps that might exist for residential/inpatient beds.[3]

### CONTRACT PROVISION RELATED TO TITLE 25 EMERGENCY DETENTION

The contract states that funds "may not be used to provide services, other than gatekeeping, to a person emergently detained under Title 25 within the first seventy-two (72) hours of detention." This contract provision likely stems from the statutory requirement that counties are responsible for the housing and treatment costs for individuals held under emergency detention.[4] Some providers reported that they believe providing Title 25 assessments to determine if an individual needs emergency detention or involuntary hospitalization is an unfunded state mandate. However, Title 25 assessments are listed as an optional service in Division contract documents. It is likely providers have individuals who present at community programs requiring an assessment and then community provider staff complete the assessments. "Gatekeeping" services are reimbursable under the contract. These services are essentially case management services for individuals who have been detained or involuntarily hospitalized and include engaging in hospital discharge planning and facilitating transfer

[3] Email correspondence with Wyoming Division of Behavioral Health staff, August 22, 2019.

[4] Wyo. Stat 25-10-112(a)

to a lower level of care.

### Observations

- The Division's requirement that providers submit a service delivery plan identifying region needs and how the program proposes to meet those needs reflects a positive linkage between the contracting process and fulfilling community needs.
- Other than performance contracting, the Division's behavioral health provider contracts do not include any "out of the ordinary" requirements or mandates when compared to other state's behavioral health contracts.
- The target of a minimum 85 percent utilization rate for transitional and long-term group homes and supervised living for adults with an SMI does not appear to support integrated community living and supports.
- Contract performance measures and targets reflect a positive effort to achieve client outcomes. Of the three states reviewed, only Wyoming includes performance contracting for behavioral health. Performance contracting works best when the state and contractors actively and regularly monitor and report on contractor performance, and when the measures and targets selected by the state have meaning and acceptance from the contractor. For example, some providers expressed concerns about the continued use of the Global Assessment of Functioning (GAF) scale. The scale was included in DSM-IV but replaced in DSM-5 with the World Health Organization Disability Assessment Schedule, a survey or interview with detailed items.[5]

### Recommendations

- The Division, in partnership with contract providers, should revisit performance measure requirements and targets included in provider contracts to ensure that these outcome and workload measures are meaningful, support best practices including integrated community-based placements and services, and reflect current and realistic needs in each region or community.
- The Division should review the requirement that providers submit a LOCUS quarterly for each adult client in a residential placement. The LOCUS requires a significant about of time to complete and clinician time is limited given the workforce challenges experienced by community providers. If the requirement is maintained, the Division should put the data to use and communicate their findings to providers.

## Review of Data

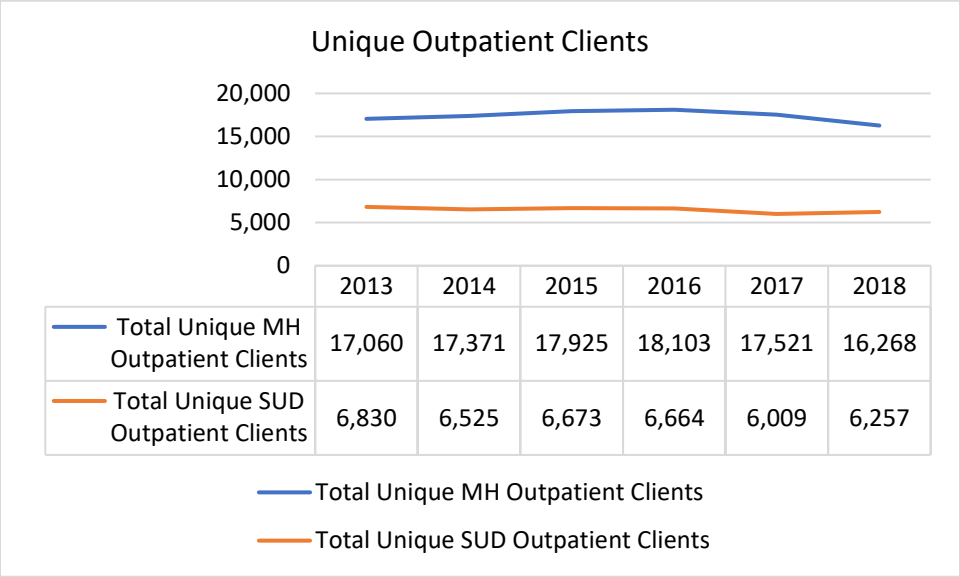
The Division provided WICHE BHP with data for State Fiscal Years (SFY) 2013-2018 for analysis. The WICHE BHP conducted longitudinal analysis of these data to look for trends and changes over time. When appropriate comparisons to similar states, Alaska and South Dakota, were made and national

[5] American Psychiatric Association: The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA: American Psychiatric Association, 2013

data were utilized when available. Alaska and South Dakota were identified by WICHE BHP and the Division as states that are similar in their rural and frontier nature as well as their sparse population

The number of unique clients in mental health treatment has held relatively steady from SFY 2013 to SFY 2018 with a high of 18,103 unique clients in SFY 2016 to a low of 16,268 in SFY 2018. The number of unique clients in Substance Use Disorder treatment have also been steady with a high of 6,830 unique clients in SFY 2013 and a low of 6,009 unique clients in SFY 2017 (Figure 1).

Figure 1: SFY analysis of unique outpatient clients by treatment type




| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|
| Total Unique MH Outpatient Clients | 17,060 | 17,371 | 17,925 | 18,103 | 17,521 | 16,268 |
| Total Unique SUD Outpatient Clients | 6,830 | 6,525 | 6,673 | 6,664 | 6,009 | 6,257 |

## WHO IS BEING TREATED?

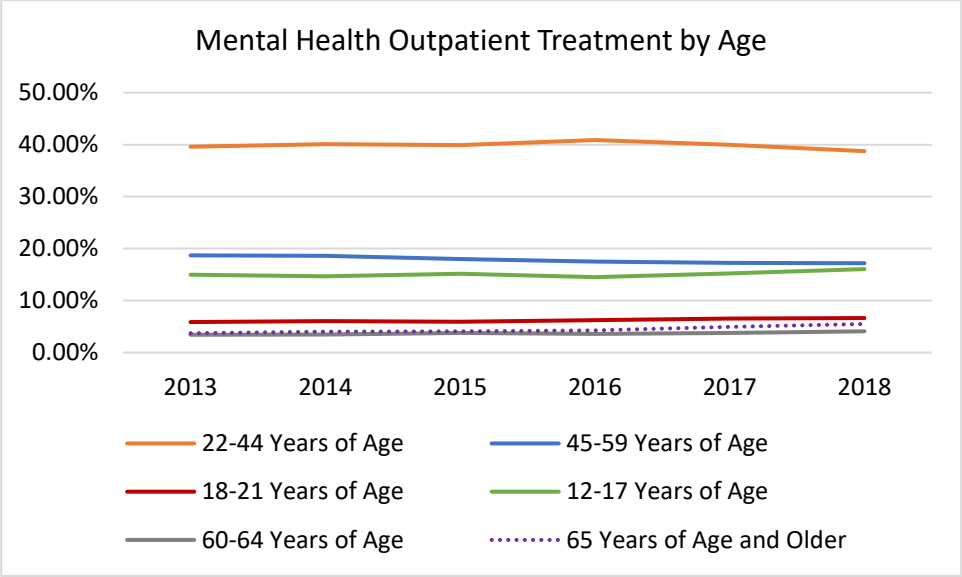
### Demographics

The racial and ethnic demographics for Wyoming are largely homogenous in SFY 2018 the Mental Health Outpatient clients were 87.6% White, 4.4% other/unknown, 3.9% multiracial, 2% Native American/Alaskan, 1.4% Black/African American, 0.4% Asian, and 0.2% Native Hawaiian/Other Pacific Islander. Substance use disorder clients for the same fiscal year had the following racial and ethnic demographic makeup: 85.4% White, 4.5% Other/unknown, 3.6% Native American/Alaskan, 3.6% multiracial, 2.2% Black/African American, 0.4% Asian, and 0.3% Native Hawaiian/Other Pacific Islander. These numbers are remarkably consistent across the years from SFY 2013- SFY 2018 across both Mental Health and Substance Use Disorder treatment admissions.

The highest utilizers of treatment for Mental Health treatment are those in the 22-44-year-old range and this is consistent from SFY 2013 to SFY 2018 (Figure 2). In both South Dakota and Alaska, people in the 22-44-year-old age range were the highest utilizers of mental health treatment in 2018. In South Dakota the 22-44-year-old age range made up 26.3% of the people in treatment and in Alaska, this group made up 30.1% of the people in treatment for mental health. Nationally, people in the 22-

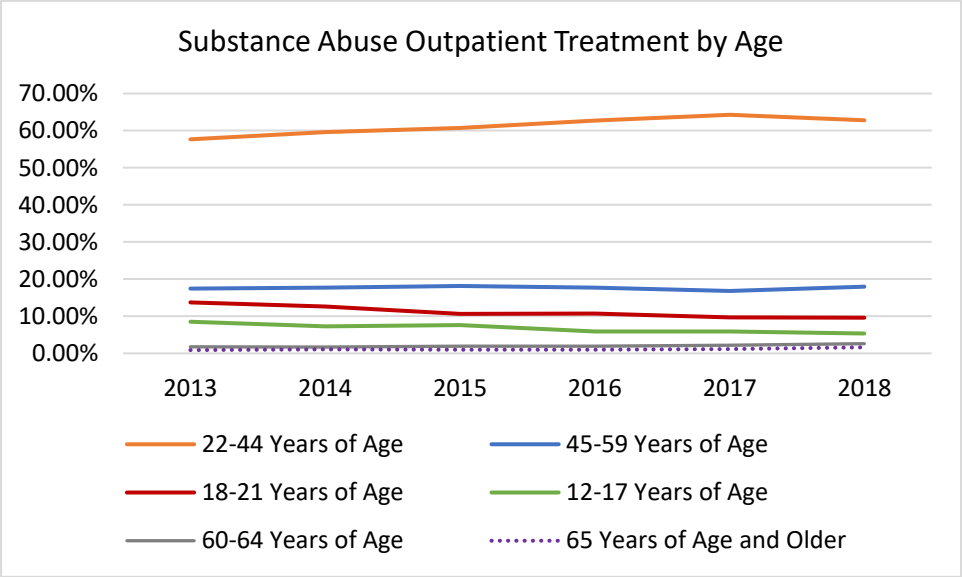
44-year-old age group comprise 31.7% of the people in mental health treatment.

Figure 2: SFY 2013 – SFY 2018 Analysis of mental health outpatient treatment admissions by age.




The same trend is true for people entering substance use disorder treatment as again, the highest utilizers of treatment are those in the 22-44-year-old range (Figure 3). These data are consistent with SAMHSA's data on substance use disorder treatment admissions and discharges [6].

Figure 3: SFY 2013 – SFY 2018 Analysis of substance use disorder outpatient treatment admissions by age.




[6] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. *Treatment Episode Data Set (TEDS): 2017. Admissions to and Discharges from Publicly-Funded Substance Use Treatment.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.

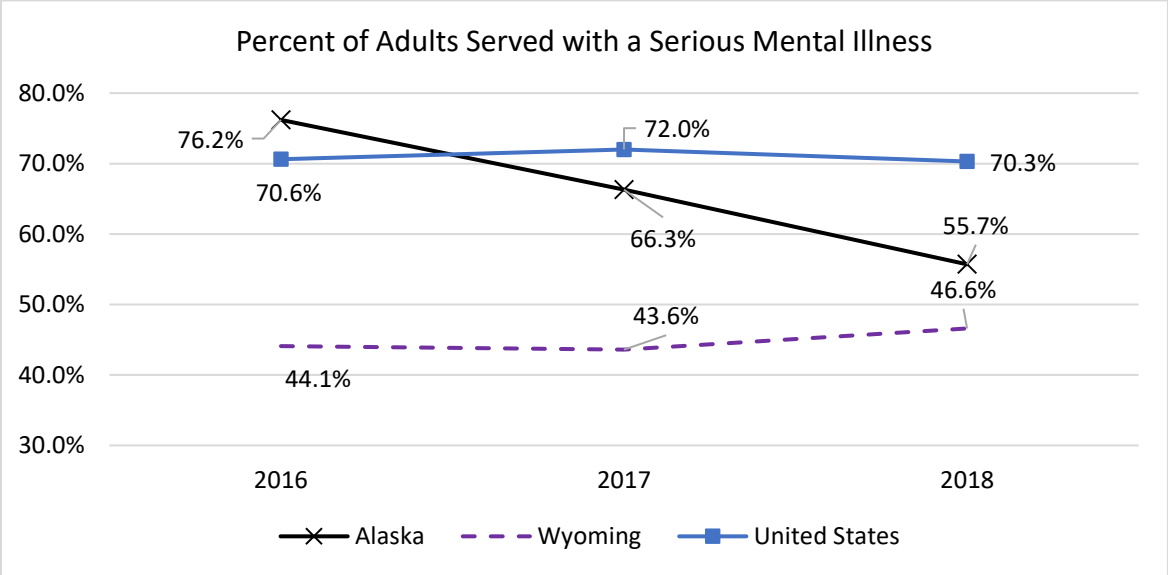
**Diagnoses**

SAMHSA's Uniform Reporting System[7] provided comparison data between Wyoming and the U.S. overall, Alaska, and South Dakota. These are publicly available data sets from each state's annual reporting to SAMHSA as part of their Federal Block Grant Reporting.

People in Treatment for Serious Mental Illness/Serious Emotional Disturbance

The number of adults in treatment with a Serious Mental Illness (SMI) in Wyoming is lower than national averages and lower than Alaska, one of the states identified as being similar in population to Wyoming (Figure 4). The Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that in Region 8 between 2013 and 2017 among adults aged 18 and older 5% of the civilian population, over the age of 18 have an SMI[8]. Given the relatively normal distribution of people with an SMI throughout the country, the data for Wyoming indicate that the public behavioral health system is serving a more generalized population.

Figure 4: SFY 2016 – SFY 2018 Analysis of percent of adults served with a serious mental illness (data for South Dakota are unavailable).

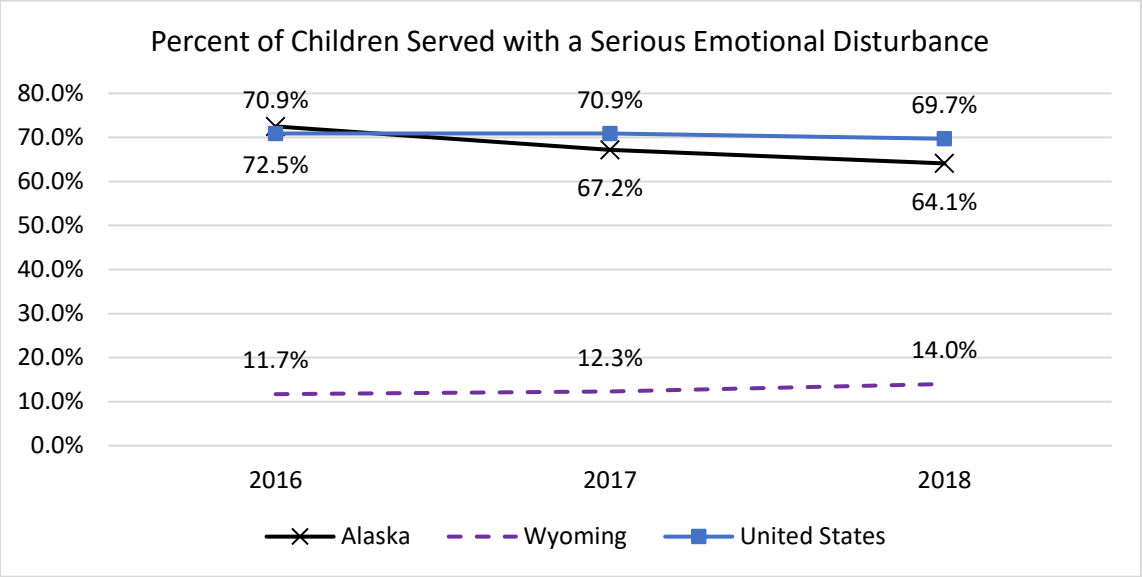



[7] Substance Abuse and Mental Health Services Administration Uniform Reporting System https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system

[8] Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Region 8, Volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services.* HHS Publication No. SMA-19-Baro-17-R8. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.

