

# BEHAVIORAL HEALTH REDESIGN

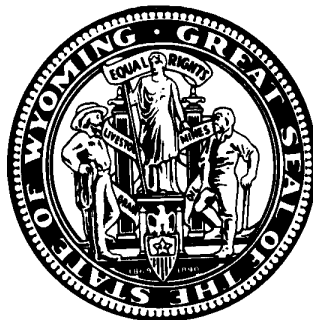
INITIAL REPORT

TO THE

SELECT COMMITTEE ON  
MENTAL HEALTH & SUBSTANCE ABUSE

AND THE

JOINT LABOR, HEALTH  
& SOCIAL SERVICES COMMITTEE



Wyoming Department of Health  
September 1, 2021

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# BACKGROUND - HISTORY

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This section provides a high-level overview of how Wyoming's behavioral health system has evolved over time.

We begin with a brief digression on how the care for individuals with mental illness fit into the history of “poor relief” in the United States generally.

As a quick summary, this welfare policy has swung between two poles over the past three hundred years: (1) treating individuals in community settings, and (2) treating individuals in central institutions. Only the most recent swing of this pendulum — from the 1950s to today — has been towards serving people in community-based settings.

## Early community settings: “indoor” and “outdoor relief”

In the 18<sup>th</sup> and early 19<sup>th</sup> centuries, many elderly and disabled Americans were cared for at home. Since most people lived in multigenerational families on a farm or in a small town, old age or disability meant some loss of economic output, but it was often not catastrophic.<sup>1</sup>

When families could not provide, however, public assistance in early America followed a model that was imported from England by the colonists; i.e., the Elizabethan Poor Laws of 1601.<sup>2</sup> Under this system, the poor were informally divided into two main groups, and public aid was either provided, or not, accordingly:

- The “**undeserving poor**” were [actual or apparent] able-bodied people who “chose” not to work. These people were provided no relief. In many cases — particularly for individuals with mental illness — they were often imprisoned or physically abused.
- The “**deserving poor**” were generally split into two subgroups:
  - The “**able-bodied poor**” were able and looking for work, but unable to find it due to economic conditions (i.e., today's unemployed). These individuals were often sent to workhouses or poor farms.
  - The “**impotent poor**” were individuals who clearly could not work: individuals with physical disabilities, the “feeble minded” (individuals with developmental or intellectual disabilities), and the frail elderly. The impotent poor were typically cared for in community poorhouses (also known as almshouses), largely administered in an ad-hoc fashion by towns and counties.

While poor children and orphans were often placed in almshouses, Elizabethan-era poor laws also set up proto-“foster care” placements of children in willing homes, usually as indentured servants.

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<sup>1</sup> Grundmann, Herman. “Adult assistance programs under the Social Security Act.” SSA Bulletin. 11  
<https://www.ssa.gov/policy/docs/ssb/v48n10/v48n10p10.pdf>

<sup>2</sup> <https://www.sochealth.co.uk/national-health-service/health-law/poor-law-1601/>

Children therefore straddled the line between “able-bodied” and “impotent,” but were largely considered part of the “deserving poor.”

Since all poverty was considered partly a moral failing, however, both poorhouses and workhouses (known as “indoor relief”) provided spartan accommodations in an effort to deter dependency and encourage moral reform.<sup>3</sup> In some cases, however, members of the “deserving poor” were also provided cash or in-kind goods and services (e.g. food, fuel), in a system known as “outdoor relief.” Both “indoor” and “outdoor” relief systems were operated at the local community level.

### **The beginnings of state oversight and institutional care**

By the mid-19<sup>th</sup> century, industrialization and urbanization had put increasing strain on the ability of families to provide care for elderly and disabled relatives. As Grundmann notes,

“In the urban industrial environment, older workers were at a disadvantage in competing for jobs demanding more physical exertion, skill, training, and education, and providing less flexible working conditions than many kinds of farm work. The younger urban worker, residing in cramped quarters, found it difficult in good times, and impossible in economically hard times, to provide for his family, educate his children, and also care for his aging parents.”<sup>4</sup>

In crowded cities, this inability to care for family members led to significant growth in the indigent population and worsening conditions at public poorhouses.<sup>5</sup> Exceptionally inhumane conditions began to draw the notice of public authorities. As an 1857 report to the New York State Senate put it:

“The evidence taken by the committee exhibits such a record of filth, nakedness, licentiousness, general bad morals, and disregard of religion and the most common religious observances, as well as gross neglect of the most ordinary comforts and decencies of life, as if published in detail would disgrace the State and shock humanity.”<sup>6</sup>

Investigations like these, coupled with advocacy by social reformers, ultimately led to certain groups of the “deserving poor” being removed from the system of local poorhouses and placed into more centralized, State-operated care facilities.

- Orphans and poor children were generally moved out of poor houses by the end of the 19<sup>th</sup> century. States typically funded a system of “free” (read: “non-indentured servitude”) foster care homes and orphanages, either as public institutions or privately-operated under State regulatory and licensing authorities.<sup>7</sup>

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<sup>3</sup> Watson, Sidney. “From almshouses to nursing homes and community care: lessons from Medicaid’s history.” Georgia State University Law Review. Vol. 29. Spring 2010. 941.

<sup>4</sup> Grundmann, 11.

<sup>5</sup> <http://socialwelfare.library.vcu.edu/issues/poor-relief-almshouse/>

<sup>6</sup> McGowan, Brenda. “Historical evolution of child welfare services.” *Child Welfare for the Twenty-first Century: A Handbook of Practices, Policies, and Programs*. 2005.

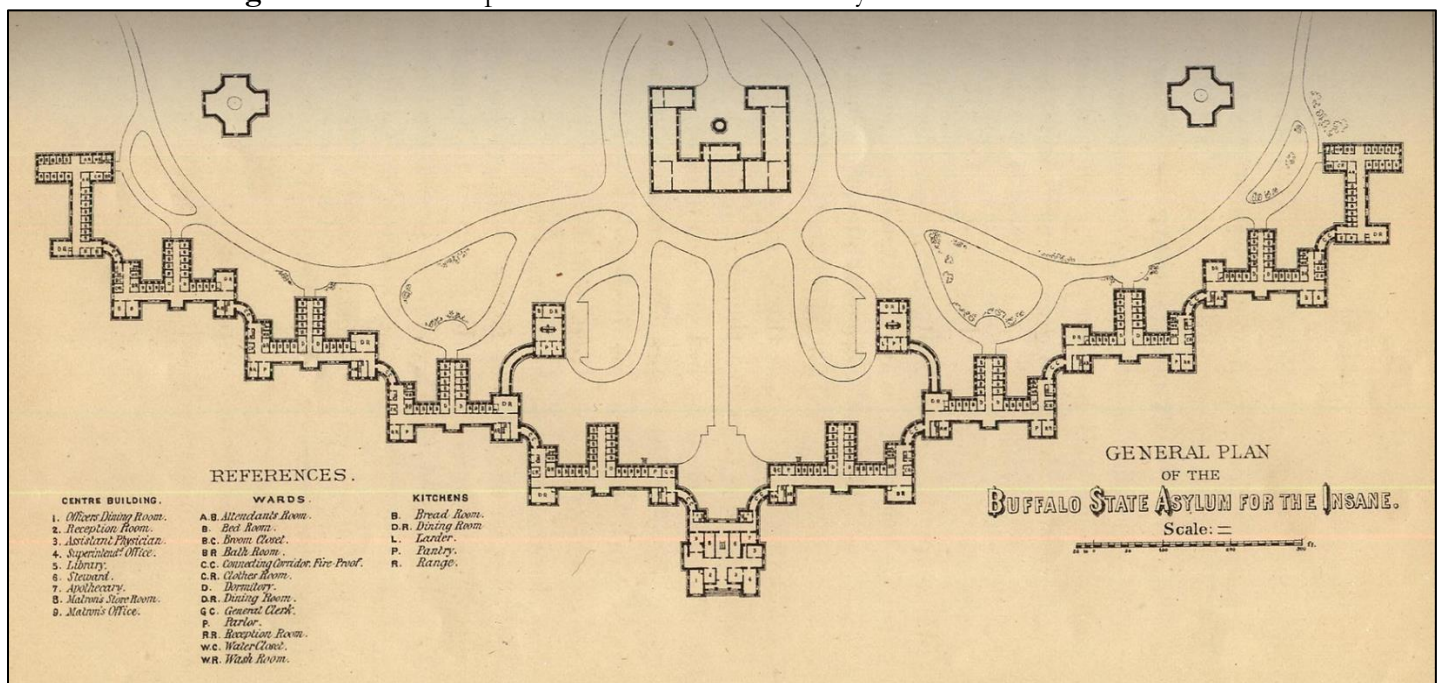
<sup>7</sup> McGowan. 19.