Similarly, when data on children with Serious Emotional Disturbance (SED) are reviewed, Wyoming data are again below the numbers seen for Alaska and the nation as a whole (Figure 5). The State of Mental Health in America 2018[9], published by Metal Health America, ranks Wyoming as 36 out of the 50 states for the combination of the prevalence of mental illness and lower rates of access to care. This indicates that there is a relatively high prevalence of children in Wyoming with serious emotional disturbance and a low rate of utilization of services.

Figure 5: SFY 2016 – SFY 2018 Analysis of percent of children with serious emotional disturbance (data for South Dakota are unavailable).




The data for both groups, adults with SMI and children with SED, indicate that the Wyoming public behavioral health system has become more of a generalist system rather than one focused on serving the neediest of the community. Historically, the public behavioral health system has been focused on helping people with these conditions get into treatment and into recovery, the disparity between the data for Wyoming compared to Alaska and the nation indicate that the Wyoming system has moved away from focusing on people who are the most acutely and seriously ill, which is unexpected especially given improved mental health insurance parity. Contracted providers described seeing higher percentages of clients with SMI and SED than reflected in these data. The Division may wish to explore this difference.

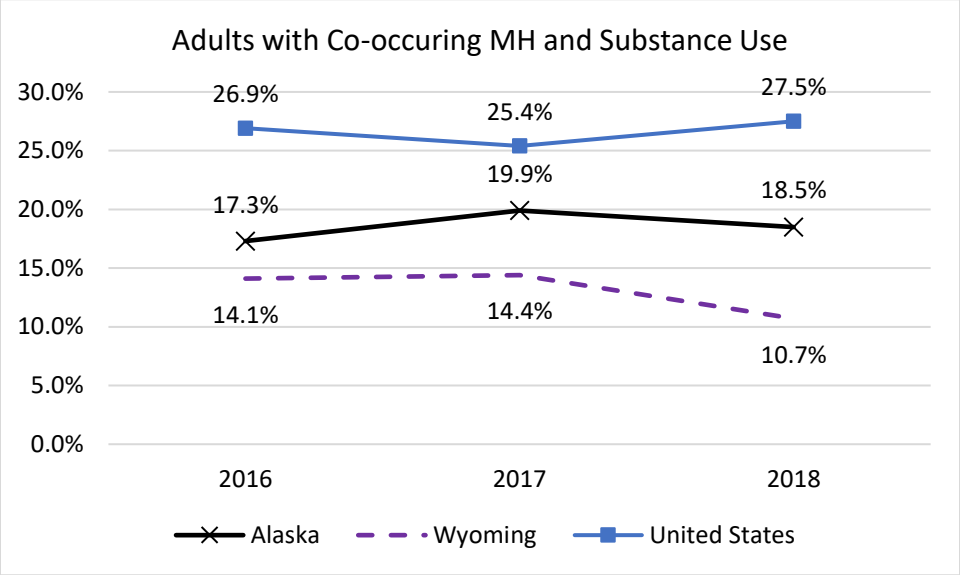
<u>People in Treatment for Co-occurring Mental Health and Substance Use Disorder</u>

As with data about the percent of people in treatment with SMI/SED, data about people in treatment in Wyoming for co-occurring mental health and substance use are lower than those seen in

[9] Mental Health America, page 11
https://www.mhanational.org/sites/default/files/2018%20The%20State%20of%20MH%20in%20America%20-%20FINAL.pdf

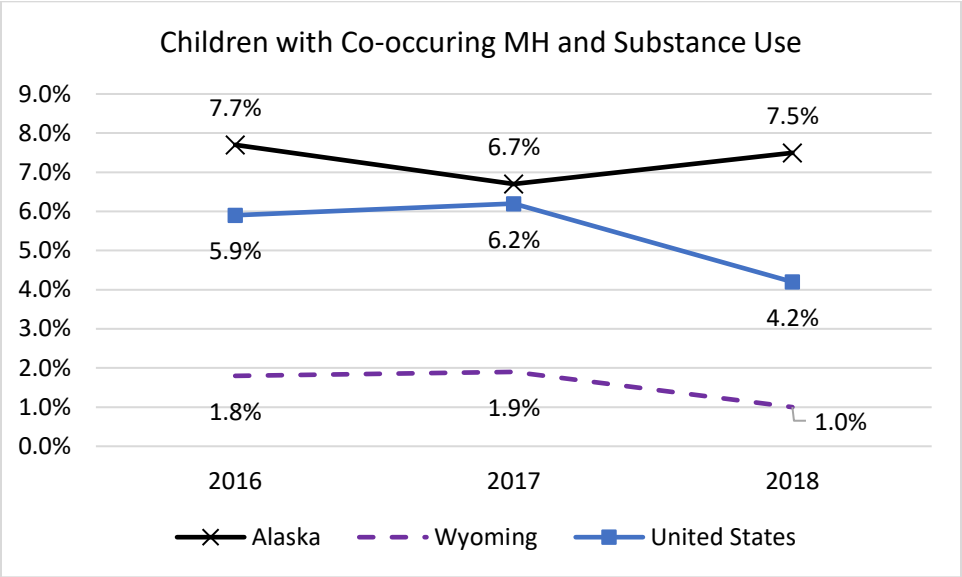
Alaska and nationally (Figure 6) due to Wyoming's data collection system not identifying persons with co-occurring disorders. The number of adults in treatment for co-occurring mental health and substance use disorder issues in Wyoming in 2018 is 61% lower than the national average and 42% lower than the data from Alaska.

Figure 6: SFY 2016 – SFY 2018 analysis of adults with co-occurring mental health and substance use disorder (data for South Dakota are unavailable)




Children in treatment for co-occurring mental health and substance use issues are again lower than those found in Alaska and nationally (Figure 7). Using SFY 2018 for comparison, Wyoming is 76% below the national average and is 86% lower than Alaska. The disparity for both adults and children in treatment for co-occurring mental health and substance use disorders indicates again, that the state may be serving too general a population.

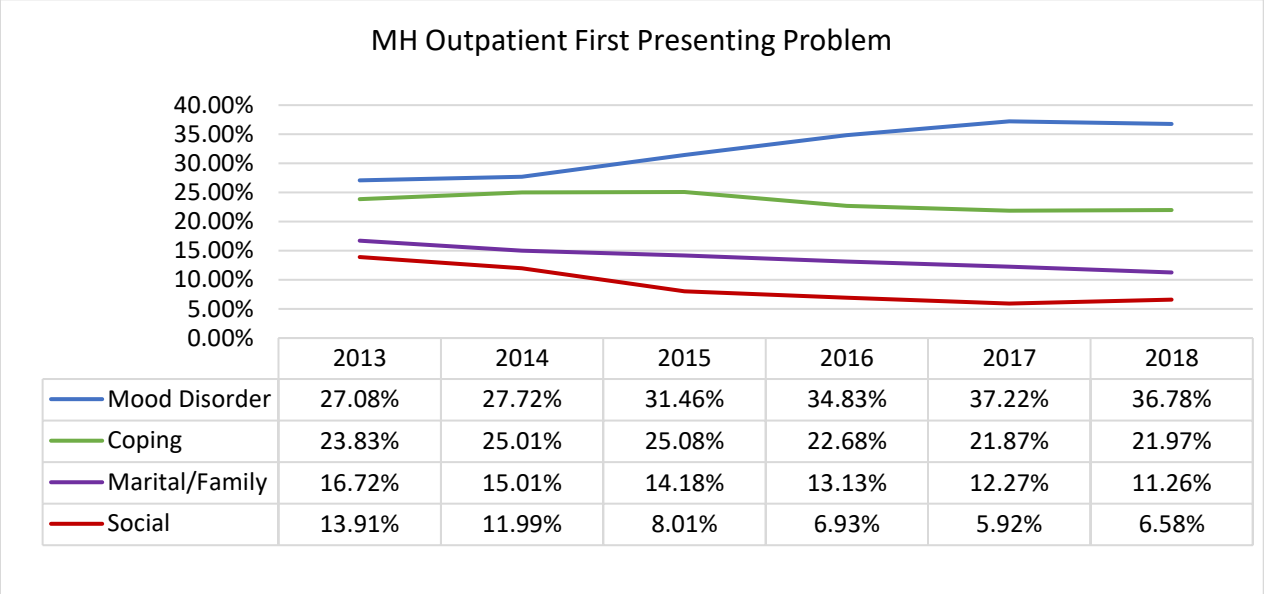
Figure 7: SFY 2016 – SFY 2018 Analysis of children with co-occurring mental health and substance use disorder (data for South Dakota are unavailable).




First Presenting Problem for People in Mental Health Outpatient Treatment

In Wyoming's public behavioral health system, the most common first presenting problem of people in mental health outpatient treatment is mood disorder, followed by: issues coping, marital/family issues, and social issues (Figure 8). The prevalence of mood disorders has increased 36% between 2013 and 2018. The dramatic appearance of this shift is due to the shift from the ICD9 to the ICD10 coding protocols that happened in October of 2015. However, mood disorders have consistently been the most frequent first presenting problem for people entering outpatient mental health treatment.

Figure 8: SFY 2013 – SFY 2018 Analysis of mental health outpatient treatment by first presenting problem




| | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|
| Mood Disorder | 27.08% | 27.72% | 31.46% | 34.83% | 37.22% | 36.78% |
| Coping | 23.83% | 25.01% | 25.08% | 22.68% | 21.87% | 21.97% |
| Marital/Family | 16.72% | 15.01% | 14.18% | 13.13% | 12.27% | 11.26% |
| Social | 13.91% | 11.99% | 8.01% | 6.93% | 5.92% | 6.58% |

The primary diagnoses associated with SMI are schizophrenia-spectrum disorders, severe bipolar disorder, and severe major depression. Given that none of those are present in the most frequent first presenting problems, this further indicates that the Wyoming public behavioral health system has shifted to a less acute more general population base.

Recommendation

- Consider what the focus of the public behavioral health system should be (general population or focused on those with SED or SMI). If the focus should be on people with SMI/SED; consider ways to incentivize their treatment and the barriers faced by providers in treating these groups.
    - Consider working with providers to explore the difference between the SMI and SED populations they describe working with and those reported to SAMHSA.

## WHERE DO PEOPLE IN TREATMENT LIVE?

To assess whether the public behavioral health system in Wyoming has treatment facilities located in the "right" areas, areas where the people in treatment live, the persons' in treatment county of residence was then normalized to the population of each county (creating a number of people in treatment from each county per capita). This reduces variation due simply to the population in each county. The top five most frequent county of residence are presented in descending order of frequency throughout. Appendix D contains detailed tables for all the data presented below.

### Mental Health Treatment

Per capita, the counties in which mental health outpatient clients most frequently reside are

Sweetwater, Washakie, Hot Springs, Weston, and Goshen counties. These counties represent the West, Basin, Northeast and Southeast regions of the state. Mental health residential clients, per capita, most frequently reside in Washakie, Uinta, Converse, Fremont, and Park counties. These counties represent the Basin, West, and Central regions of the state. Crisis stabilization clients, per capita, most frequently reside in Washakie, Uinta, Laramie, Natrona, and Sweetwater counties. These represent the Basin, West, Southeast, and Central regions of the state.

**Substance use disorder Treatment**

Per capita, the counties in which substance use disorder outpatient treatment clients most frequently reside are Washakie, Sweetwater, Natrona, Johnson, and Hot Springs. These counties represent the Basin, West, Central, and Northeast regions of the state. Substance use disorder residential treatment clients, per capita, most frequently reside in Carbon, Converse, Hot Springs, Sweetwater, and Natrona counties. These counties represent the Southeast, Central, Basin, and West regions of the state. Clients in social detox treatment, per capita, most frequently reside in Fremont, Laramie, Sheridan, Sweetwater, and Niobrara counties. These counties represent the Central, Southeast, Northeast, and West regions of the state.

**Summary**

Washakie County, in the Basin region, is the most frequent county of residence per capita for substance use disorder outpatient treatment, mental health residential treatment, and crisis stabilization. Sweetwater County, in the West region, appears in the top five most frequent county of residence for mental health outpatient, crisis stabilization, substance use disorder outpatient treatment, substance use disorder residential treatment, and social detox. Sweetwater County has a substance use disorder residential treatment facility, a social detox and a crisis stabilization location. Sweetwater County is the fourth largest in the state with a population of 43,051[10].

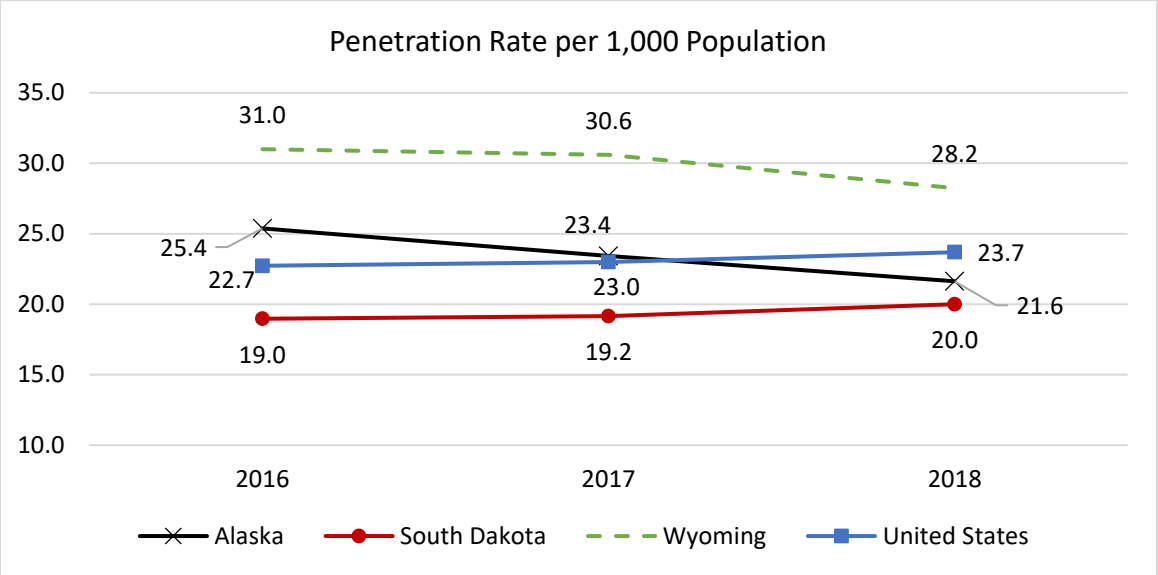
## ACCESS

**Mental Health Penetration Rates in Wyoming, Alaska, South Dakota**

Penetration rates measure the percentage of individuals receiving mental health services per 1,000 population and provide insight about access to mental health services. Wyoming has a higher penetration rate overall than that seen nationally or in Alaska and South Dakota (Figure 9). This indicates that access to mental health treatment is less of an issue in Wyoming than in the U.S. as a whole, in Alaska or South Dakota. While a high penetration rate is an indicator of more individuals accessing treatment, it does not mean that the people who are more acutely ill (e.g., individuals with an SMI or SED) are being treated.

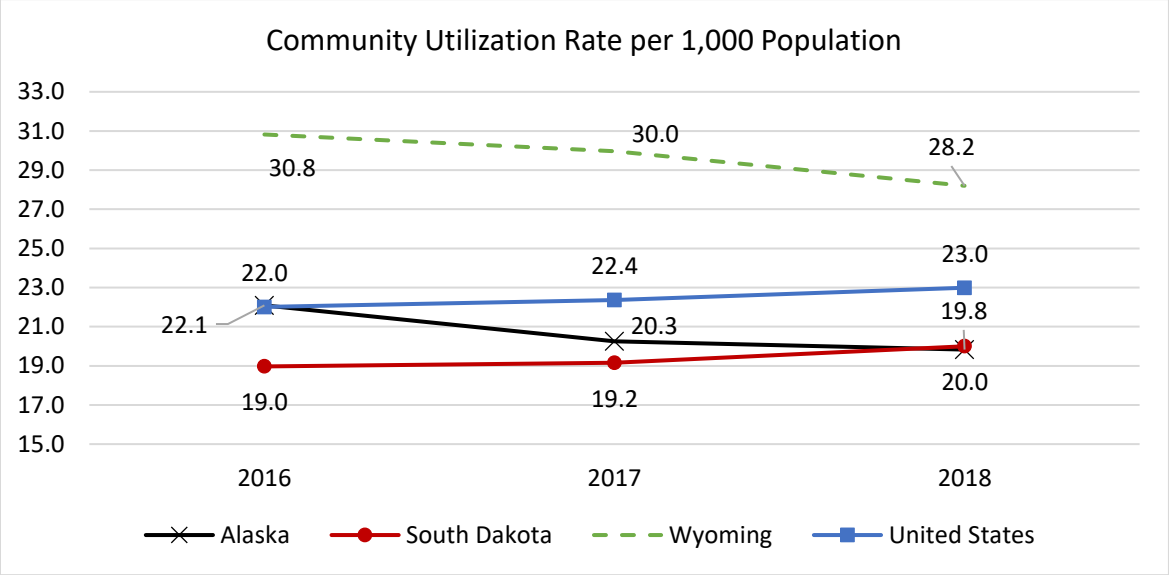
[10] United States Census Bureau. Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018. U.S. Census Bureau, Population Division. Web. May 2019. http://www.census.gov/.

Figure 9: SFY2016 – SFY 2018Penetration rate per 1,000 population




When community utilization rates are examined Wyoming again has higher utilization rates than those seen nationally or in Alaska and South Dakota (Figure 10). Once again, this indicates that access to treatment is less of an issue in Wyoming than in the U.S. as a whole, in Alaska or South Dakota. A high community utilization rate indicates that people are accessing behavioral health treatment in the community which is great. The system is designed to help people in receive treatment in their community. However, as with the overall penetration rate, this does not indicate that the people who are more acutely ill (e.g., individuals with an SMI or SED) are being treated.

Figure 10: SFY 2016 – SFY 2018 Community utilization rate per 1,000 population




## Focus Group Results

**Community Stakeholder Focus Groups**

Focus groups were conducted with consumers and advocates of the behavioral health system in Wyoming. The focus group questions are provided in Appendix A. These focus groups were conducted on June 11, 2019. We held a focus group at the inaugural Pathways to Wellness Consumer and Advocate Conference in Casper Wyoming. We met with approximately 34 consumers to listen to their feedback about what is working and where there are gaps and room for improvement in the public behavioral health system. We held a second focus group with the Behavioral Health Advisory Council. At this second group, similar questions were asked and again the group was able to provide feedback on what is working and where there are gaps and room for improvement in the public behavioral health system.

Strengths

Participants in both focus groups identified several strengths of the current behavioral health system, including the dedication of the staff delivering services. Consumers and advocates indicated they are aware of the challenges faced by staff at the centers and are appreciative of their compassion and dedication to their communities. In particular, the providers who specialize in working with children and adolescents were identified as being excellent. Peer services, where available, are highly valued by consumers and advocates. Likewise, high fidelity wrap-around services are highly valued and appreciated where they are available.

The behavioral health services identified as the most helpful by consumers and advocates are, peer services (where available), high fidelity wrap-around services, youth alternatives to try to reach

students, and crisis stabilization centers (where available). In particular, the Iris Clubhouse in Casper was identified as an outstanding program in which people receive individualized care and support from providers and the community. This program uses the international clubhouse model[11]. There was significant support for increasing the availability of programs like this across Wyoming.

Gaps

When asked to identify what types of services are needed across Wyoming both groups identified access to treatment as a gap. Participants noted that the same service array is not available across the state so the type of services a person receives is dependent upon where they live. The scarcity of psychiatrists, providers specializing in serving children and adolescents, clinicians with training in working with people with both mental health issues and intellectual disabilities, and a lack of peer specialists. Participants also noted that turnover negatively impacts clients as they don't have a consistent person to work with and that the changes in their primary practitioner is disruptive enough that some cease treatment. The groups noted the lack of inpatient beds as another gap in treatment. In addition to the lack of inpatient treatment, participants noted that there are limited resources to help people transition from inpatient settings back into the community. The groups felt that increasing transition services would help people to be more successful in their communities.

Participants also noted that crisis services are needed across the state. The crisis stabilization centers that exist are well received and people feel that they are beneficial, but the groups identified the need for additional resources for people in crisis. Coordination with law enforcement was identified as a key part of this solution as few law enforcement staff are trained in crisis intervention and the groups felt that this could go a long way toward decriminalizing a behavioral health crisis and keeping people from being taken to jail. The groups noted that people are often taken to jail while in crisis leading to a perception that mental illness is being criminalized.

Other feedback

Participants offered feedback on several other topics:

- improving communication between behavioral health agencies across Wyoming would help the system;
- fixing problems with Medicaid billing as this is impacting the state General Fund.;
- increasing awareness of behavioral health issues and reducing stigma, including educating legislators that it costs less to treat people before their issues become a crisis;
- addressing the high cost of services, transportation and insufficient workforce;
- implementing a public media campaign to let people know what services are available; and,
- increasing the use of tele-health to help alleviate difficulties in getting specialists into rural and frontier communities. Tele-health can also be used to increase the reach of peers and wrap-around services.

[11] https://clubhouse-intl.org/

**Provider Focus Groups June 2019**

As previously noted, the WICHE BHP conducted video calls with two providers from each region of the state, as defined by the Division. The focus group questions for providers can be found in Appendix B. This series of focus groups were conducted throughout the month of June 2019. The providers were asked questions about the strengths, gaps, and suggestions for improving the public behavioral health system.

Strengths

Providers view the variety of services and programs provided across the state is a strength. They indicate programming is often based on the needs of the community and they do their best to be responsive to those needs. Participants indicated that the rural nature of the area facilitates the creation of good working relationships with staff at other human services agencies in the communities. The centers interviewed all described robust referral networks with clients entering their system through schools, probation and parole, primary care physicians and through self-referrals by people who have encountered their office through word of mouth or through an outreach campaign.

Many of the providers indicate that they conduct outreach efforts through ongoing efforts within the community. For instance, many spoke about having booths at community events and helping to host events throughout the year. Sometimes these events are focused on certain outcomes such as reducing stigma associated with behavioral health treatment or increasing the awareness of veterans to the services they provide. They indicate that they participate in suicide prevention work, conferences throughout the state, social media, health fairs, opioid awareness campaigns, and recovery month events.

The providers state they have done a lot of work to cultivate relationships with other behavioral health agencies, with the other human services agencies and other community partnerships in each area. They indicate many referrals come in through those partnerships (e.g., DFS, court system, schools, disability centers, group homes, law enforcement, county commissioners, etc.). They discussed how the rural nature of the state allows for informal interactions and meetings between behavioral health leaders and the leaders of these other organizations.

Gaps

Most providers cited funding issues as their greatest concern. They indicated they want to provide more services, but they don't have the funding or staff to deliver the services. For example, they would like to provide transition services for people leaving inpatient treatment to help them be successful in the community, but lack of funding prohibits the development of these services. They also indicated that lack of funding makes it hard to recruit and retain staff, especially qualified staff with a master's degree. Turnover then becomes a problem that drives clients away as they get frustrated with the lack of consistency in their clinician. This then impacts the breadth of services they can provide. Few have established community partnerships that can help to off-set these challenges. Medicaid billing issues were raised in nearly every call with providers as an issue that is preventing them from delivering the service array that they hope for. Providers also reported concerns about being able to

meet the needs of people without private insurance.

Other gaps cited by providers included:

- transportation to an appropriate level of care;
- lack of residential beds for substance use disorder clients;
- the waitlist to get into inpatient treatment facilities;
- lack of workforce and turnover;
- lack of housing;
- need to develop relationships with tribal members;
- the desire to work with law enforcement but lack of staffing prevents these relationships;
- detox services; and
- adequate prioritization of crisis services and standardization of how those services are to be provided across the state by the state.

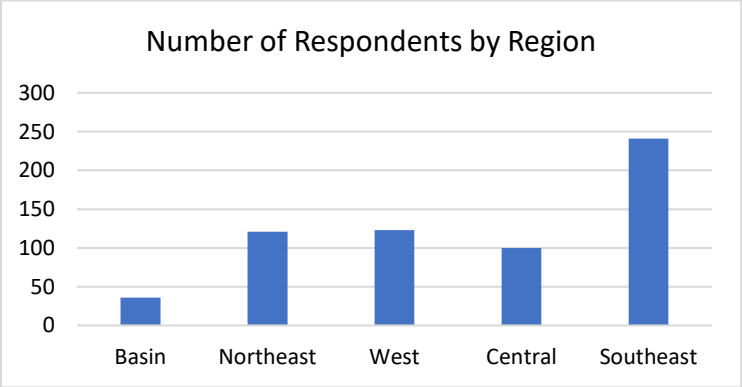
# Stakeholder Survey Results

## STATEWIDE

Respondents

A total of 621 participants, including consumers, providers, advocates, etc., completed an online Wyoming Behavioral Health Needs Assessment. Participants from each region, including the Southeastern (n = 241), Western (n = 123), Northeastern (n = 121), Central (n = 100), and Basin (n = 36) regions (Figure 11).

Figure 11: Number of respondents by region




Respondents were primarily female (n = 486) and white non-Hispanic (n = 574). Some participants who are American Indian/Alaska Native (n = 6), Asian (n = 3), African American (n = 4), Native Hawaiian/Pacific Islander (n= 2), and Hispanic/Latino (n = 29) also completed the survey.

Underserved Populations in Wyoming

When asked if there are any specific populations that are not being served or who are underserved in the statewide behavioral health system in Wyoming, participants identified several groups. The most highly noted populations believed to be underserved were the intellectual and developmental disability population, children/adolescents, individuals with traumatic brain injuries, seniors, individuals with serious mental illness, and individuals who are lower SES or not on Medicare. Other highly noted underserved populations included individuals with trauma or PTSD, those with dual diagnoses, addiction issues, and racial/ethnic minorities.

Gaps

Statewide, the top three behavioral health system gaps identified by the participants were (1) the lack of mental health services and providers (especially, with regard to the lack of psychiatrists, child and senior services, and substance use disorder services), (2) limited inpatient beds for both mental health and substance use disorder, and (3) the high cost of care.

Participants were also asked which civil inpatient psychiatric services are most needed in Wyoming. Most participants rated intermediate-term services (between 30-90 days) and long-term services (90 days or more) as the two most needed.

Barriers

Respondents also provided information on what they felt the top three barriers to providing and/or receiving services throughout the state. The top three barriers were identified as (1) limited funding/resources, (2) lack of available providers, and (3) the high cost of services. Other highly noted barriers included limited transportation and distance to care, the lack of facilities especially for inpatient services, and a lack of concern and knowledge about behavioral health issues in the community.

Suggestions for Improvements

When asked which three recommendations participants had to improve the current behavioral health system in Wyoming, the top responses were to (1) increase funding, (2) hire more providers and provide incentives for current providers to stay, and (3) to increase the number of inpatient facilities/beds. Other highly discussed recommendations were to provide education on mental health in the schools and community to decrease stigma, increase/expand Medicaid funding, improve the coordination of care between agencies, and to provide more telehealth services.

Finally, participants were asked to share any additional comments or suggestions they had for improving the behavioral health system in Wyoming. Although most of these items were listed previously, participants reiterated that there is a great need to help the State legislature understand Wyoming's funding needs regarding mental health and having that State support to provide services. They also suggested hiring more providers to reduce wait times and stress, that people with mental illness and substance use disorder issues no longer be put in jail but receive treatment, providing training on mental health for the community to help decrease stigmas, providing more low-cost services or waivers for clients to use with any provider, creating more crisis shelters/services, increasing reimbursement rates with Medicaid, and providing more inpatient treatment centers/beds would be most helpful.

## REGIONAL

The next sections will provide information on the behavioral health strengths, weaknesses, gaps, and recommendations within each of the five regions.

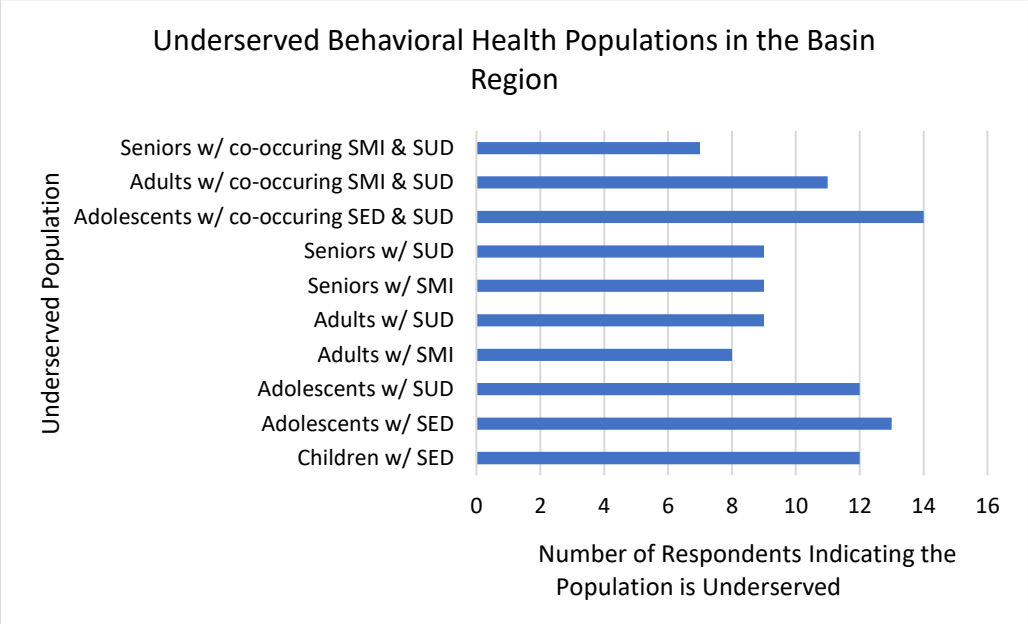
### Basin Region

The Basin Region had the fewest participants of any region (n = 30). Most of the participants were from State Agencies (n = 11), followed by advocates (n = 5), and private behavioral health practitioners (n = 5).

Underserved Populations

Basin Region participants indicated a need for more services for individuals in each group inquired about. The top underserved populations identified for the Basin Region included, (1) adolescents with co-occurring serious emotional disturbance and substance use disorders, (2) adolescents with serious emotional disturbance, (3) adolescents with substance use disorders, and (4) children with serious emotional disturbance (Figure 12).