- Juvenile delinquents, or children over the age of seven who committed crimes, had previously been treated the same as indigent adults, and many were sent to the same workhouses and poor houses that housed dependent children and the poor elderly. In the mid-19<sup>th</sup> century, “reform schools” and other specialized institutions began to be set up to provide some level of education and work training to young offenders in a different setting.
- In the case of individuals with mental illness — who were often jailed, if not in the poorhouse — reformers like Dorothea Dix and Thomas Story Kirkbride ultimately convinced many states to construct centralized institutions.

Dix and Kirkbride were instrumental in founding the “Asylum Movement,” which believed that people with mental illness could be rehabilitated and even cured through a program of structured “moral treatment” in clean, open and humane settings. The architecture of many of the newly constructed “Insane Asylums” reflected this belief.

Figure 1, below, shows the layout of a typical “Kirkbride plan,” with typical “bat wing” construction designed to allow as much fresh air and sunlight into patient rooms as possible.

**Figure 1:** “Kirkbride plan” for the Buffalo State Asylum for the Insane.<sup>8</sup>



- Similar institutions were constructed for individuals with developmental disabilities. As with the Asylum Movement, the contemporary focus was on structured education and rehabilitation, hence the common moniker of “training school” for many of these institutions.

<sup>8</sup> Plan of the Buffalo State Asylum downloaded from PBS LearningMedia, <https://www.pbslearningmedia.org/resource/reimagining-buffalo-landmark-kirkbride-plan/the-kirkbride-plan-lesson-plan/Rights> to use this asset do not expire. Asset Copyright: 2019 WNYPBA

In Wyoming, the Asylum Movement manifested itself through the 1886 construction of the “Wyoming Insane Asylum,” now the Wyoming State Hospital, in Evanston.<sup>9</sup> Its counterpart for individuals with intellectual and developmental disabilities, the “Wyoming State Training School,” now the Wyoming Life Resource Center, was established in Lander for similar reasons in the early 20<sup>th</sup> century.

### **Institutional failings and de-institutionalization**

Despite the Asylum Movement’s high aspirations of rehabilitation, by the early 20<sup>th</sup> century, institutional care for the groups previously removed from poorhouses had degenerated. Most had reverted to large-scale custodial care under appalling conditions. This was mostly due to three factors:

- State resources were never adequate to fulfill the small census sizes and therapeutic plans proposed by the Asylum Movement. In many cases, institutions ended up supporting themselves through the forced, unpaid labor of their inmates, known as “institutional peonage.”
- Along with industrialization, poverty had dramatically increased in the late 19th century, further straining State resources.
- Enlightenment conceptions of mental illness and developmental disabilities as ‘curable’ had been supplanted by Social Darwinist thinking and eugenics. These new philosophies saw asylum inmates as incapable of rehabilitation. Along with less humane treatment modalities, which often included policies like seclusion and castration, this philosophy also led to far longer institutional stays — often, for life.

In the early and mid-20<sup>th</sup> century, public awareness of inhumane conditions, often spurred by exposés like LIFE Magazine’s “Bedlam 1946” and Geraldo Rivera’s 1972 Willowbrook School documentary,<sup>10</sup> became the ultimate impetus behind large-scale “de-institutionalization.” This process, however, proceeded at different paces, and with different outcomes, for each group.

In the case of individuals with mental illness, it was the development of effective psychotropic drugs in the 1950s that led to increased confidence that people could be safely treated in the community. The federal Joint Commission on Mental Health’s 1961 “Action for Mental Health” report, for example, which championed this idea, directly led to the Community Mental Health Center Act, which began funding for community-based mental health treatment and prevention.

These developments kicked off the major wave of de-institutionalization in the 1960s and 1970s for individuals with mental illness, shown in Table 1, on the next page.

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<sup>9</sup> <https://www.wyohistory.org/encyclopedia/wyoming-state-hospital>

<sup>10</sup> <https://www.youtube.com/watch?v=7MU7JYerhF4>

**Table 1:** Milestones in de-institutionalization - individuals with mental illness

Year	Change	Legislation / Case
1946	National Institute of Mental Health created	National Mental Health Act of 1946
	LIFE publishes “Bedlam 1946,” an exposé of poor conditions at multiple State-operated psychiatric hospitals. To many Americans, the images from these facilities resembled contemporary footage from concentration camps in Nazi Germany.	
1952	Discovery of non-selective monoamine oxidase inhibitors (iproniazid) for treating depression	
1954	Introduction of first-generation anti-psychotic medications (chlorpromazine/Thorazine) to the US	
1957	Development of tricyclic antidepressants (imipramine/Tofranil)	
1963	Federal funding provided for construction of community mental health centers	Community Mental Health Center Act
1970	FDA approves lithium for mood disorders	
1973	Institutional peonage outlawed. Patients of public institutions who work must be considered employees and paid minimum wage.	Souder v. Brennan
1975	“One Flew Over the Cuckoo’s Nest” released	

This movement culminated nationally with the 1999 Supreme Court *Olmstead* decision, which ruled that States have a duty to provide reasonable accommodation and services for disabled individuals in community settings. Institutionalization, wrote the Court, is problematic for two main reasons:

- First, that “institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life”, and;
- Second, that “confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement and cultural enrichment.”

In its decision, the Court developed a three-part test for evaluating the qualified right of individuals with disabilities to receive funded support in the community:

- The person’s treatment professional determine that community supports are **appropriate**;
- The transfer from institutional care to a less-restrictive setting is **not opposed** by the affected individual; and,
- The provision of services in the community can be **reasonably accommodated**, taking into account the resources available to the State and the needs of other similarly-situated individuals with disabilities.



Today, it is evident that de-institutionalization has been more successful for some groups than others. The degree of success has been either driven by, or reflected in, how much financial support has been provided in the community. For example, the role of orphanages today is virtually nonexistent as children are generally served through the foster care system. Individuals with intellectual disabilities are likewise largely served in the community through Medicaid Home and Community Based Services (HCBS) instead of large centralized institutions.

In the case of individuals with severe mental illness — who have always been on the boundary between the “deserving” and “undeserving” poor — deinstitutionalization has been less successful, with conditions, in many cases, reverting somewhat to those in the early 19<sup>th</sup> century, where county jails were the default “treatment” option. The infamous example today is the Cook County Jail in Chicago, where an estimated one third of inmates have a form of mental illness.<sup>11</sup>

### **The shift towards community treatment in Wyoming**

The development of Wyoming’s system of state-funded Community Mental Health and Substance Abuse Centers has paralleled these national trends. Generally speaking, in response to the de-institutionalization movement, a network of locally-led non-profit organizations grew up to provide regionally-focused access to mental health services around the State.

Through fits and starts, that mission ultimately solidified around a “general access” model, where the State contracts with these centers to provide services to any and all comers, regardless of pay source.

Please note that the Wyoming Association of Mental Health and Substance Abuse Centers (WAMHSAC) has published an excellent and comprehensive report on this history, which is attached. We highlight significant milestones in Table 2, below.

**Table 2: Milestones in CMHC development in Wyoming**

Year	Event
1955	Gov. Simpson appoints members to Mental Health Survey Committee.
1956	Mental Health Survey report released, showing deficiencies in access to mental health care around the state.
1957	Statute provides for the establishment and operation of joint community health boards
1961	Wyoming’s Community Mental Health Services Act (Chapter 144, 1961 Session Laws), creates the Division of Mental Health within the Department of Public Health in order to serve as a central agency to receive and distribute federal grant funds.
1963	Casper, Cody, Lander, Sheridan, Cheyenne and Rock Springs operating Mental Health Center Boards
1965	“As Wyoming Sows” report recommends regionalizing behavioral health services (Southwest / Fremont / Big Horn Basin / Northeast / Central / Southeast).
1969	Department of Health and Social Services created, combining public health with welfare functions.
1979	Behavioral Health Division created in the Department of Health in order to centralize and standardize state contracts with CMHCs.
1981-84	Development of standards for state contracts. This was often contentious, particularly regarding State role of managing (or micromanaging) center requirements.

<sup>11</sup> <https://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/>



1987	Medicaid behavioral health coverage available to CMHCs
1994	Chris S. lawsuit exposes significant issues with care provided at the Wyoming State Hospital.
1997	Development of the Wyoming Client Information System (WCIS) to collect service and demographic data.
2002	HB59 Substance Abuse Planning and Accountability increases State funding significantly for substance abuse.
2005	Chris S. settlement agreement requires improvements at the State Hospital, CARF accreditation of CMHCs.
2007	Result of Select Committee on Mental Health and Substance Abuse Services — SF79 — significantly increases State funding for CMHCs.
2014-16	Facilities Task Force develops new missions for State Hospital and Life Resource Center, requiring the facilities to operate on a continuum of care.
2021	New State Hospital facility opened.