Figure 12: Underserved behavioral health populations in the Basin region




In addition to the categories listed above, residents in the Basin Region reported that the entire community and LGBTQ populations are underserved.

Strengths of the Behavioral Health System

Participants indicated that the top three strengths related to the availability and adequacy of services within the behavioral health system in the Basin Region are (1) the wide variety of areas of

expertise among providers, (2) having caring providers, and (3) the availability of crisis beds.

Weaknesses of the Behavioral Health System

Participants indicated that the top three weaknesses related to the availability and adequacy of services with the behavioral health system in the Basin Region are (1) the lack of qualified providers, (2) the lack of services available for mental health and substance use disorder, and (3) limited funding/resources.

Gaps in the Behavioral Health System

The primary behavioral health service gaps indicated for the Basin Region were gaps in services, including the lack of halfway houses, female-only crisis housing, group therapy, and inpatient care. When asked why these services are unavailable in the Basin Region, participants primarily responded that there are not enough credentialed staff and providers. Other explanations included that the population is too small to warrant additional facilities or groups, that there is insufficient community support due to stigma, that state contracts remove consumer choice in providers, and that there is not enough funding.

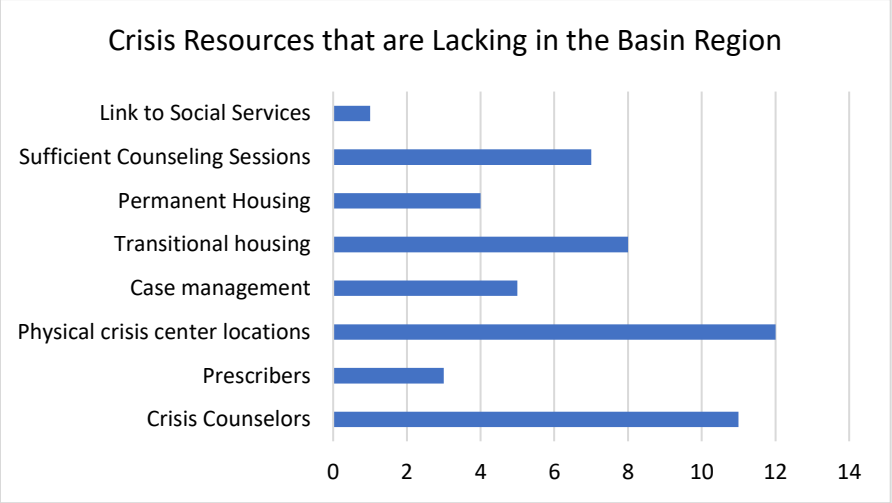
Participants also reported that the top three most needed community-based mental health services in the Basin Region are, (1) out-of-home residential services, (2) assessment and evaluation services, and (3) recovery supports.

The top three substance use services most needed in the Basin Region included (1) low-intensity residential, (2) residential detox, and (3) medium-intensity residential.

The top two civil inpatient psychiatric services most needed in the Basin Region are (1) acute stay and (2) short-term stay services.

When asked if there are adequate resources in the Basin Region for individuals experiencing a crisis, none of the participants answered “yes.” They reported a variety of crisis resources that are lacking in the Region, including physical crisis center locations, available crisis counselors, and transitional housing (Figure 13).

Figure 13: Crisis resources that are lacking in the Basin region




Barriers to Behavioral Health Service Delivery

The top three barriers to behavioral health service delivery identified in the Basin Region include, workforce shortages (lack of providers), distance to treatment, and a lack of funding. Related to these issues, several participants commented that the ruralness of this region makes it difficult to obtain services. In other words, because the population is small and spread out over large distances, it is difficult to justify increases in funding or service provision.

Suggestions for Improvement

When asked to offer any suggestions for improving the array of services in the Basin Region, participants noted that providing more mental health and substance use disorder education in schools, mental health education for families, and changing state contracts so consumers have more choices about where they can receive services may be helpful.

When asked what three changes participants or their organizations could make to improve the behavioral health system in the Basin region, the majority said they could offer classes on mental health to educate the staff and community about these issues. They also mentioned focusing on increasing the quality rather than quantity of services, increasing the number of providers, and doing more to advocate for patient's rights.

**Northeast Region**

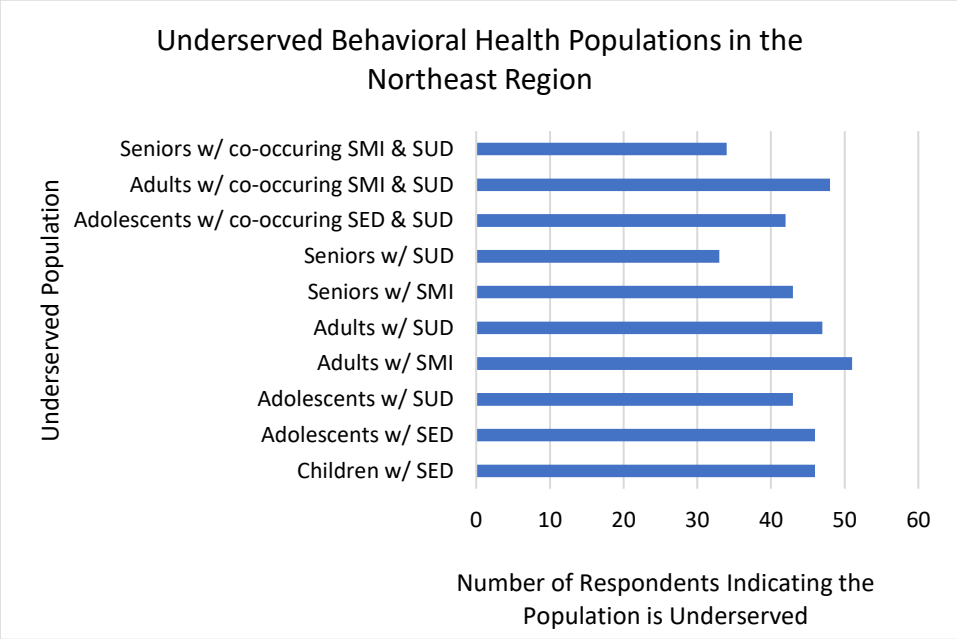
The Northeast Region had a total of 121 respondents. Most of the participants were from State Agencies (n = 32), followed by advocates (n = 17), and consumers (n = 14).

Underserved Populations

Northeastern Region participants indicated a need for more services for individuals in each group inquired about. The top underserved populations identified for the Northeastern Region

included, (1) adults with co-occurring serious mental illness and substance use disorders, (2) adults with substance use disorders, (3) children with serious emotional disturbance, and (4) adolescents with serious emotional disturbance (Figure 14).

Figure 14: Underserved behavioral health populations in the Northeast region




In addition to the categories listed in the survey, residents in the Northeast Region felt that individuals who are uninsured, homeless, in need of inpatient hospitalizations, Veterans, unemployed, and/or incarcerated are underserved. One individual also noted that family members, especially children, of people with mental illness are also underserved.

Strengths of the Behavioral Health System

Participants indicated that the top three strengths related to the availability and adequacy of services with the behavioral health system in the Northeast Region are (1) the wide variety of providers with varying areas of expertise, (2) having access to caring providers, and (3) the number of providers offering sliding fee scales. The other highly rated strength in this region was related to services, such as the Yes House after school programs and the drug court/diversion programs.

Weaknesses of the Behavioral Health System

Participants indicated that the top three weaknesses related to the availability and adequacy of services with the behavioral health system in the Northeast Region are (1) the lack of providers, (2) the lack of inpatient beds, and (3) the high cost of care.

Gaps in the Behavioral Health System

The primary behavioral health service gaps indicated for the Northeastern Region were (1) the

long wait lists/delays in services, (2) the lack of providers (especially psychiatric providers who can prescribe medications), and (3) the lack of inpatient beds. Other highly noted gaps included the high cost of services and that crisis management services are not available 24/7. The primary responses as to why these gaps exist in the Northeastern Region were identified as being related to the lack of funding and resources in the region and the lack of, or inability to retain, quality providers. Other highly noted reasons for the unavailability of services were barriers to treatment (e.g., high cost, lack of insurance, long wait times, etc.), lack of facilities, and stigma and lack of community support.

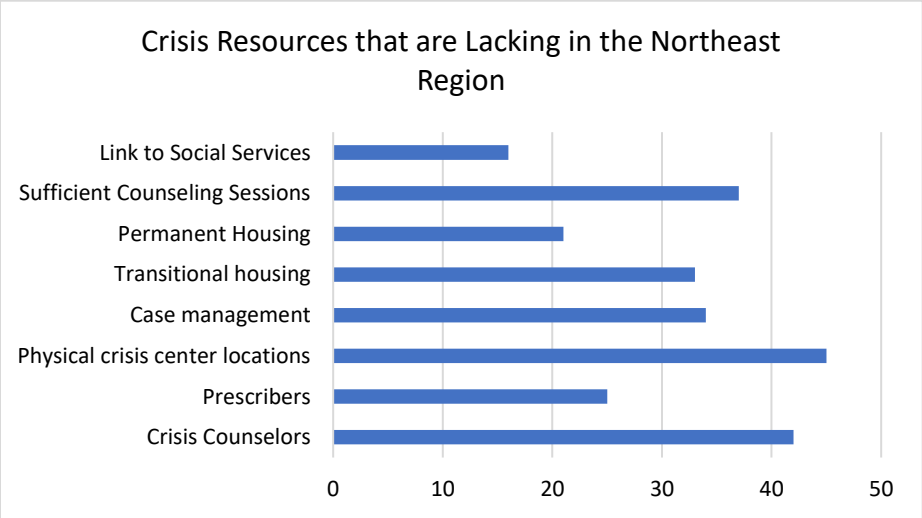
Participants also reported that the most needed community-based mental health services in the Northeastern Region are, (1) outpatient and medication services including individual, group, and family therapy, (2) intensive support services such as intensive outpatient, case management, assertive community treatment, and multi-systemic therapy, (3) assessments, specialized evaluations, service/crisis planning, consumer/family education and outreach, and (4) community support rehabilitative services such as case management, supported employment, permanent supported housing, skill building, and traditional healing services.

The top three substance use services most needed in the Northeastern Region included (1) residential detox, (2) high-intensity residential, and (3) medically monitored intensive residential.

The top two civil inpatient psychiatric services most needed in the Northeastern Region are (1) long-term and (2) intermediate-term services.

When asked if there are adequate resources in the Northeastern Region for individuals experiencing a crisis, 91% of participants answered “no.” They reported a variety of crisis resources that are lacking in the Region, including physical crisis center locations, available crisis counselors, and sufficient counseling sessions (Figure 15).

Figure 15: Crisis resources that are lacking in the Northeast region



Barriers to Behavioral Health Service Delivery

The top three barriers to behavioral health service delivery identified in the Northeastern Region include, a lack of funding, distance to treatment, and workforce shortages (lack of providers). In their qualitative responses, participants reiterated these barriers and noted that the high cost of services is also a barrier to many consumers.

Suggestions for Improvement

When asked to offer any suggestions for improving the array of services in the Northeastern Region, participants noted that increased state funding for behavioral health services, crisis stabilization services in each region, improved parent education and support services, programs to increase awareness and prevention of mental health and substance use disorder in elementary schools, increased availability and retention of mental health counselors, faster low-income permanent housing options, and more financial assistance or sliding scale services for low-income consumers. Other suggestions included creating long-term residential treatment facilities, utilizing more telehealth services, and providing more early intervention, wrap around care, and case management services.

When asked what three changes participants or their organizations could make to improve the behavioral health system in the Northeastern region, participants said that they could collaborate more with other agencies, provide more outreach and education, and hire more providers. Several participants also noted that they could advocate for more funding from the legislature and provide more crisis services.

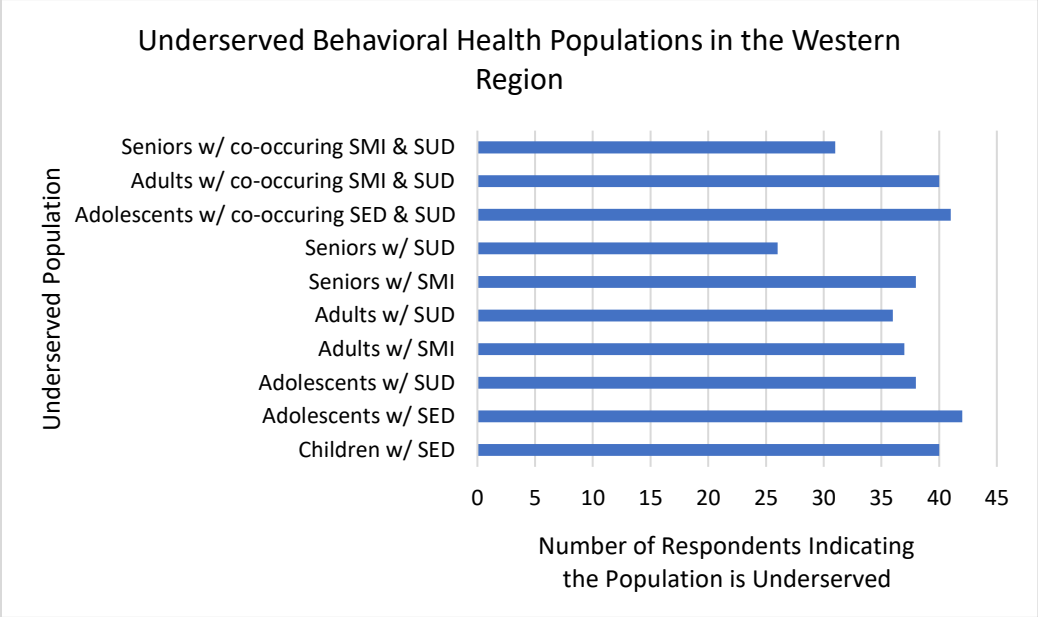
**Western Region**

The Western Region had a total of 123 respondents. Most of the participants were from State Agencies (n = 20), followed by community behavioral health providers (n = 15), and advocates (n = 15).

Underserved Populations

Western Region participants indicated a need for more services for individuals in each group inquired about. The top underserved populations identified for the Western Region included, (1) adolescents with serious emotional disturbance, (2) adolescents with co-occurring serious emotional disturbance and substance use disorders, (3) children with serious emotional disturbance, and (4) adults with co-occurring serious mental illness and substance use disorders (Figure 16).

Figure 16: Underserved behavioral health populations in the Western region




In addition to the categories listed in the survey, many residents in the Western Region felt that all residents are underserved. Others noted that those in need of inpatient hospitalization and those with developmental disabilities are also underserved.

Strengths of the Behavioral Health System

Participants indicated that the top three strengths related to the availability and adequacy of services with the behavioral health system in the Western Region are (1) that there are a variety of quality services, including Southwest Counseling, (2) that good providers are available for mental health and substance use disorder, and (3) that there are low cost/sliding scale services offered.

Weaknesses of the Behavioral Health System

Participants indicated that the top three weaknesses related to the availability and adequacy of services with the behavioral health system in the Western Region are (1) the lack of providers (especially psychiatrists), (2) lack of inpatient beds, and (3) the high cost of services.

Gaps in the Behavioral Health System

The primary behavioral health service gaps indicated for the Western Region were (1) the lack of providers (especially psychiatrists and child specialists) and (2) inpatient beds. Three other highly noted gaps in the region included long wait times, the high cost of services, and community stigma about mental health. The primary responses as to why these gaps exist in the Western Region are a lack of funding and providers, and barriers to treatment such as high costs of care and long wait times.

Participants also reported that the most needed community-based mental health services in the Western Region are, (1) acute intensive services such as mobile crisis, peer-based crisis services, and medically monitored intensive inpatient, (2) outpatient and medication services including

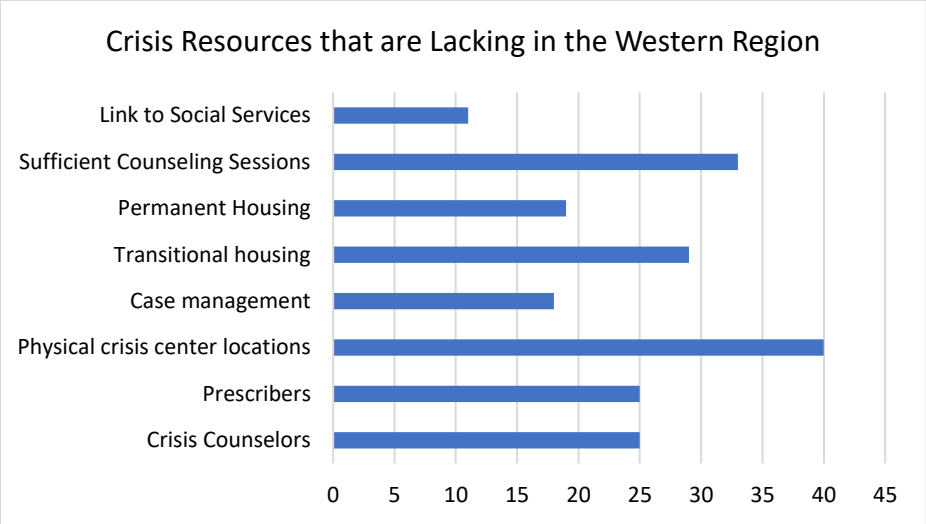
individual, group, and family therapy, and (3) community support rehabilitative services such as case management, supported employment, permanent supported housing, skill building, and traditional healing services.

The top three substance use services most needed in the Western Region included (1) medically monitored intensive residential, (2) residential detox, and (3) medium-intensity residential.

The top two civil inpatient psychiatric services most needed in the Western Region are (1) intermediate-term and (2) short-term services.

When asked if there are adequate resources in the Western Region for individuals experiencing a crisis, 87% of participants answered "no." They reported a variety of crisis resources that are lacking in the Region, including physical crisis center locations, sufficient counseling sessions, and transitional housing (Figure 17).

Figure 17: Crisis resources that are lacking in the Western region




## Barriers to Behavioral Health Service Delivery

Similar to other regions, the top three barriers to behavioral health service delivery identified in the Western Region include, a lack of funding, distance to treatment, and workforce shortages (lack of providers). In their qualitative responses, participants reiterated these barriers and also noted that the high cost of services is also a barrier to many consumers.

## Suggestions for Improvement

When asked to offer any suggestions for improving the array of services in the Western Region, participants primarily noted the importance of increased funding for services and facilities, the need for more inpatient beds, and the need for more providers, especially those who can prescribe. Several participants also noted that more prevention services and services for consumers who are of lower

socioeconomic status.

When asked what three changes participants or their organizations could make to improve the behavioral health system in the Western region, most participants said they could hire more providers, especially psychiatrists. Others noted that they could advocate for changes to Medicaid, provide public awareness and education on mental health issues, and expand the services they offered.

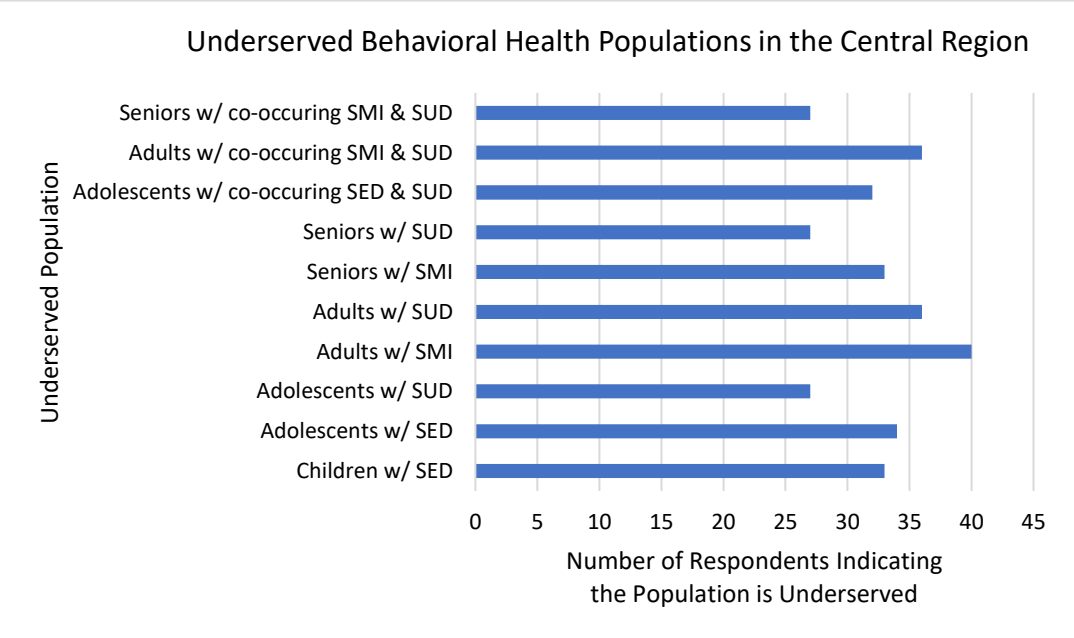
**Central Region**

The Central Region had a total of 100 respondents. Most of the participants were from State Agencies (n = 32), followed by private behavioral health providers (n = 13), and community behavioral health providers (n = 9).

Underserved Populations

Central Region participants indicated a need for more services for individuals in each group inquired about. The top underserved populations identified for the Central Region included, (1) adults with serious mental illness, (2) adults with substance use disorders, and (3) adults with co-occurring serious mental illness and substance use disorders (Figure 18).

Figure 18: Underserved behavioral health populations in the central region




In addition to the categories listed in the survey, residents in the Central Region felt that individuals in need of inpatient hospitalization or crisis services, Native Americans, Veterans, incarcerated populations, and people with developmental disabilities are underserved.

Strengths of the Behavioral Health System

Participants indicated that the top three strengths related to the availability and adequacy of services with the behavioral health system in the Central Region are (1) the dedicated and caring providers, (2) inpatient hospital access, and (3) the collaboration between state agencies and communities to provide care.

Weaknesses of the Behavioral Health System

Participants indicated that the top three weaknesses related to the availability and adequacy of services with the behavioral health system in the Central Region are (1) the lack of providers (especially psychiatrists and those specializing in children), (2) the high cost of services/poor Medicaid reimbursement rates, and (3) the lack of inpatient beds. Other highly noted weaknesses included long wait times/wait lists for services and medications and a general lack of services in the region.

Gaps in the Behavioral Health System

The primary behavioral health service gaps indicated for the Central Region were (1) the lack inpatient services, (2) the lack of providers (including prescribers and child psychiatrists), and (3) the high cost of services. The primary responses as to why these gaps exist in the Central Region were (1) limited funding and budget cuts, (2) not enough credentialed staff or providers, (3) limited inpatient beds and more facilities closing, and (4) difficulty in attracting and retaining providers in the area.

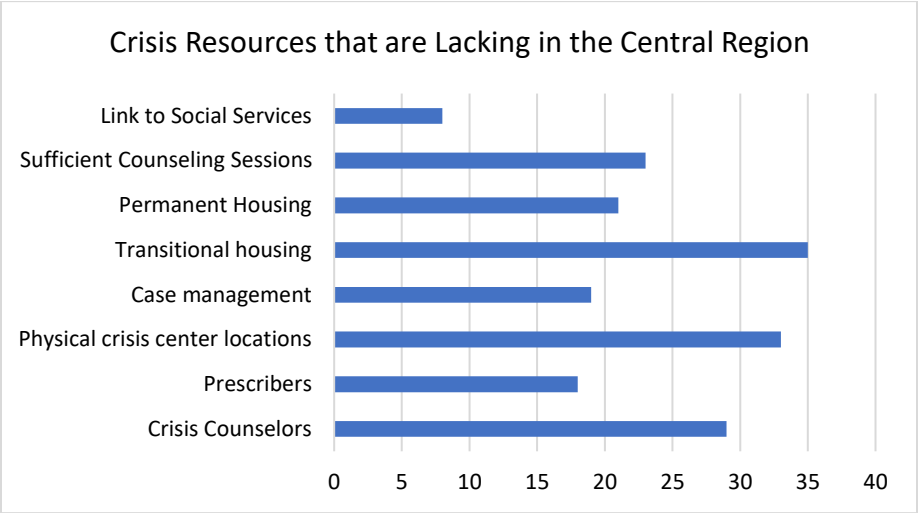
Participants also reported that the most needed community-based mental health services in the Central Region are, (1) intensive support services such as intensive outpatient, case management, assertive community treatment, and multi-systemic therapy, (2) community support rehabilitative services such as case management, supported employment, permanent supported housing, skill building, and traditional healing services, and (3) outpatient and medication services including individual, group, and family therapy.

The top three substance use services most needed in the Central Region included (1) medically monitored intensive residential, (2) high-intensity residential, and (3) residential detox.

The top two civil inpatient psychiatric services most needed in the Central Region are (1) long-term and (2) intermediate-term services.

When asked if there are adequate resources in the Central Region for individuals experiencing a crisis, 94% of participants answered “no.” They reported a variety of crisis resources that are lacking in the Region, including transitional housing, physical crisis center locations, and available crisis counselors (Figure 19).

Figure 19: Crisis resources that are lacking in the Central region




Barriers to Behavioral Health Service Delivery

The top three barriers to behavioral health service delivery identified in the Central Region include, a lack of funding, distance to treatment, and workforce shortages (lack of providers). In their qualitative responses, participants reiterated these barriers and also noted that the high cost of services is also a barrier to many consumers.

Suggestions for Improvement

When asked to offer any suggestions for improving the array of services in the Central Region, participants noted that securing proper funding from the state, providing mental health and substance use disorder education in the schools and through public agencies, and creating more inpatient facilities and crisis beds would be helpful. Several participants also noted that streamlining treatment and services for incarcerated populations and keeping people out of the legal system for alcohol and drug offenses would be helpful. Other suggestions included creating long-term psychiatric care, using more telehealth services, working to eliminate stigma associated with seeking mental health services, including local Tribes in planning and decision-making, and improving warm handoffs.

When asked what three changes participants or their organizations could make to improve the behavioral health system in the Central region, the biggest response was to provide more education on mental health to the community, followed by providing more services for low-income families, and improving collaborations with other agencies. Several participants also noted that they could hire more providers and offer more crisis services.

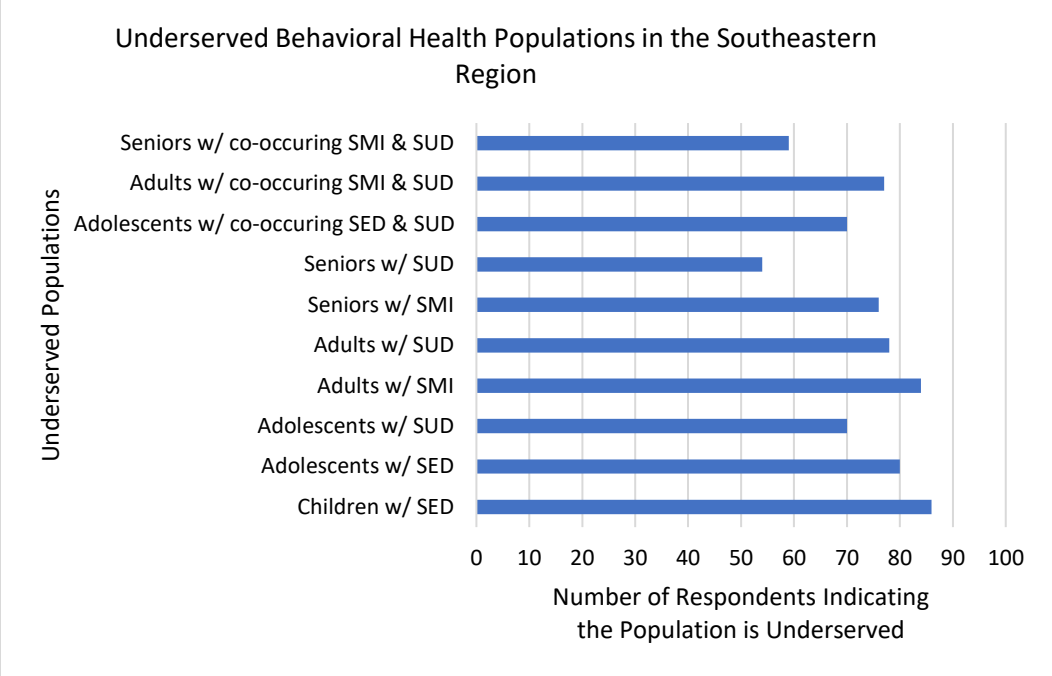
## Southeast Region

The Southeastern Region had the most respondents of any region with a total of 241 respondents. Most of the participants were from State Agencies (n = 90), followed by advocates (n = 28), community behavioral health providers (n = 19), and consumers (n = 19).

Underserved Populations

Southeastern Region participants indicated a need for more services for individuals in each group inquired about. The top underserved populations identified for the Southeastern Region included, (1) children with serious emotional disturbance, (2) adolescents with serious emotional disturbance, and (3) adolescents with substance use disorders (Figure 20).

Figure 20: Underserved behavioral health populations in the Southeast region.




In addition to the categories listed in the survey, residents in the Southeast Region many participants indicated that all residents and those with intellectual and developmental disabilities are underserved. Others noted that individuals who are homeless, on probation and parole, Veterans, women/mothers, suicidal, and/or incarcerated are also underserved.

Strengths of the Behavioral Health System

Participants indicated that the top three strengths related to the availability and adequacy of services with the behavioral health system in the Southeast Region are (1) the array of providers who care about the people they work with, (2) that the cost of services is low, and (3) that there is good community support and outreach related to mental health and substance use issues. The other highly rated strength in this region was related to services, such as high-fidelity wrap-around and outpatient substance use disorder treatment programs.

Weaknesses of the Behavioral Health System

Participants indicated that the top three weaknesses related to the availability and adequacy of services with the behavioral health system in the Southeast Region are (1) the lack of providers

(especially for children), (2) the general lack of services, and (3) the high cost of services. Other highly noted areas of weakness for this region included limited resources/funding and inpatient beds.

Gaps in the Behavioral Health System

The primary behavioral health service gaps indicated for the Southeastern Region were (1) the high cost of services, (2) the lack of providers, and (3) long wait times. Other highly noted gaps included the lack of inpatient beds and stigma about mental health. The primary responses as to why these gaps exist in the Southeastern Region are a lack of funding and providers, high cost of care, and lack of available facilities.