Of recent significance in this timeline is the Chris. S settlement, whose primary objectives centered on de-institutionalization, Olmstead compliance, and the further development of community-based treatment.<sup>12</sup>

- The development, support and maintenance of community based mental health services aimed at providing the least restrictive treatment and most appropriate environment for individual treatment;
- The advancement of community mental health services for all Wyoming citizens regardless of age;
- Compliance by the State with the Olmstead decision;
- The creation, support and maintenance of a crisis network throughout the state;
- Adherence to nationally-recognized accreditation standards for CMHCs;
- Creation of programs to eliminate the use of jails as a “depository” for those with mental illness;
- Increasing access to mental health services;
- Maintenance of appropriate staffing at the State Hospital and CMHCs;
- The fostering of active treatment at the State Hospital;
- Revision of Title 14 to protect parent/child relationships.

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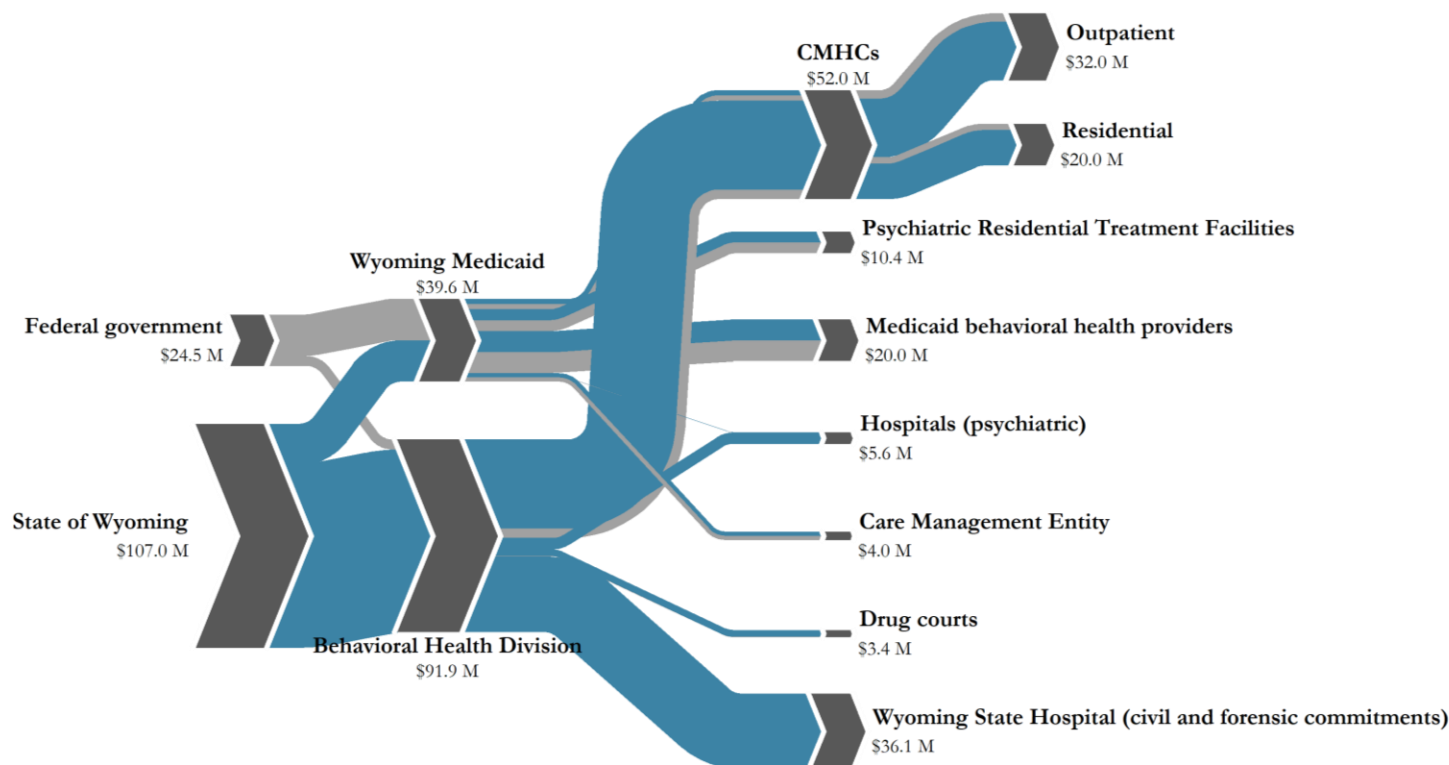
<sup>12</sup> Article II, 2.04. Chris S. Stipulated Settlement Agreement. 94-CV-311-J.

## BACKGROUND - CURRENT SYSTEM

The historical developments outlined in the previous section created in the system we have today. This section outlines the current structure and funding of that system, focusing particularly on the significant role played by the Community Mental Health and Substance Abuse Centers.

Figure 2, below, illustrates the entire context of behavioral health funding that passes through the Department of Health on an annual basis. The diagram is oriented with revenue sources on the far left. These flow through WDH programs in the middle, and ultimately end up paying various provider types on the right. On the figure, the blue flows denote State General Funds (SGF) and gray flows show federal dollars (FF).

**Figure 2:** Annual estimated WDH behavioral health funding



The current Behavioral Health Redesign effort concerns itself specifically with the use of the ~ **\$47 million in annual funding that flows from the Behavioral Health Division to the Community Mental Health and Substance Abuse Centers in the top right of the diagram**. This funding includes both ~\$20 million in residential services and ~\$27 million in outpatient services. It does not include Medicaid.

Table 3, on the next page, shows the history of this funding, broken down by source (State General Funds, Federal Funds and Tobacco Settlement Funds). Note that funding levels largely remained at a fairly consistent \$50 - 55 million after the large appropriations initiated by the Select Committee on

Mental Health and Substance Abuse Services in 2007, though this level was reduced as part of the recent budget cuts for the 2021/22 biennium, highlighted in blue.

**Table 3:** Community Mental Health and Substance Abuse Center funding through state contracts, by funding source, SFY 2013 - 2022

SFY	SGF	FF	TSF	Total
2013	\$46,759,185	\$2,702,806	\$4,411,951	<b>\$53,873,942</b>
2014	\$46,204,424	\$2,562,260	\$4,797,502	<b>\$53,564,186</b>
2015	\$46,405,494	\$2,572,886	\$4,791,602	<b>\$53,769,982</b>
2016	\$46,339,640	\$3,094,544	\$4,791,602	<b>\$54,225,786</b>
2017	\$40,774,041	\$3,464,382	\$4,791,602	<b>\$49,030,025</b>
2018	\$42,745,371	\$5,883,987	\$4,781,380	<b>\$53,410,738</b>
2019	\$43,634,303	\$3,152,193	\$5,478,232	<b>\$52,264,728</b>
2020	\$43,302,747	\$6,974,258	\$5,478,232	<b>\$55,755,238</b>
2021	\$35,470,758	\$4,565,842	\$6,975,272	<b>\$47,011,873</b>
2022	\$34,554,727	\$6,051,614	\$5,002,517	<b>\$45,608,858</b>

Currently, twelve (12) Centers provide both mental health and substance use disorder services, two (2) centers provide mental health services only, and four (4) centers provide substance use disorder services only. Services include both outpatient and regional, mostly residential, services.

- Outpatient treatment services are available in each county of the state and are provided in-office or at various community locations (e.g., schools, jails, client homes).
- Regional residential treatment services are more intensive and include mental health group homes, crisis stabilization, and substance use disorder residential treatment. There are five (5) regions within the state: Basin, Central, Northeast, Southeast, and West.

Until recent years, the contract structure for CMHC/SACs required that the centers deliver a specified total quantity of “service hours” for outpatient mental health and substance abuse. The Behavioral Health Division then multiplied the mandated service hours by an average rate of \$87 per hour to determine the CMHC’s or SAC’s annual contract amount, irrespective of the cost of delivery, case severity, or acuity of the patients served.

This total amount was paid to the provider in twelve (12) monthly installments over the course of the fiscal year.

In the past few years, this formula has been modified to some degree, such that:

(1) For outpatient services:

- Providers receive approximately 1/3 of funding as base payment, in monthly installments.
- For the remaining 70%, providers must draw down dollars based on two different rates:
  - \$87/hour for general access clients;
  - \$120/hour for “priority populations,” which overlap with but differ somewhat from the “priority populations” specified in HEA56.

(2) For residential services, owned and operated by the CMHCs:

- The State contracts with centers for specific types of residential beds - MH/SUD/crisis stabilization, etc.;
- CMHCs are paid on a monthly basis; and,
- CMHCs must maintain a certain occupancy percentage for each category of bed.