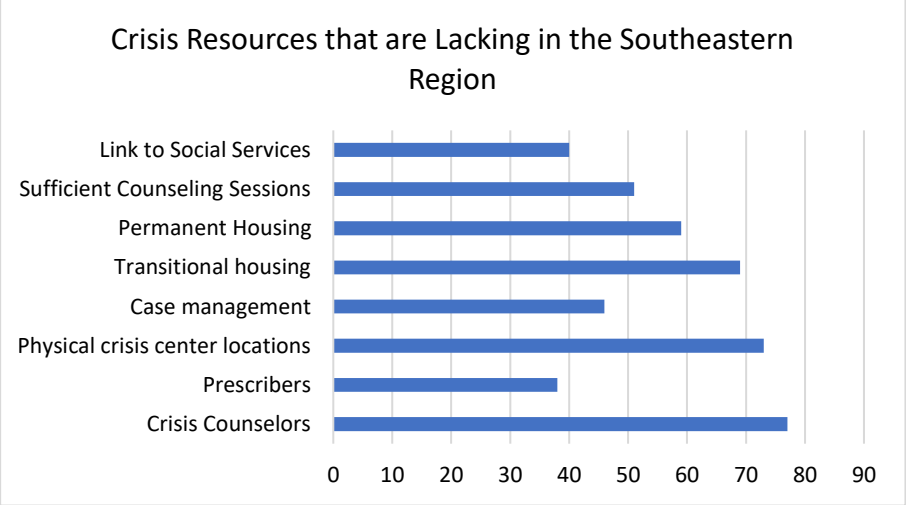
Participants also reported that the most needed community-based mental health services in the Southeastern Region are, (1) intensive support services such as intensive outpatient, case management, assertive community treatment, and multi-systemic therapy, (2) acute intensive services such as mobile crisis, peer-based crisis services, and medically monitored intensive inpatient, and (3) community support rehabilitative services such as case management, supported employment, permanent supported housing, skill building, and traditional healing services.

The top three substance use services most needed in the Southeastern Region included (1) medium-intensity residential, (2) medically monitored intensive residential, and (3) high-intensity residential.

The top two civil inpatient psychiatric services most needed in the Southeastern Region are (1) intermediate-term and (2) long-term services.

When asked if there are adequate resources in the Northeastern Region for individuals experiencing a crisis, 88% of participants answered “no.” They reported a variety of crisis resources that are lacking in the Region, including limited crisis counselors, physical crisis center locations, and transitional housing options (Figure 21).

Figure 21: Crisis resources that are lacking in the Southeast region



Barriers to Behavioral Health Service Delivery

The top three barriers to behavioral health service delivery identified in the Southeastern Region include, a lack of funding, workforce shortages (lack of providers), and distance to treatment. In their qualitative responses, participants reiterated these barriers and noted that the high cost of services, the stigma surrounding mental health in the community, and a general lack of available services are additional barriers.

Suggestions for Improvement

When asked to offer any suggestions for improving the array of services in the Southeastern Region, participants primarily noted that they would like to see an increase in support from the State to keep providers and facilities in the area. A variety of needed services were mentioned, including inpatient facilities, acute psychiatric facilities for minors, therapeutic daycares and foster care, mobile crisis intervention units, and early intervention, habilitative and wrap around services, etc. For instance, one participant noted, "I think it would be very beneficial to find some incentive to bring in a more diverse array of service providers who specialize in certain populations such as developmentally disabled or delayed, conduct disorders, dissociative disorders, personality disorders, etc. This may alleviate the wait time for getting services, and better serve the population. Getting an acute psychiatric facility for minors would also improve the services here greatly, since right now kids have to be sent hours away for treatment, completely disrupting every aspect of their lives and adding to trauma." Several participants also mentioned that increasing the services for individuals with disabilities, providing long-term housing options, and providing continued/follow-up care to consumers after their treatment would be helpful.

When asked what three changes participants or their organizations could make to improve the behavioral health system in the Southeastern region, the most common response was to improve communication and collaboration between agencies, followed by increasing use of family and peer support, and providing mental health education to decrease stigma. Others noted that they could increase providers, provide case management training and more home and community-based services, and provide an integrated behavioral health team to work with inmates in prison and then continue working with them after they are released.

**Regional Analysis Summary**

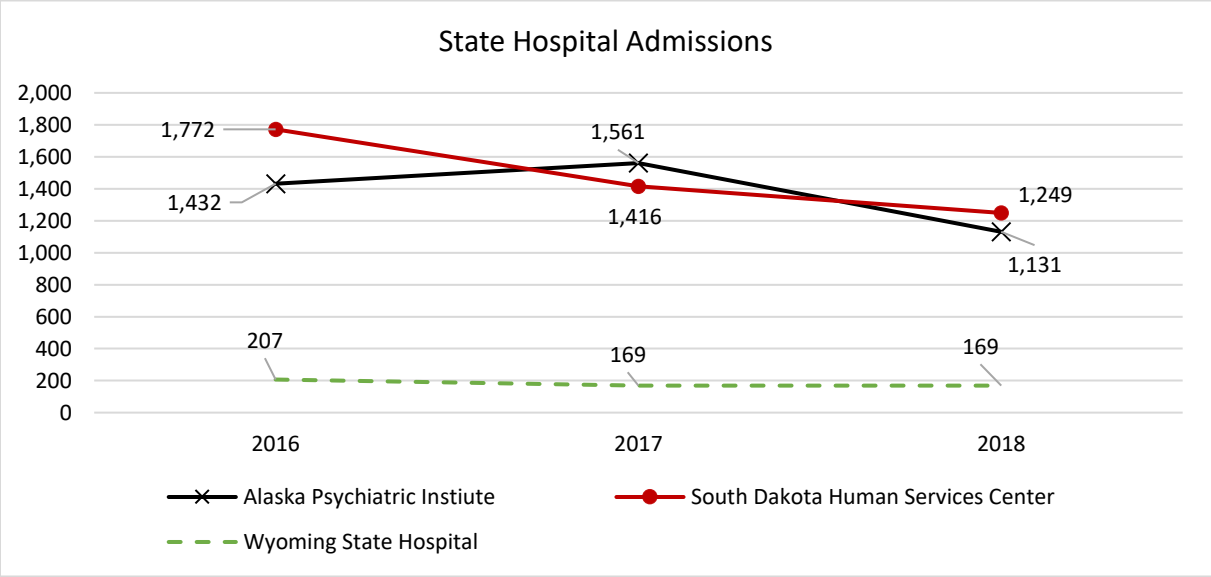
Throughout the five regions consistent themes arose in response to the survey questions. Across the state, when asked about underserved populations, three regions (Basin, Western and Southeast) identified children and adolescents as being underserved and two regions (Northeast and Central) identified adults with SMI. The strength of the behavioral health system identified by four regions (Northeast, Western, Central, and Southeast) is the caring providers. Throughout the survey, participants identified the staff of the behavioral health system as its greatest strength. The other frequently identified strength was the variety of services provided; three regions (Basin, Northeast andWestern). When asked about weaknesses within the public behavioral health system in each

region, all five regions identified not having enough providers and especially prescribers. The gaps in the system varied by region with the Basin region identifying the lack of female specific halfway houses, the Central region identified a lack of inpatient beds, and the other three regions again focused on the scarcity of providers (Northeast, Western, and Southeast). Respondents in all five regions noted the lack of resources for people in crisis. When asked "Do you feel that adequate resources exist in your region for individuals experiencing a crisis?" between 87% and 100% of respondents answered "no". This indicates that across the state, participants in the survey feel that there are not enough crisis resources. Three consistent themes emerged regarding barriers to service delivery within the public behavioral health system; workforce shortage, lack of funding and distance to treatment. The Basin and Southeast regions identified workforce shortages as a barrier and the remaining three regions (Northeast, Western & Central) identified funding and distance to treatment as barriers. Finally, when asked for suggestions to improve the system, respondents noted education and increased financial support for providers as areas for focused improvement. Two regions, Basin and Central identified school mental health and education in schools about mental health as areas for improvement. Three regions, Northeast, Western, and Southeast identified increasing funding for and increased support to help keep providers in their regions.

## Continuum of Care Analysis

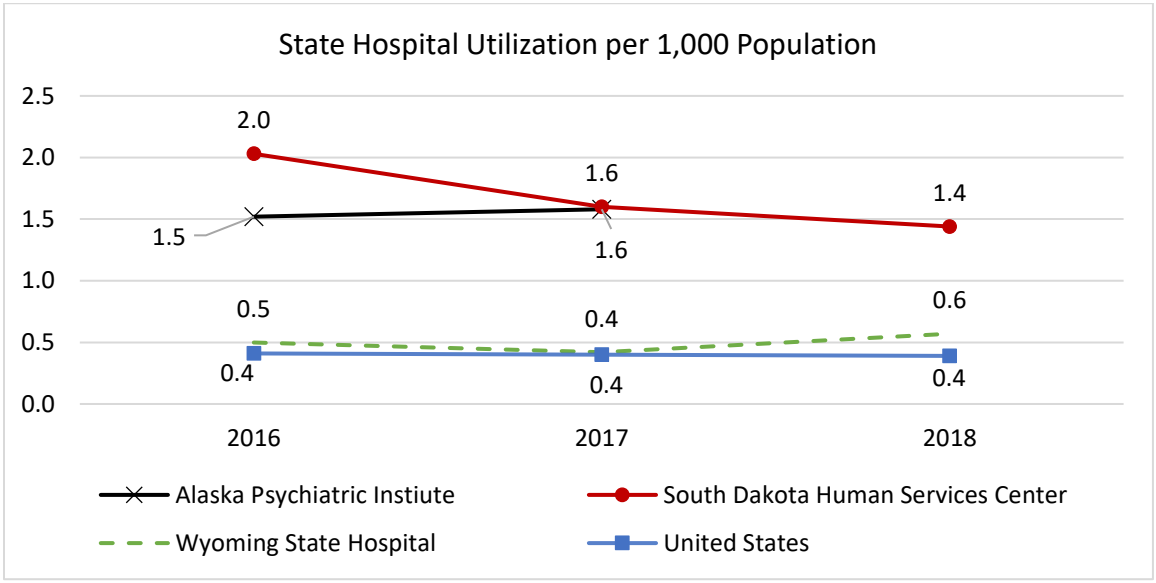
The Wyoming State Hospital (WSH) serves court ordered forensic and civil patients who are being held involuntarily pursuant to Title 25. A waiting list exists for people committed to the WSH. This is due in part to staffing issues that prevent the hospital from operating at full. The WSH has had similar struggles to the community mental health centers in recruiting and retaining staff. WSH has 103 total staffed inpatient beds which is 17.83 beds per 100,000 people. For comparison, Alaska has 38 total staffed inpatient beds or 5.15 beds per 100,000 people and South Dakota has 173 total staffed inpatient beds which is 19.61 beds per 100,000 people. Possibly due to a generally longer average length of stay, staffing issues and the waiting list, WSH has had fewer admissions than seen in Alaska or South Dakota.

Figure 22: SFY 2016 – SFY 2018 State hospital admissions




When WSH utilization is examined per capita, Wyoming is just slightly higher than the national average but lower than both Alaska and South Dakota.

Figure 23: SFY 2016 – SFY 2018 State hospital utilization per 1,000 population (Alaska data not available for 2018)



State hospital readmission within 30 days (Figure 24) and 180 days (Figure 25) are lower in Wyoming than nationally or in Alaska or South Dakota. When staff at WSH were asked, they were surprised by the low number of readmissions. This may indicate that people are not being readmitted due to the waitlist or other factors besides successful discharge.

Staff at the WSH felt that more could be done to help people successfully transition to the community and that many clients could be better served in the community but that insufficient community resources exist. Specifically, they mentioned the difficulties in discharging geriatric patients with dementia and other cognitive issues into the community. Staff reported that many nursing homes were reluctant to admit these patients due to previous aggressive behavior, and that often these individuals are placed on an involuntary civil commitment to the WSH.

Figure 24: SFY 2016 – SFY 2018 Discharged civil patients readmitted within 30 days

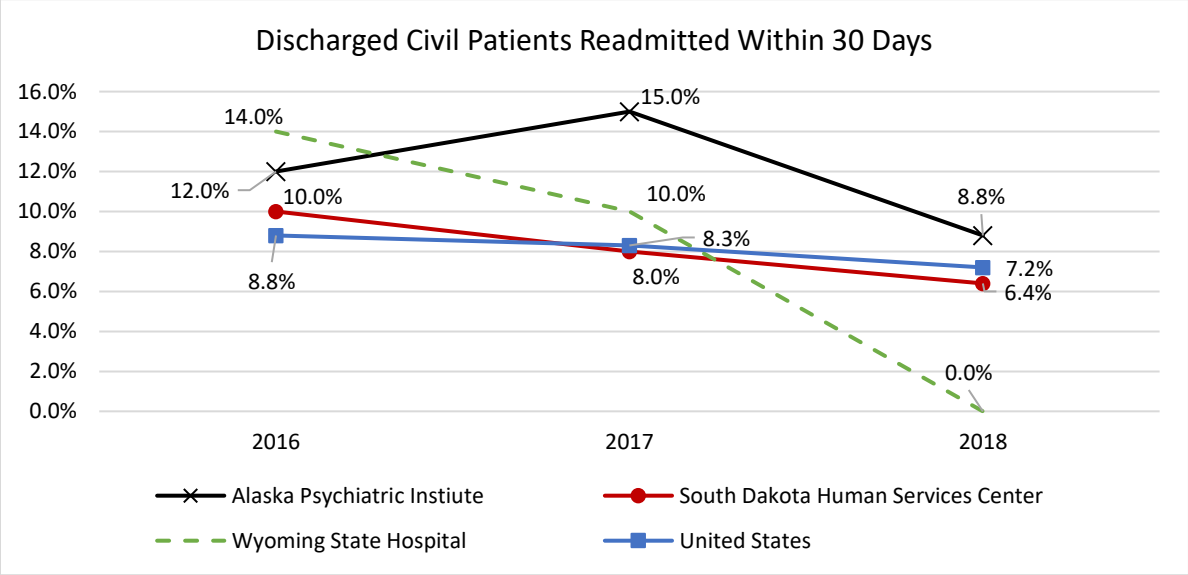
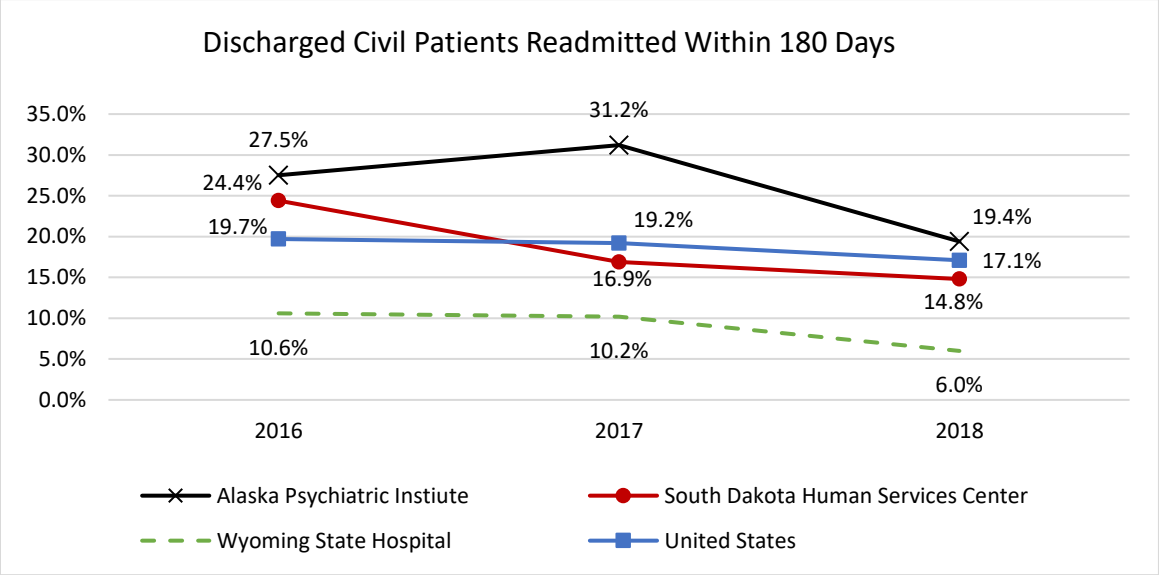


Figure 25: SFY 2016 – SFY 2018 Discharged civil patients readmitted within 180 days




Recommendation:

- Consider increasing transition support for people leaving inpatient treatment to facilitate their reintegration into the community.