Services are provided to any Wyoming resident, without eligibility criteria and regardless of the severity of their illness, though service hours provided to clients with another pay source are not supposed to be included in the totals reported to the state. In addition to the contract amounts, services may be billed to the client on a sliding fee scale or, if covered, to third party sources such as insurance and Medicaid.

# WHAT PROBLEM ARE WE TRYING TO SOLVE?

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Simply put, the problem is two-fold:

- The State expends significant resources serving a relatively small group of high-needs individuals in institutional settings, when they potentially could be cared for more effectively and economically in the community; and,
- For the general public, access to mental health services has improved significantly since the 1960s and 70s. While gaps certainly remain, it is important to note some basic facts:
  - The number of private practice mental health professionals in Wyoming has increased over time in most parts of the State;
  - Private insurance plans are more comprehensive and affordable for low-income individuals, both in terms of premiums and cost-sharing;
  - All insurance plans are required to cover mental health services; and,
  - Medicaid programs cover more outpatient mental health services now than in previous years.

Taking the second point first, it's important to recognize that the current system of CMHCs was established when access to mental health services around Wyoming was extremely limited (as illustrated in the history section).

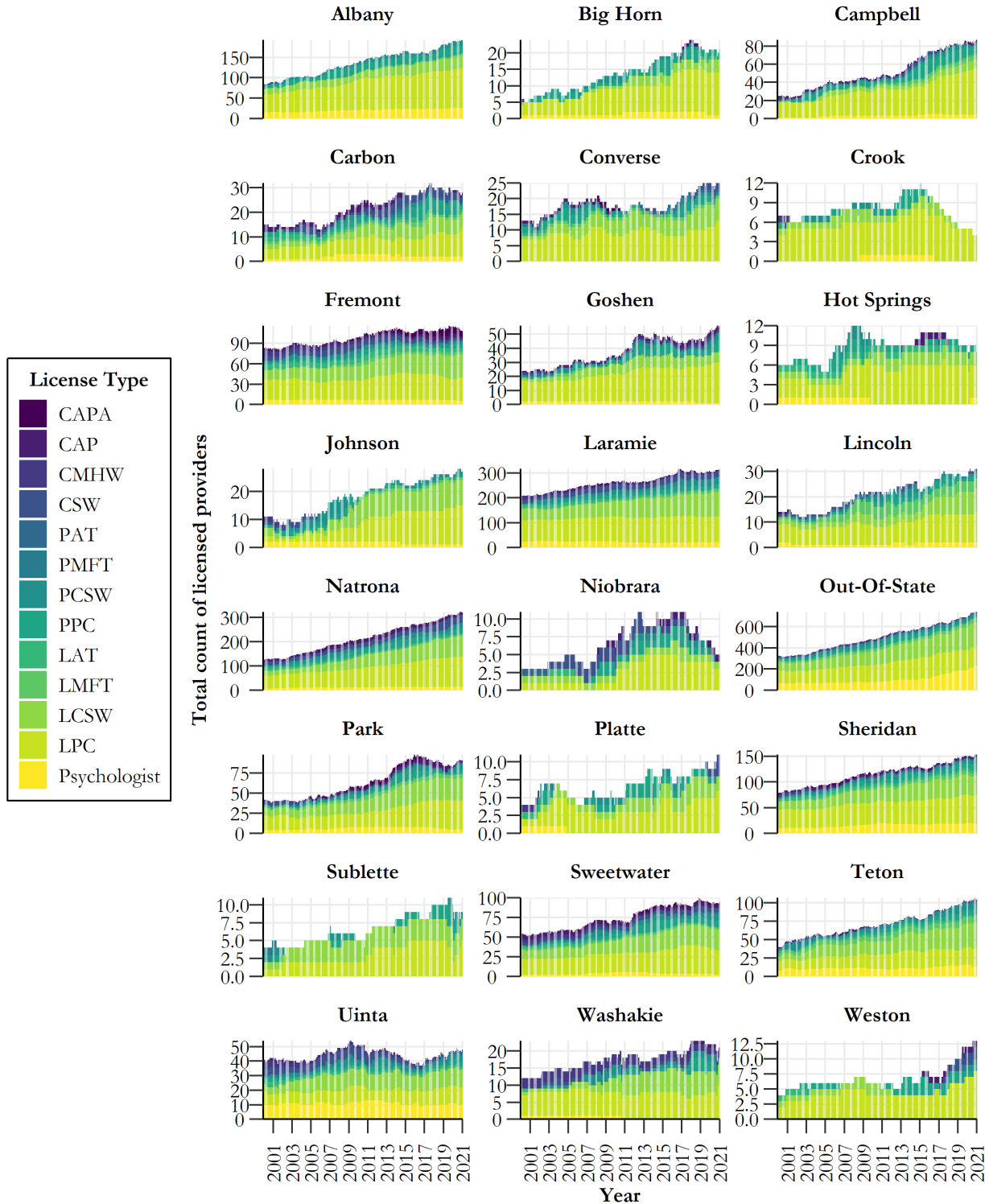
That landscape has changed. In terms of general access to providers, Figure 3, on the next page, and Figure 4 on the subsequent page, show both the absolute number of licensed non-psychiatrist mental health professionals<sup>13</sup> by county and the number per-capita, from 2000 to 2021. Note on the figures that:

- Over the last twenty years, only Crook County has seen a decrease in the number of licensed professionals, on both an absolute and per capita basis.
- While not all of these licensed professionals see patients, there is no basis to conclude that the percentage of actual practitioners has systematically increased or decreased over time or space. The trend in licensure thus likely parallels the trend in practitioners.
- The number of registered out-of-State licensees continues to steadily increase, from ~ 300 in 2000 to over 700 today. Many of these out-of-State providers see patients via telehealth.

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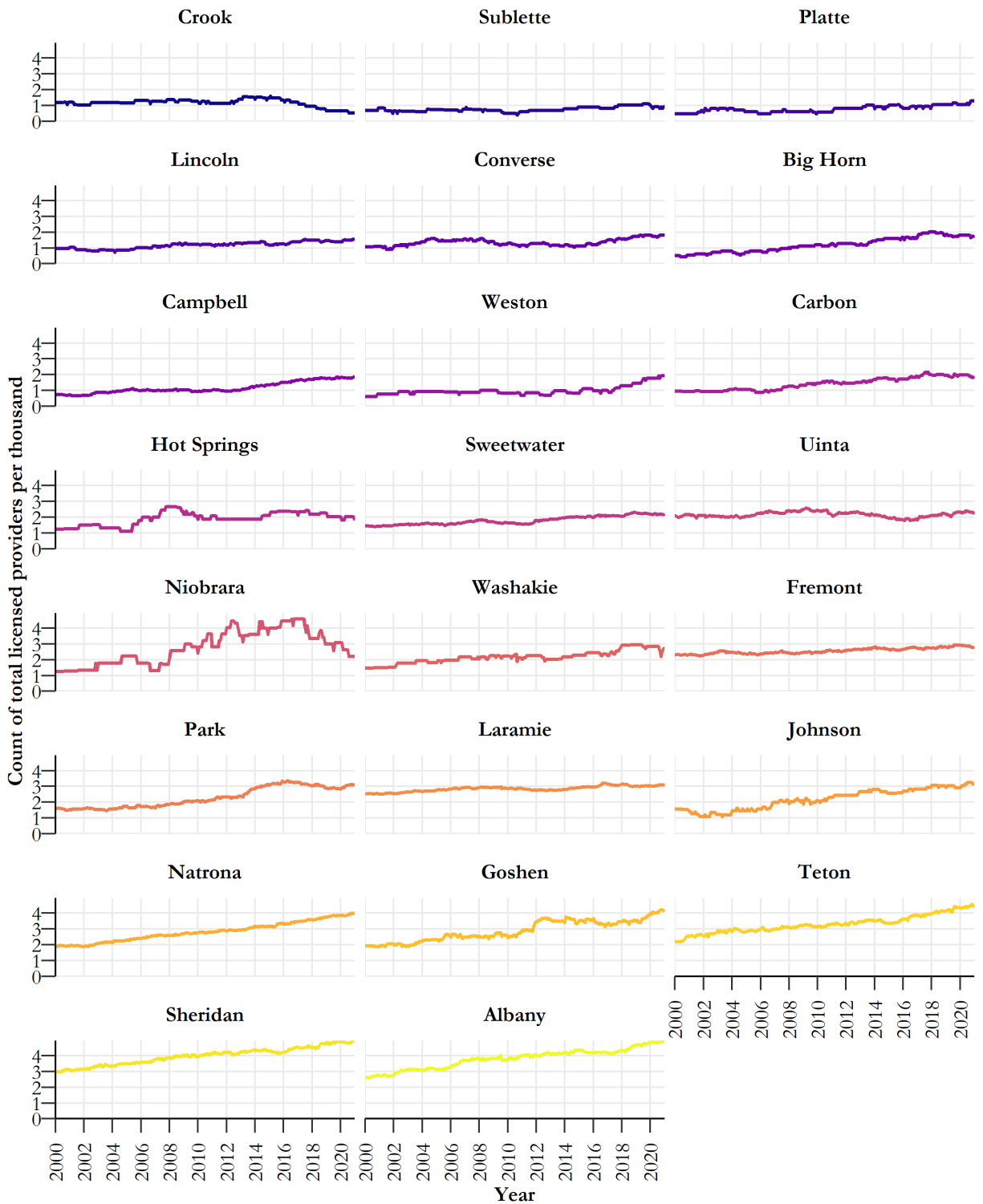
<sup>13</sup> These include Psychologists, Licensed/Provisional Professional Counselors (LPC and PPC), Licensed/Provisional Clinical Social Workers (LCSW/PCSW), Licensed/Provisional Addictions Therapists (LAT/PAT), Licensed/Provisional Marriage and Family Therapists (LMFT/PMFT), Certified Social Worker (CSW), Certified Mental Health Worker (CMHW), Certified Addictions Practitioner (CAP) and Certified Addictions Practitioner Assistant (CAPA).

**Figure 3:** Count of unique licensed mental health providers by county, 2000 - 2020<sup>14</sup>



<sup>14</sup> Data from Wyoming Mental Health Professions Licensing Board and Board of Psychology. Counts are based on months between issued and expiration date. Since some providers hold multiple licenses, data was de-duplicated using the hierarchy shown in the legend.

**Figure 4:** Mental health licensed providers per thousand people by county.<sup>15</sup>



<sup>15</sup> Population data from FRED. Excludes all out-of-state providers (who might be providing care via telehealth or across state lines).



In addition to an increased number of providers, mental health services have also become much more affordable to the general public. This is largely due to the passage of federal legislation in the late 2000s<sup>16</sup> that significantly increased the benefit generosity of private insurance plans through:

- Developing the principle of “mental health parity;” i.e., that insurers cover mental health services as equally as they do medical/surgical services;
- Providing generous federal subsidies for both premiums **and** cost-sharing (e.g., deductibles, co-payments) for individuals between 100% and ~300% of the Federal Poverty Level. Table 4, below, shows how the availability of these subsidies by income bracket for childless adults.

**Table 4:** Insurance subsidies available for childless adults in Wyoming

Federal Poverty Level bracket	Upper bound of income in 2021 for a single person	Premium subsidy	Cost-sharing subsidy (cost now baked into Silver-level premiums in Wyoming)
0 - 100%	\$12,880	No subsidy available	
101 - 138%	\$17,774	Benchmark premium capped at 2.07% of income.	Plan covers 94% of average medical costs.
139 - 150%	\$19,320	Benchmark premium capped at 3.10% of income.	Plan covers 94% of average medical costs.
151 - 200%	\$25,760	Benchmark premium capped at 4.14% of income.	Plan covers 87% of average medical costs.
201 - 250%	\$32,200	Benchmark premium capped at 6.52% of income.	Plan covers 73% of average medical costs.
250 - 300%	\$38,640	Benchmark premium capped at 8.33% of income	No cost-sharing subsidy, multiple plans available in various levels of generosity (metal levels)
300 - 400%	\$51,520	Benchmark premium capped at 9.83% of income	
400% +		Benchmark premium temporarily capped at 8.5% of income due to American Rescue Plan	

All the above is not meant to imply that there aren’t gaps in the system. Many people still lack insurance coverage. Insurance plans do not cover all services. And there are still provider shortages across the State. It is undeniable, however, that the landscape has changed significantly, particularly for the general population, since the period of de-institutionalization that created the mission of today’s CMHCs.

<sup>16</sup> Specifically, the Affordable Care Act (2010) and the Mental Health Parity and Addiction Equity Act (2008).

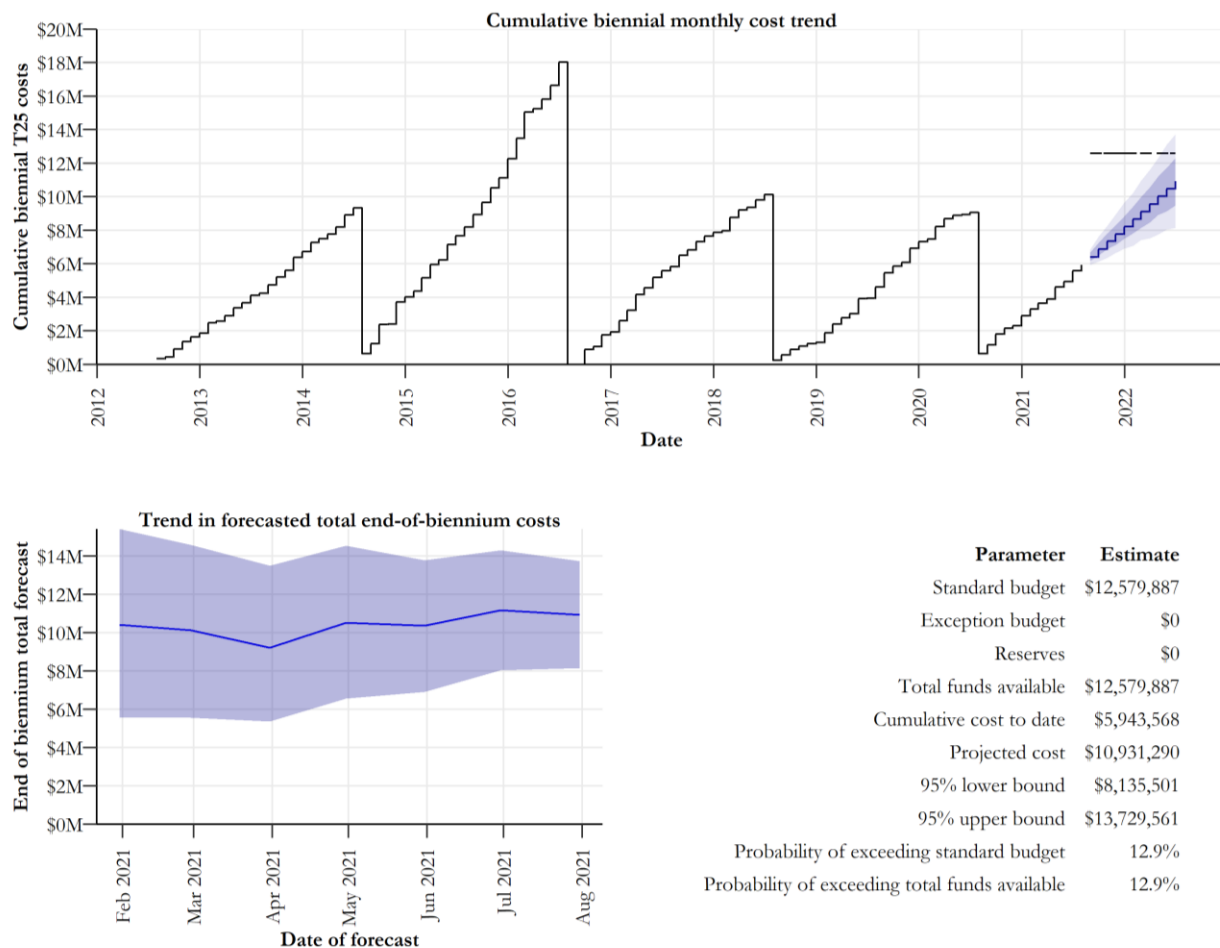
This brings us back to the first part of the problem: because Wyoming’s system of state-funded mental health and substance use disorder treatment has been set up on a general access model, high-needs individuals have been falling through the cracks.

The fundamental problem is that when **everyone is a priority, no one is a priority**. And, in many cases, these high-needs folks end up cycling through institutional settings at significant cost to the State.

Individuals going through Title 25 involuntary hospitalization — i.e., due to their mental illness, being a danger to themselves or others — are the most salient example. Because of logistical bottlenecks at the State Hospital (many of which the Facilities Task Force and accompanying projects are addressing), the State pays for overflow Title 25 capacity at designated psychiatric hospitals around the State.

These costs have typically run between \$8 - \$10 million per biennium, though the 2015/16 biennium saw costs as high as \$18 million. Figure 5, below, shows the Title 25 cost trend over time, as well as the projection for the end of the 2021/22 biennium.