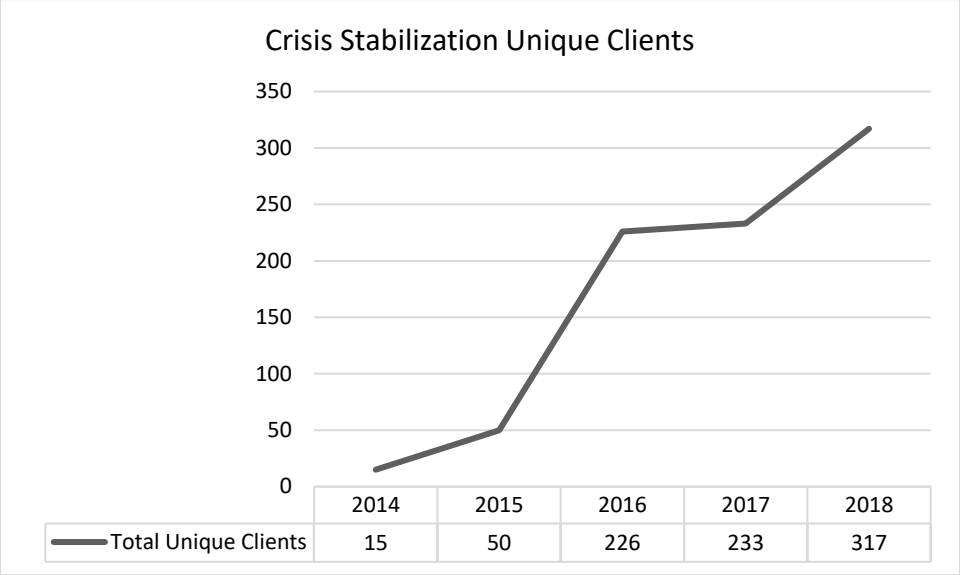
## INNOVATIVE WORKFORCE, PROGRAM, AND SERVICE DELIVERY OPTIONS

### Crisis System Innovation

Crisis Stabilization Utilization and Residential Bed Utilization

Stakeholders and providers repeatedly raised the issue of the need for increased capacity to serve people during a behavioral health crisis. Data from the Division show a 2013% increase in the number of unique clients utilizing crisis stabilization beds across the state; going from 15 people in 2014 to 317 people in 2018 (Figure 26). Despite this increase in the utilization of crisis stabilization beds, there remain unused bed days at all crisis stabilization facilities. The crisis stabilization center in Uinta region has the highest utilization rate at 84% over the course of SFY 2018. The lower utilization rates at the other facilities may be due to a variety of reasons: the centers not being in the optimal location, the distances that people must travel to get to them, or a lack of awareness of the centers.

Figure 26: SFY 2014 – SFY 2018 Analysis of unique clients using crisis stabilization beds




Considerations

Due to the staffing shortages across the state and the diverse geography; creating bricks and mortar crisis centers is not a viable option. The limited budget of the public behavioral health system poses another challenge to implementing a new crisis system. Despite these challenges, Governor Gordon has identified the need for the state and communities to do more to help people in crisis, so a solution must be reached.

Recommendations

- Develop a state-wide crisis system to help reduce the frequency of people in crisis presenting to the emergency room or jail; and
    - Crisis services may reduce costs to the system by helping people be served in their community and reducing the need for the costs of their treatment to be absorbed by other systems.
- Explore the feasibility of creating a statewide crisis hotline, staffed 24/7 for people to call during a crisis. This service can help direct people to community resources and to higher levels of care when appropriate. The benefits of a program like this are:
    - Helps people stay in their communities when possible;
    - Directs people to an appropriate level of care and;
    - Reduces the burden on law enforcement and emergency rooms to handle all levels of crisis.
    - This service could be staffed as a hotline and warmline where clinicians and peers are able to assist callers.
    - Increase the utilization of peers. Throughout the focus groups with consumers of the public behavioral health system and advocates, the desire to increase the utilization of peers was

repeatedly mentioned. The use of a hotline and warmline could help to increase the utilization of peers through their ability to staff the warmline.

**Evidence Based Practices**

In Wyoming's annual reporting to SAMHSA through the Uniform Reporting System no utilization of EBPs is noted. Some centers that participated in the focus groups say that they are doing their best to implement EBPs, so the lack of data reported to SAMHSA does not mean that the centers are not doing any EBP work, just that there is not currently a structure in place that requires the use of EBPs or the monitoring of their fidelity. SAMHSA approved EBPs have not been evaluated in a rural or frontier setting and given the differences in population and geography between urban, rural, and frontier areas, it must be acknowledged that some modifications may be necessary in order to implement EBPs in Wyoming. Many rural and frontier states have made these modifications to EBPs most notably to assertive community treatment (ACT). SAMHSA's fidelity tool requires a large population of clients and a large staff, both of which are difficult to achieve in a rural or frontier setting. Given those challenges, South Dakota, Colorado, and Nevada have worked to create modified ACT fidelity models. These models emphasize the aspects of SAMHSA's fidelity model that are most closely linked to improved client outcomes. The modifications are largely made to the number of clients and staff required, this allows for smaller groups of clients and fewer staff, which is more realistic in a rural or frontier setting such as Wyoming. The development and expansion of evidence-based practices includes an investment in workforce development for all levels of the behavioral health workforce. It also necessitates the engagement of employers and community housing entities, to integrate individuals in their local communities.

<u>Recommendations</u>

- Increase the use of EBPs across the state. While true fidelity may not be feasible, the EBPs may be modified to work in a rural or frontier setting while improving the outcomes and quality of services.
    - This can address the concern raised in the focus groups that there is little standardization of the behavioral health services provided across the state.
    - Consider working with EBP experts or state staff from South Dakota, Colorado, or Nevada to learn about their modifications and the rationale behind them and assess whether Wyoming may be able to adapt the EBPs in a similar fashion.

**Tele-Health Innovation**

Tele-health may provide a viable way for Wyoming to increase the number of specialist providers without needing to recruit or retain staff. The use of a virtual waiting room can leverage the availability of psychiatrists or other specialists in other areas of the country to supplement the providers residing in Wyoming. People can present at their local mental health center or hospital but then be connected to an expert anywhere in the country to help prescribe meds or to receive other types of specialized treatment or these services can be offered remotely, through a service. This could reduce the cost associated with recruiting specialists to move to Wyoming and the cost of turnover

which was highlighted in the focus groups and the survey. This reduces the burden on the mental health centers and helps to reduce the burden on local treatment providers (psychologists, social workers, case managers) as they don't need to be experts, but instead know how to connect their clients to experts when appropriate. Recent research shows that tele-mental healthcare is an effective alternative to traditional treatment[12] and, rural patients in emergency rooms have seen reduced wait times with the utilization of tele-health[13]. The increasing availability of these services may be a cost-effective way for Wyoming to increase the number of specialist providers. An additional benefit to increasing utilization of tele-health is the reduction in isolation and increased support for rural professionals. Isolation has been identified as a factor in people leaving rural settings[14], knowing that they will have continued access to professional support via technology may help to reduce turnover.

Recommendations

- Increase the use of tele-health to help provide the services of behavioral health specialists into all communities as needed.
    - Note: Access to adolescent specialists and psychiatrists are needed throughout the state.

[12] Langarizadeh, M., Tabatabaei, M. S., Tavakol, K., Naghipour, M., Rostami, A., & Moghbeli, F. (2017). Telemental Health Care, an Effective Alternative to Conventional Mental Care: A Systematic Review. *Acta informatica medica : AIM : journal of the Society for Medical Informatics of Bosnia & Herzegovina : casopis Drustva za medicinsku informatiku BiH*, 25(4), 240–246. doi:10.5455/aim.2017.25.240-246

[13] Rural ER Patients See Health Care Provider More Quickly if Hospital is Equipped with Telemedicine Services. NewsWise, University of Iowa, January 2018. https://www.newswise.com/articles/rural-er-patients-see-health-care-provider-more-quickly-if-hospital-is-equipped-with-telemedicine-services

[14] Rural Health Information Hub https://www.ruralhealthinfo.org/topics/rural-health-recruitment-retention

**Creation of Partnerships to Recruit Behavioral Health Staff**

In all but one provider focus group the issue of staffing shortages was cited as an issue. Recruitment and retention of staff were cited as some of the biggest issues that the behavioral health providers are facing. Many providers discussed that they have tried to recruit students from schools but that they move on once they are licensed. Working with schools in Wyoming increases the likelihood that new staff will be well-suited for the communities in which they will work. Additionally, the partnerships with schools in Wyoming may have continuing education as a component as health care providers have cited a lack of opportunities for continuing education as a reason for leaving work in a rural setting[15]. Helping new staff to feel less isolated and more connected to the community could reduce staff turnover.

<u>Recommendation</u>

- Consider the feasibility of creating partnerships with the University of Wyoming and community colleges to help recruit behavioral health staff who have ties to Wyoming communities to help reduce turnover and create a more robust flow of staff.

[15] Chipp, C., Dewane, S., Brems, C., Johnson, M. E., Warner, T. D., & Roberts, L. W. (2011). "If only someone had told me…": lessons from rural providers. *The Journal of rural health : official journal of the American Rural Health Association and the National Rural Health Care Association, 27*(1), 122–130. doi:10.1111/j.1748-0361.2010.00314.x

# Appendix A – Consumer Focus Group Questions

**Wyoming Needs Assessment**

**Focus Group Questions for Consumers/Families**

1) What are some of the strengths of the behavioral health system in Wyoming?
2) Do most people you know currently have access to the types of behavioral health services they need within the state of Wyoming?
    a. If not, which types of services are needed?
    b. What are the gaps in behavioral health services in your community or in the state of Wyoming?
    c. Note: Behavioral health services can include prevention, early intervention, treatment, crisis intervention, and recovery/supports.
3) Are any services provided by Peer Specialists in Wyoming? *(**Only asked of the consumer group, not the Behavioral Health Advisory Council**)*
        a. The Wyoming Department of Health defines Peer Specialists as, "Individuals who work throughout the United States in mental health, substance use treatment, physical health, hospital, and other settings. Peer Specialists are uniquely qualified because of their training and personal recovery from a serious mental health situation and/or addiction. Initial and ongoing training increase their competency in this growing profession… Wyoming includes many job descriptions within its definition of peer specialists including recovery coach, recovery specialist, peer wellness coach, peer mentor, and peer advocate" (https://health.wyo.gov/behavioralhealth/mhsa/initiatives/peer-specialists/).
    b. If so, what types of services do they offer? Are these services beneficial? Why or why not?
4) What do people do when local behavioral health providers cannot meet their needs?
    *a. Prompts: Do they travel to other parts of the state? Do they travel out of state? Do they use telehealth services? Do they stop pursuing care?*
    *b.* If they travel to see providers, how far on average do you think they have to go to get the services they need?
5) Which behavioral health services are the most helpful? Please explain why.
6) Which behavioral health services are the least helpful? Please explain why.
7) What are the three changes you would recommend to improve behavioral health services in Wyoming?
8) What are the barriers/challenges to addressing behavioral health needs within the state of Wyoming?
9) What crisis resources/services are available in Wyoming?
    a. Do you think these services are adequate? If not, what is needed?

# Appendix B – Provider Focus Group Questions

**Wyoming Needs Assessment**

**Community MH/SA Provider Interviews**

1. Please give us an overview of your agency and the communities you serve.
    a. Tell us about the populations served by your agency.
    b. What types of programs and services do you deliver?
2. Do you feel that you are meeting all the needs of your community?
    a. If not, what are the gaps?
3. Tell us about your relationship with other human service agencies in your community?
4. Tell us about your referral network.
5. Tell us about your outreach services?
6. Tell us about the workforce challenges in your agency?
    a. What impact does this have on your program and services?
    b. Do you have any community partnerships that help offset the challenges?
7. What are the biggest challenges to the public behavioral health system?
    a. What improvements would you like to see in the system in the next 2 years?
8. What type of information would make this needs assessment report most valuable to your agency? To your region? To the state?
    a.
9. What additional information would you like to provide to this interview?

# Appendix C – Survey

The mic is open!

The Wyoming Department of Health, Behavioral Health Division is conducting a Behavioral Health Needs Analysis to help plan for the future behavioral health (mental health and substance use) needs in the State. Your perceptions and experiences will help us understand what is working well and what is needed, as well as provide creative solutions to improve the behavioral health system in Wyoming.

We would like to start by asking you just a few questions about yourself. Then we have several questions about the Wyoming public behavioral health system. Please answer as many as you can, but feel free to skip any you do not wish to address.

We will not be able to associate any responses to specific individuals by name.

We welcome your input!

1. Please identify the category or categories that best describe your experience with the Wyoming's Public
Behavioral Health System.

- Consumer or Person in Recovery
- Primary Care Provider or Administrator
- Wyoming State Hospital Provider
- Family Member of an Adult Consumer
- Family Member of a Child Consumer
- Community Behavioral Health Provider or Administrator
- Inpatient Behavioral Health Provider or Administrator
- State Agency
- Private Behavioral Health Provider
- Advocates who are not State employees or providers
- Other (please specify)

2. What is your Gender?

- Male
- Female
- Non-binary/third gender
- Prefer not to answer

3. What is your age?

- Under 18
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65+
- Prefer not to answer
- Other (please specify)

4. Ethnicity/Race (Check all that apply)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Hispanic or Latino

5. What is your Region of Residence?

- Basin Region - Counties: Park, Big Horn, Washakie, Hot Springs
- Northeast Region - Counties: Sheridan, Johnson, Campbell, Crook, Weston
- West Region - Counties: Teton, Sublette, Lincoln, Uinta, Sweetwater
- Central Region - Counties: Natrona, Converse, Niobrara, Fremont
- Southeast Region - Counties: Carbon, Albany, Laramie, Platte, Goshen

6. Which behavioral health population groups, if any, do you believe are significantly underserved IN YOUR REGION (region as noted in #4 above)? [Check all that apply]

- Children with emotional/mental health disorders
- Adolescents with emotional/mental health disorders
- Adolescents with substance use disorders
- Adults with mental health disorders
- Adults with substance use disorders
- Older Adults with mental health disorders
- Older Adults with substance use disorders
- Adolescents with co-occurring mental health and substance use disorders
- Adults with co-occurring mental health and substance use disorders
- Older Adults with co-occurring mental health and substance use disorders
- Comment 1:
- Comment 2:
- Comment3:

7. What do you think are the top three (3) *strengths* about the availability and adequacy of services within the behavioral health system (mental health and/or substance use) in YOUR REGION?

- Comment 1:
- Comment 2:
- Comment 3:

8. What do you think are the top three (3) *weaknesses* about the availability and adequacy of services within the behavioral health system (mental health and/or substance use) in YOUR REGION?

- Gap 1:
- Gap 2:
- Gap 3:

9. Please describe behavioral health service system gaps in YOUR REGION. Please consider services that are helpful but not available, cost of services, timeliness of receiving services, populations that are underserved, integrated healthcare, stigma, etc.

10. Why are those services unavailable?

- Gap 1:
- Gap 2:
- Gap 3:

11. What are the top 2-3 behavioral health service system gaps in STATEWIDE? Please consider services that are helpful but not available.

- Barrier 1:
- Barrier 2:
- Barrier 3:

12. What are the top 2-3 *barriers* to providing and/or receiving services in YOUR REGION?

- Barrier 1:
- Barrier 2:
- Barrier 3:

13. What are the top 2-3 *barriers* to providing and/or receiving services in STATEWIDE?

- Comment 1:
- Comment 2:
- Comment3:

14. Are there any specific populations that you believe are *not* served or are underserved in the STATEWIDE behavioral health system in WYOMING, which should be served by the behavioral health system? (For example: individuals with intellectual/developmental disabilities, individuals with traumatic brain injuries, or any other groups) Please tell us about the services you think are needed for these groups.