**Figure 5:** Title 25 overflow costs at designated hospitals - August 2021 projection



These overflow costs are incurred by a relatively small handful of people — approximately 350 to 400 per year. Approximately 30% of these individuals will have had at least one previous Title 25 hospitalization.

When we matched the individuals going through involuntary hospitalizations at designated hospitals with records for individuals served in Wyoming’s state-funded CMHC/SAC system, Table 5, below, makes it clear that a significant number (35 - 45%) are falling through the cracks.

**Table 5:** Title 25 / CMHC overlap

CY	People with at least one T25	Percent treated at CMHC
2017	371	55%
2018	378	63%
2019	384	59%

These numbers do not include individuals who may have been diverted from an involuntary hospitalization (emergency detentions, for example, are paid for by the counties, so the State does not receive a bill and thus track these comprehensively), but that doesn’t minimize the evident problem. Considering that all of these individuals were hospitalized involuntarily for psychiatric conditions, it should be assumed that this remainder would have benefited from community treatment as well.

A similar pattern can be seen for Department of Corrections’ probationers and parolees. Table 6, below, shows what percent of this group were seen by CMHC/SACs between 2014 and 2018, stratified by risk of recidivism.<sup>17</sup>

**Table 6:** Department of Corrections / CMHC overlap, 2014 - 2018<sup>18</sup>

COMPAS risk group	No. treated at CMHC	No. not treated at CMHC	Percent treated at CMHC
High	808	573	59%
Med	843	711	54%
Low	988	1138	46%

Since most (i.e., over 80%) of these individuals demonstrated some need for mental health or substance use disorder services in prison, probationers and parolees are another group that appear to be under-served in the community.

When both of these populations are under-served, there are ramifications for the State Hospital and corrections systems. We do not (yet) have any direct causal evidence that receipt of community behavioral health services reduces recidivism in Wyoming, but there are some promising correlations that support this commonsensical idea.

<sup>17</sup> The Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) tool is designed to measure risk of recidivism.

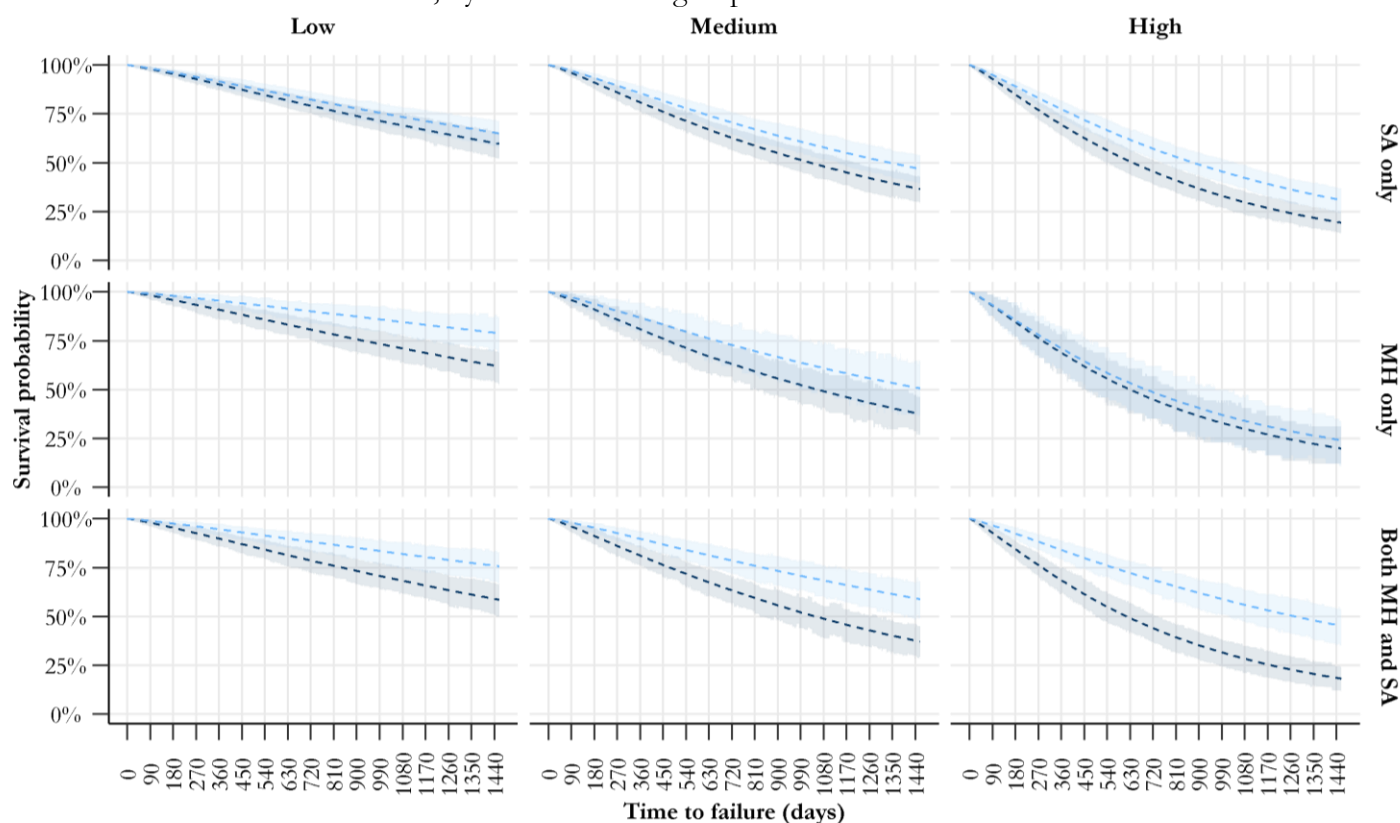
<sup>18</sup> Based on merging 2014-18 probation/parole episode data with WCIS data. Presented to Justice Reinvestment effort.

Figure 6, below, shows evidence that, for high-risk (COMPAS) probation/parolees, receipt of both mental health and substance use disorder services (bottom right panel) is associated with lower recidivism. On this figure, recidivism is measured by “time to failure”; i.e., starting from 100% “surviving” in the community, how long did it take before X% of probation/parolees were back in prison.

The columns on the panel represent the three COMPAS risk groups — low, medium and high — and the rows represent the services that were received — Substance Abuse, Mental Health, or both — for the group in light blue. The comparison group, who received no services, is shown by the dark blue dashed lines.

The difference between the two curves represents the correlation between receipt of services and recidivism. For example, on the bottom right panel, 50% of high-risk probationers and parolees who did **not** receive services were back in jail after 500 - 720 days. For the high-risk group who received both MH and SA services, 50% were back in jail after 1080 - 1500 days.

**Figure 6:** Estimates of recidivism for Department of Corrections (DOC) probation/parolees, SFY 2014-18, by COMPAS risk group and services received.



While we cannot say that the receipt of behavioral health services **caused** the lower recidivism (it could be, for example, that the types of high-risk clients who chose to engage behavioral services were actually lower-risk than their COMPAS score would indicate), the correlation is certainly promising and worthy of further study.

Ultimately, this gets at the problem we’re trying to solve with this redesign.

# LEGISLATIVE REQUIREMENTS AND THE REDESIGN PROCESS

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This section provides a brief overview of the process required of the Department of Health in the Behavioral Health Redesign.

The primary driver of this effort was House Enrolled Act 56, passed during the 2021 General Session. Along with some minor statute updates, the legislation will change (currently effective in July 2022) three significant aspects of Wyoming's State-funded behavioral health system:

- It defines a set of “priority populations” to be the primary focus for services provided by State dollars in Behavioral Health Centers (previously CMHC/SACs);
- It establishes a system of three tiers by which these populations should be prioritized for funding, as shown in Table 7, below; and,
- It directs the Department of Health to proceed with a reform and redesign of the state-funded mental illness and substance use disorder treatment system.

**Table 7:** Priority population tiers

Tier	Subgroup	Population
1	A	State-level justice involved
	B	Non-state level justice involved
	C	Families at high risk
	D	Adults with acute mental illness
	E	Adults with severe mental illness
2	-	Indigent clients with high needs
3	-	Indigent general access clients

On this last point, Section 3 of HEA-56 required the Department to consult with affected stakeholders on the redesign, specifically on five (5) topics:

- Eligibility requirements for priority populations;
- The design of Essential Subsidy Payments (ESPs) to target and support geographic areas with limited access to mental health and substance use disorder services for the general population;
- The design of a pay-for-performance system that rewards providers for clients achieving outcomes that support independence and self-reliance;
- Implementation of a case management system to track outcomes; and,
- Delivery of housing and crisis shelter assistance to priority populations.

Section 3 reads:

(a) The department of health shall consult with affected mental illness and substance use disorder treatment providers and other stakeholder organizations as determined by the department regarding the reform and redesign of the state funded mental illness and substance use disorder treatment programs required under this act and other related topics, to include the following subjects:

(i) Eligibility requirements for receipt of state funding consistent with the priority populations as defined by W.S. 35-1-613(a) (xxii) as created under section 1 of this act;

(ii) Eligibility requirements for receipt of essential subsidy payments under W.S. 35-1-620(b) (x), as created under section 1 of this act, in order to target geographic areas with inadequate access for general access clients to mental illness and substance use disorder treatment providers. A methodology for establishing the manner in which, and amount in which, essential subsidy payments could be provided to eligible behavioral health centers and other eligible service providers shall also be considered under this paragraph;

(iii) A pay for performance program methodology and standards for priority populations as defined by W.S. 35-1-613(a) (xxii) and priority population tiers under W.S. 35-1-620(b) (ix) as created under section 1 of this act that rewards providers for administering the case management process as provided by paragraph (iv) of this subsection and for achieving outcomes that support independence and self reliance, including but not limited to:

(A) Prevention of psychiatric hospitalization;

(B) Prevention of reincarceration in an institution as defined by W.S. 7-13-401(a) (vi) or other penal institution;

(C) Competitive employment in an integrated setting, as provided under W.S. 9-2-1002(a) (xiii) and (xv);

(D) Independent housing.

(iv) Implementation of a case management process and applicable standards for continuing assessment, planning, treatment facilitation, care coordination and evaluation of priority populations to promote patient safety, quality of care and cost effective outcomes;

(v) Delivery of housing and crisis shelter assistance to priority populations to be provided by behavioral health centers.

(b) On or before September 1, 2021, the department shall report to the joint labor, health and social services interim committee on the discussions, findings and recommendations generated by the consultations required under subsection (a) of this section. As part of

the report, the department shall present recommendations on funds that could be repurposed to best implement the policy changes required under section 1 of this act and the recommendations contained in the report, which shall include identifying potential budget units from which funds could be repurposed, including but not limited to:

- (i) Unit 2506 (MH Outpatient);
- (ii) Unit 2507 (SA Outpatient);
- (iii) Unit 2508 (MH Residential);
- (iv) Unit 2509 (SA Residential).

(c) On or before September 1, 2025, the department of health shall report to the joint labor, health and social services interim committee and provide an update on the status of the department's administration of the reform and redesign of the state funded mental illness and substance use disorder treatment programs required under this act. The report shall include any recommendations for modifying the priority populations specified in W.S. 35-1-613(a)(xxii) or the priority populations tiers specified in W.S. 35-1-620(b)(ix) as created under section 1 of this act.

(d) The department of health and department of family services shall promulgate rules and regulations necessary to implement section 1 of this act by July 1, 2022.

Following the passage of HEA56, the Department of Health organized a series of meetings for the summer, in order to meet the September 1<sup>st</sup> reporting deadline.

Three primary groups were involved, to varying degrees, in each meeting:

**1. The Steering Committee.** This group recommended final policy decisions to the Department of Health for this report. Membership was comprised of three (3) Agency directors:

- Director Michael Ceballos / Interim Director Stefan Johansson - Department of Health
- Director Korin Schmidt - Department of Family Services
- Director Dan Shannon - Department of Corrections

... and four (4) Legislators:

- Rep. Lloyd Larsen - H54 - Chairman, Select Tribal Relations
- Rep. Sue Wilson - H07 - Chairman, House Labor
- Sen. Wendy Schuler - S15
- Sen. Troy McKeown - S24



**2. Affected Stakeholders.** This group worked with members of the Steering Committee and staff to provide input into the policy decisions. Membership included:

- Andi Summerville - Executive Director, Wyoming Association of Mental Health and Substance Abuse Centers
- All 14 WAMHSAC Center Directors
- Jen Davis, Wyoming Governor's Office
- Wyoming Department of Health, MHSA Section members
- Wyoming Department of Health, Health Care Financing

**3. Broader public;** i.e., anyone who was willing to attend the public portions of each meeting. The Department specifically invited the following organizations:

- Wyoming Hospital Association (and affected members)
- County Commissioners
- County Attorneys
- National Alliance on Mental Illness
- Protection and Advocacy
- Eastern Shoshone and Northern Arapaho Tribes

At the first meeting, the Steering Committee and Affected Stakeholder groups decided to tackle the redesign effort through the parallel effort of five working groups. These working groups included:

**1. Eligibility,** whose charge it was to create specific and actionable criteria for eligibility in rule and policy. These criteria included:

- Timeframes, diagnoses, criteria for each priority population;
- Required documents to substantiate;
- Verification of eligibility status, spot checks;
- Who submits applications;
- Role of providers vs. individual vs. State in process; and,
- Defining “step down” criteria — how do people leave priority population status? (i.e., they can't be on program forever).

**2. Transitions.** The objective of this group was to outline how priority populations, many of whom are being discharged from institutional settings, are “matched” with providers. Specific topics included:

- Institutional transitions and “warm” handoffs;
- Incentives for individuals to see providers;
- Role of State staff in arranging handoff;
- Role of law enforcement; and,
- Past HB31 efforts (DOC - WDH).

**3. Outcomes.** This group was intended to specify outcomes that State cares about, specifically:

- A list of outcomes that should be simple, measurable, and related to meaningful participation in the community (e.g. housed / employed / in school / on medication);
- Defining how the outcomes should be measured;
- Identifying who measures them; and,
- What kind of oversight and auditing takes place.

**4. Payment.** This group was intended to define how providers are paid and how much risk is borne by providers vs. the State. Potential topics included:

- Fee for service (claims processing);
- Outcomes-based payments;
- Block grants;
- Capitation;
- Essential Subsidy Payment design; and,
- Phase-in plan for new model.

Due to the importance of the payment topic, we ultimately decided not to form a specific workgroup, but to have a larger meeting with both Steering Committee and Affected Stakeholders dedicated to this topic.

As noted later in this report, not much progress was made on this front, simply due to lack of time.

**5. Partnership.** The purpose of this group was to flesh out the contractual relationship of the State to the centers. Questions included:

- Is any oversight required beyond outcomes? i.e., Service definitions? Provider qualifications? Quality standards?
- Building capacity for billing, receiving grants or accessing other funding sources.
- Potential ability to build statewide coordination capacity.
- Potential plow-back of demonstrated savings elsewhere (e.g. Title 25); and,
- Partnerships with other agencies - e.g. Workforce Services, housing authorities.

Due to a lack of specifics from other workgroups that might have informed these questions, however, this group only held two meetings.

These groups -- the Steering Committee, the Affected Stakeholders, and the various workgroups -- held a series of meetings throughout the summer, listed in Table 8, below.

**Table 8:** Behavioral Health Redesign meeting schedule - summer of 2021

Date	Location	Group	Purpose
4/9	Online	Steering Committee	Initial meeting to discuss framework, set schedule
5/4	Casper	All	First public meeting to decide on framework, establish working groups
5/11	Online	Eligibility	Work session 1
5/12	Online	Transitions	Work session 1
5/17	Online	Partnership	Work session 1
5/24	Online	Eligibility	Work session 2
5/26	Online	Transitions	Work session 2
6/1	Online	Partnership	Work session 2
6/7	Online	Eligibility	Work session 3
6/14	Online	Outcomes	Work session 1
6/18	Online	Outcomes	Work session 2
6/21	Online	Outcomes	Work session 3
6/29	Riverton	All	Second public meeting to review and discuss proposals made by work groups
7/13	Online	Eligibility	Work session 4
7/19	Online	Outcomes	Work session 4
7/22	Online	Eligibility	Work session 5
7/29	Online	Eligibility	Work session 6
8/9	Online	Outcomes	Work session 5
8/11	Online	Outcomes	Work session 6
8/17	Rawlins	All	Third public meeting to discuss payment issues
8/23	Online	Steering Committee	Meeting to discuss and approve report
8/25	Online	All	Final public meeting to present report

Progress on all topics was mixed, with certain areas (e.g., eligibility criteria and outcomes) being fleshed out more than others (i.e., payment, partnership).

Unfortunately, this summer's effort was **not** able to answer some of the questions required in Section 3 of HEA-56; i.e., how to reallocate current behavioral health funding.

Given the long history of the system and the complexity of the topic, fully developing the Behavioral Health Redesign will require a longer effort. The one-day meeting for payment model discussions, for example, did not result in agreement on how to move forward. While additional meetings may have helped, some of the questions (again, payment) were too important to be decided by a smaller subgroup.

The following three sections of this report — Eligibility, Transitions and Outcomes — describe the work completed during the Redesign effort. The subsequent section — Next Steps — outlines the remaining material that needs to be developed. The last section — Proposed Legislation — provides a draft bill for consideration by the Joint Labor, Health, and Social Services Committee.