- Comment 1:
- Comment 2:
- Comment3:

15. What, if any, barriers to service delivery do providers face or what major challenges do they have in serving the target population?

- Workforce shortage
- Workforce training needs
- Client access problems
- Distance to treatment
- Lack of funding
- Other (please specify)

16. What three (3) community-based MENTAL HEALTH services are most needed in YOUR REGION?

- Healthcare including services integrated with primary care
- Prevention/promotion including screenings
- Assessments, specialized evaluations, service/crisis planning, consumer/family education and outreach
- Outpatient and medication services including individual, group and family therapy
- Community support rehabilitative services such as case management, supported employment, permanent supported housing,
- skill building and traditional healing services
- Other supports such as personal care, supported education, respite and recreational
- Intensive support services such as intensive outpatient, intensive case management, assertive community treatment, and multisystemic therapy
- Out-of-home residential including crisis residential/stabilization, and therapeutic foster care
- Acute intensive services such as mobile crisis, peer-based crisis services, and medically monitored intensive inpatient
- Recovery Supports including peer supports, coaching and supports for self-directed care
- Other (please specify)

17. What three (3) substance use services are most needed within YOUR REGION?

- Residential detoxification (social detox model)
- Low intensity residential services (typically transitional residential programs)
- Medium intensity residential services (typically a nursing home type of setting that specializes in working with people with
- substance use disorders)
- High-intensity residential services (typically Therapeutic Communities designed for many criminal justice involved offenders)
- Medically monitored intensive residential treatment (typically thought of as residential - 2-6 week stays to stabilize severe
- addiction that is not responding to lower levels of care)

18. Please offer any suggestions you have to improve the array of services from physical healthcare – to early intervention and prevention - to outpatient treatment and community supports (such as vocational and housing) - to acute and long term residential and inpatient - to recovery supports in YOUR REGION. Other (please specify)

- Comment 1:
- Comment 2:
- Comment3:

19. What two (2) civil (not forensic) inpatient psychiatric services are most needed in WYOMING?

- ACUTE STAY (5 or fewer days)
- SHORT-TERM (6 and up to 30 days)
- INTERMEDIATE-Term (30 and up to 90 days)
- LONG-TERM (90 or more days)
- Other (please specify)

20. What two (2) civil (not forensic) REGIONAL inpatient psychiatric services are most needed in WYOMING?

- ACUTE STAY (5 or fewer days)
- SHORT-TERM (6 and up to 30 days)
- INTERMEDIATE-Term (30 and up to 90 days)
- LONG-TERM (90 or more days)

21. Do you feel that adequate resources exist in your region for individuals experiencing a crisis?

- Yes
- No

22. If not, what resources are lacking?

- Crisis counselors
- Prescribers
- Physical crisis center locations
- Case management
- Transitional Housing
- Permanent Housing
- Sufficient counselling sessions
- Linking to social service supports like food assistance
- Other (please specify)
- Change 1:
- Change 2:
- Change 3:

23. What three (3) changes could you or your organization make to improve the behavioral health system
in YOUR REGION?

- Recommendation 1:
- Recommendation 2:
- Recommendation 3:

24. What three (3) recommendations do you have to improve the current behavioral health system in WYOMING?

25. Please share any additional comments or suggestions you have to improve the behavioral health system in WYOMING. Please be as specific as you can.

# Appendix D – Additional Data

## Mental Health County of Residence Per Capita

| Mental Health Outpatient by County of Residence Per 1,000 People | | | | | | |
|---|---|---|---|---|---|---|
| County of Residence | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
| Sweetwater | 52.73 | 55.93 | 57.07 | 58.49 | 52.45 | 51.89 |
| Washakie | 59.35 | 55.17 | 64.05 | 64.55 | 65.69 | 49.08 |
| Hot Springs | 64.76 | 59.28 | 58.40 | 53.79 | 42.59 | 38.20 |
| Weston | 39.76 | 36.46 | 34.45 | 31.58 | 34.02 | 36.46 |
| Goshen | 36.78 | 34.84 | 35.21 | 33.27 | 30.28 | 32.45 |
| Converse | 24.63 | 29.99 | 32.70 | 35.70 | 36.73 | 31.52 |
| Teton | 31.15 | 32.80 | 30.80 | 31.54 | 30.93 | 30.59 |
| Natrona | 33.90 | 35.61 | 32.75 | 33.41 | 32.29 | 29.27 |
| Park | 30.15 | 29.80 | 31.34 | 32.29 | 30.45 | 29.26 |
| Uinta | 29.02 | 34.04 | 37.39 | 38.38 | 34.39 | 28.87 |
| Campbell | 22.04 | 22.87 | 26.70 | 24.97 | 30.54 | 28.78 |
| Big Horn | 32.91 | 32.99 | 32.24 | 32.57 | 26.85 | 27.94 |
| Sublette | 17.73 | 26.60 | 27.92 | 30.98 | 35.36 | 26.60 |
| Niobrara | 31.41 | 32.24 | 38.11 | 43.13 | 35.18 | 26.38 |
| Platte | 33.97 | 21.13 | 33.04 | 31.99 | 26.97 | 24.52 |
| Laramie | 25.75 | 24.56 | 26.71 | 28.20 | 27.10 | 24.22 |
| Sheridan | 25.70 | 26.66 | 25.67 | 24.94 | 23.58 | 23.09 |
| Johnson | 27.66 | 24.47 | 21.75 | 26.36 | 31.09 | 22.58 |
| Lincoln | 23.31 | 27.68 | 26.45 | 20.43 | 21.87 | 22.33 |
| Carbon | 16.50 | 17.97 | 21.04 | 19.57 | 16.90 | 19.17 |
| Albany | 20.41 | 19.22 | 20.70 | 22.20 | 18.52 | 18.42 |
| Crook | 17.05 | 13.96 | 17.45 | 12.75 | 15.44 | 16.11 |
| Fremont | 18.44 | 17.56 | 16.95 | 17.61 | 19.00 | 14.87 |

| Mental Health Residential County of Residence Per 1,000 People | | | | | | |
|---|---|---|---|---|---|---|
| County of Residence | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
| Washakie | 1.6 | 2.2 | 1.9 | 1.9 | 1.6 | 2.0 |
| Uinta | 0.7 | 2.0 | 1.7 | 1.9 | 2.1 | 2.0 |
| Converse | 0.0 | 0.0 | 0.0 | 1.2 | 0.8 | 1.0 |
| Fremont | 0.0 | 0.1 | 0.6 | 0.7 | 0.7 | 0.7 |
| Park | 0.0 | 0.0 | 0.6 | 0.7 | 0.7 | 0.6 |
| Sweetwater | 0.0 | 0.5 | 0.5 | 0.5 | 0.6 | 0.6 |
| Carbon | 0.4 | 0.6 | 0.6 | 0.3 | 0.3 | 0.5 |
| Sheridan | 0.0 | 0.0 | 0.3 | 0.5 | 0.4 | 0.4 |
| Albany | 0.0 | 0.0 | 0.0 | 0.4 | 0.3 | 0.4 |
| Natrona | 0.0 | 0.0 | 0.1 | 0.2 | 0.2 | 0.2 |
| Campbell | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.2 |
| Laramie | 0.0 | 0.1 | 0.1 | 0.2 | 0.2 | 0.2 |
| Sublette | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 |
| Goshen | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 |
| Lincoln | 0.0 | 0.1 | 0.0 | 0.0 | 0.1 | 0.1 |
| Teton | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Big Horn | 0.0 | 0.0 | 0.1 | 0.0 | 0.0 | 0.0 |
| Crook | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Hot Springs | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Johnson | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Niobrara | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Platte | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Weston | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

## Substance use disorder County of Residence Per Capita

| Substance Use Disorder Outpatient County of Residence Per 1,000 People | | | | | | |
|---|---|---|---|---|---|---|
| County of Residence | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
| Washakie | 30.2 | 28.8 | 35.4 | 34.6 | 30.3 | 27.8 |
| Sweetwater | 16.9 | 18.1 | 18.1 | 19.8 | 17.6 | 17.7 |
| Natrona | 15.6 | 13.6 | 13.0 | 13.8 | 13.8 | 14.7 |
| Johnson | 13.2 | 15.2 | 12.8 | 11.8 | 12.5 | 13.7 |
| Hot Springs | 22.0 | 21.7 | 15.6 | 14.5 | 13.2 | 13.0 |
| Converse | 11.7 | 11.4 | 12.2 | 12.8 | 12.2 | 12.0 |
| Teton | 12.0 | 13.3 | 14.0 | 11.2 | 12.9 | 12.0 |
| Sublette | 7.0 | 11.4 | 15.0 | 14.8 | 14.1 | 11.7 |
| Weston | 17.1 | 15.1 | 10.9 | 13.8 | 10.9 | 11.6 |
| Sheridan | 13.5 | 13.6 | 11.9 | 10.7 | 10.0 | 10.7 |
| Platte | 13.0 | 9.9 | 13.4 | 13.8 | 8.6 | 10.2 |
| Laramie | 11.6 | 10.6 | 10.8 | 10.9 | 9.3 | 10.0 |
| Carbon | 9.9 | 11.0 | 13.2 | 10.8 | 10.1 | 9.7 |
| Lincoln | 7.6 | 8.7 | 8.7 | 7.8 | 7.6 | 9.5 |
| Big Horn | 15.1 | 12.3 | 9.7 | 11.4 | 10.3 | 9.5 |
| Goshen | 8.7 | 7.2 | 9.3 | 9.3 | 7.6 | 8.7 |
| Niobrara | 10.5 | 10.5 | 14.2 | 9.6 | 6.3 | 8.4 |
| Fremont | 10.4 | 10.1 | 9.9 | 11.1 | 8.2 | 7.3 |
| Albany | 7.9 | 6.3 | 7.0 | 7.4 | 5.3 | 6.5 |
| Crook | 7.0 | 7.1 | 7.0 | 5.9 | 6.7 | 6.3 |
| Park | 7.1 | 6.3 | 5.6 | 5.6 | 5.5 | 5.9 |
| Uinta | 6.1 | 6.0 | 5.8 | 6.7 | 6.4 | 5.8 |
| Campbell | 5.6 | 5.1 | 6.1 | 5.4 | 5.6 | 5.2 |

| Substance Use Disorder Residential County of Residence Per 1,000 People | | | | | | |
|---|---|---|---|---|---|---|
| County of Residence | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
| Carbon | 1.402712 | 1.536304 | 1.603099 | 1.202324 | 1.937078 | 2.805424 |
| Converse | 1.906158 | 2.346041 | 2.492669 | 2.639296 | 2.1261 | 2.785924 |
| Hot Springs | 3.073546 | 3.512623 | 2.854007 | 1.536773 | 1.756312 | 2.634468 |
| Sweetwater | 3.228729 | 3.066131 | 3.228729 | 2.996446 | 3.042903 | 2.346055 |
| Natrona | 2.881881 | 2.578525 | 2.768122 | 2.730203 | 2.22461 | 2.060292 |
| Campbell | 2.405722 | 2.297356 | 2.427395 | 2.730819 | 2.492414 | 2.037278 |
| Fremont | 1.745466 | 2.276694 | 3.364448 | 3.111482 | 2.45377 | 1.973135 |
| Uinta | 1.921277 | 1.674959 | 2.069067 | 1.133061 | 1.379378 | 1.82275 |
| Washakie | 2.155992 | 2.409639 | 2.790108 | 2.282815 | 3.931516 | 1.775523 |
| Park | 2.046106 | 1.670986 | 1.466376 | 1.227663 | 1.670986 | 1.705088 |
| Johnson | 2.245863 | 2.955083 | 1.182033 | 1.182033 | 1.891253 | 1.536643 |
| Sheridan | 3.34072 | 2.447657 | 2.348427 | 4.299937 | 2.083816 | 1.521516 |
| Big Horn | 2.356704 | 2.272536 | 1.767528 | 1.935864 | 2.020032 | 1.515024 |
| Platte | 1.86785 | 2.101331 | 1.634368 | 1.284147 | 2.101331 | 1.400887 |
| Lincoln | 0.926212 | 0.668931 | 0.720387 | 0.463106 | 1.132037 | 1.337861 |
| Weston | 1.578872 | 0.574135 | 1.578872 | 1.291804 | 1.435338 | 1.291804 |
| Laramie | 1.192208 | 1.262932 | 1.273036 | 1.31345 | 1.303346 | 1.242726 |
| Sublette | 1.324773 | 1.019056 | 0.917151 | 1.120962 | 0.713339 | 1.120962 |
| Crook | 0.536913 | 0.402685 | 1.073826 | 1.610738 | 0.805369 | 0.939597 |
| Goshen | 1.569976 | 0.822368 | 0.672847 | 0.448565 | 0.598086 | 0.747608 |
| Albany | 0.362685 | 0.621746 | 0.803088 | 0.466309 | 0.621746 | 0.673558 |
| Teton | 0.779862 | 0.953165 | 0.693211 | 0.563234 | 0.389931 | 0.476582 |
| Niobrara | 1.675042 | 2.093802 | 0.837521 | 1.256281 | 0.41876 | 0.41876 |

| Social Detox County of Residence Per 1,000 People | | | | | | |
|---|---|---|---|---|---|---|
| County of Residence | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
| Fremont | 13.3 | 11.0 | 8.9 | 8.0 | 8.8 | 2.6 |
| Laramie | 0.2 | 0.0 | 0.1 | 0.0 | 0.1 | 1.8 |
| Sheridan | 1.0 | 0.7 | 1.0 | 0.9 | 0.9 | 1.2 |
| Sweetwater | 0.5 | 0.5 | 1.0 | 1.6 | 1.2 | 1.2 |
| Niobrara | 0.4 | 0.0 | 0.0 | 0.4 | 0.0 | 0.8 |
| Weston | 0.0 | 0.0 | 0.1 | 0.0 | 0.3 | 0.7 |
| Platte | 0.0 | 0.0 | 0.2 | 0.0 | 0.0 | 0.6 |
| Carbon | 0.3 | 0.1 | 0.2 | 0.1 | 0.2 | 0.5 |
| Lincoln | 0.2 | 0.1 | 0.1 | 0.1 | 0.2 | 0.3 |
| Teton | 0.1 | 0.1 | 0.3 | 0.3 | 0.1 | 0.3 |
| Washakie | 0.4 | 0.1 | 0.1 | 0.3 | 0.5 | 0.3 |
| Johnson | 0.5 | 0.5 | 0.1 | 0.4 | 0.2 | 0.2 |
| Goshen | 0.1 | 0.0 | 0.0 | 0.1 | 0.1 | 0.2 |
| Sublette | 0.1 | 0.2 | 0.3 | 0.2 | 0.1 | 0.2 |
| Natrona | 0.3 | 0.2 | 0.3 | 0.2 | 0.1 | 0.2 |
| Uinta | 0.1 | 0.1 | 0.3 | 0.0 | 0.6 | 0.2 |
| Big Horn | 0.1 | 0.3 | 0.3 | 0.2 | 0.2 | 0.2 |
| Albany | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.2 |
| Crook | 0.1 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 |
| Campbell | 0.2 | 0.2 | 0.2 | 0.1 | 0.0 | 0.1 |
| Park | 0.1 | 0.0 | 0.1 | 0.0 | 0.1 | 0.1 |
| Converse | 0.3 | 0.1 | 0.2 | 0.1 | 0.1 | 0.1 |
| Hot Springs | 0.7 | 0.0 | 0.7 | 0.4 | 0.2 | 0.0 |