# ELIGIBILITY

This section is largely the work of the Eligibility workgroup, with some comments from the Steering Committee. For each priority population defined in W.S. § 35-1-613, the tables below (a) parse the statutory definitions for priority populations to come up with a ‘plain language’ interpretation and delineate how eligibility could be specified and documented, (b) explores the complications and potential issues around the definitions, and, (c) in many cases, suggests statutory refinements.

The tables are structured along the tiers defined in W.S. § 35-1-620(a)(ix), to wit:

**Table 9:** Priority population tiers

Tier	Subgroup	Population
1	A	State-level justice involved
	B	Non-state level justice involved
	C	Families at high risk
	D	Adults with acute mental illness
	E	Adults with severe mental illness
2	-	Indigent clients with high needs
3	-	Indigent general access clients

Tier 1(A) - State-level justice involved	
Statutory definition	<p>W.S. § 35-1-613(a)(xxiii)</p> <p>"State level justice involved" means <i>persons that within the previous six (6) months</i> who have been released or paroled from an institution as defined by W.S. 7-13-401(a)(vi), released or discharged from a facility as defined under W.S. 7-11-301(a)(ii) and who require continuing treatment for a mental illness or substance use disorder;</p>
Plain language interpretation	<ul style="list-style-type: none"> <li>People on parole from Department of Corrections (DOC) institutions.</li> <li>People who are court ordered for Title 7 assessment to determine competency, restoration potential, or restoration.</li> </ul>
Eligibility criteria	<ul style="list-style-type: none"> <li>Timeframe - 6 months from date of release or discharge; to date client attended an intake/clinical assessment by provider.</li> <li>Criteria - Client is in need of “continuing” treatment for a mental illness or substance use disorder as evidenced by: <ul style="list-style-type: none"> <li>Referral for continuing care by in-prison treatment providers (substance use disorder or mental health provider); facilitated by probation or parole agent via warm handoff and:</li> <li>Assessment of the client by provider post-handoff indicates the need for continuing treatment.</li> </ul> </li> </ul>
Issues/questions	1. Regarding Title 7, how do people awaiting outpatient or inpatient forensic

	<p>evaluation who are sitting in jail get mental health treatment? HEA56 seems to focus on those discharged or released. With Title 7 forensic patients, there are generally three groups:</p> <ul style="list-style-type: none"> <li>▪ Pre-trial, in jail, awaiting Title 7 evaluation or transport. This is the group likely not eligible under this category; jails are supposed to provide care, but treatment offered varies and can be refused.</li> <li>▪ Post-restoration or post-evaluation, back in jail awaiting hearing/trial. Jails are supposed to provide care, but treatment offered can vary, and sometimes clients refuse treatment/medication in this situation.</li> <li>▪ Post T7 process, after adjudication. Small number of individuals, not a large issue.</li> </ul> <p>2. What are the required resources / relationships (e.g. county attorneys, sheriffs, judges) for community providers to treat (e.g. mandatory medication) individuals in jail? This is not an eligibility issue, but something that needs to be planned for.</p>
Working group recommended statute changes	<p>"State level justice involved" means <i>persons that within the previous six (6) months</i> who have been released or paroled from an institution as defined by W.S. 7-13-401(a)(vi), <del>released</del> or <u>are awaiting admission or evaluation from or have been evaluated by discharged from</u> a facility as defined under W.S. 7-11-301(a)(ii) and who require continuing treatment for a mental illness or substance use disorder;</p>
Steering Committee modifications	<p>The Steering Committee <b>concurs</b> with this change.</p>

Tier 1(B) - Non-state level justice involved	
Statutory definition	<p>W.S. § 35-1-613(a)(xxi)</p> <p>A. Persons who within the previous six (6) months have been placed on probation and made subject to an intensive supervision program under W.S. 7-13-1102 that includes treatment for a mental illness or a substance use disorder;</p> <p>B. Persons who within the previous six (6) months have been convicted of or pled nolo contendere to a criminal offense and ordered to enroll in an intensive outpatient treatment program for a mental illness or substance use disorder as part of their sentence;</p> <p>C. Persons on probation, parole or who have been conditionally released, who within the previous six (6) months have been sanctioned under</p>

	<p>W.S. 7-13-1802(b)(iv) through (vi) and ordered to receive treatment for a mental illness or a substance use disorder;</p> <p>D. Qualified offenders under W.S. 7-13-1301 through 7-13-1304 who within the previous six (6) months have been ordered to receive treatment for a substance use disorder.</p>
Plain language interpretation	<ul style="list-style-type: none"> <li>▪ Those on Intensive Supervised Probation who require any treatment.</li> <li>▪ Those convicted or who pled no contest to any criminal offense from any court, and ordered to receive intensive outpatient treatment for MI or SUD. <i>[Note: see “questions” and “statutory change recommendations” regarding this section]</i></li> <li>▪ Probation and parole clients who were sanctioned and ordered for any treatment for MI or SUD. Sanction options come about when the person is not completing treatment as required. Sanctions can only be done with felons.</li> <li>▪ Someone convicted of a felony (or 3rd DUI in 10 years) and who were assessed by the AOAA program and recommended for any treatment. This would include most of the people on supervised probation.</li> </ul>
Eligibility criteria	<ul style="list-style-type: none"> <li>▪ Timeframe - 6 months from court order or sanction order.</li> <li>▪ Eligibility Criteria - referral from probation or parole officer for those meeting conditions established in statutory definition.</li> <li>▪ Documentation - Referral from DOC probation/parole or court order.</li> </ul>
Issues/questions	<ul style="list-style-type: none"> <li>▪ The second of the four categories raised several questions: <ul style="list-style-type: none"> <li>○ Does the general language around conviction imply all courts? If so, this could be a large number of people. If this not intended, recommend clarification.</li> <li>○ Does the phrase “intensive outpatient treatment” imply a level of care from the statute versus a general emphasis on the need for treatment?</li> </ul> </li> <li>▪ Should pre-trial / misdemeanor / city court groups be included as a way to address issues before they get worse? Or does this expand the bucket too much?</li> <li>▪ Difficulty of counting/measuring people on unsupervised probation.</li> <li>▪ The legality of court ordering someone to treatment before they have been found guilty of a crime. This may happen as part of someone’s condition for release on pre-trial bond. If they fail to meet the condition they can be put back in jail.</li> </ul>

	<ul style="list-style-type: none"> <li>Recommendation: look at ways to track court referral sources (municipal/circuit/district) for all offenses for further decision making.</li> </ul>
Working group recommended statute changes	B. Persons who within the previous six (6) months have been convicted of or pled nolo contendere to a criminal offense and ordered to enroll in a <del>an intensive outpatient</del> treatment program for a mental illness or substance use disorder as part of their sentence;
Steering Committee modifications	The Steering Committee <b>concurs</b> with this change.

Tier 1(C) - Families at high risk	
Statutory definition	<p>W.S. § 35-1-613(a)(xvi)</p> <p>A. Children who have been discharged from an acute psychiatric facility or a psychiatric residential treatment facility within the previous six (6) months, and their immediate family members as defined by rule of the department of family services;</p> <p>B. A child or the parent, legal guardian or other immediate family member of a child, as defined by rule of the department of family services, who has been referred to a behavioral health center by the department of family services for treatment for a mental illness or a substance use disorder and the treatment is necessary to prevent the removal of the child from the child's home or to reunify the child with the child's family;</p> <p>C. A child who has been referred to a behavioral health center for treatment for mental illness or a substance use disorder that impacts the child's life and the treatment is necessary to prevent child's involvement in the judicial system.</p>
Plain language interpretation	<ul style="list-style-type: none"> <li>Kids being discharged from facilities like Wyoming Behavioral Institute (WBI), Saint Joe's and out-of-state Psychiatric Residential Treatment Facilities (PRTFs), or inpatient hospital settings.</li> <li>A child or the parent, legal guardian or other immediate family member of a child who has been determined by DFS to meet criteria as a "candidate for foster care," or any other child or family member engaged with DFS determined to be in need of services in order to resolve a current incident or divert from further judicial system involvement. This also would include the parent, legal guardian or other immediate family member of a child who is currently named in an active DFS case or is at</li> </ul>



	<p>risk of in an out-of-home placement.</p> <ul style="list-style-type: none"> <li>Families who show up at crisis centers prior to DFS involvement; i.e., non-DFS involved. This would often include referrals from schools, law enforcement, physicians/ER, and other community organizations that have contact with youth.</li> </ul>
Eligibility criteria	<ul style="list-style-type: none"> <li>Timeframe - 6 months from date of discharge</li> <li>Documentation - For Categories 1 and 2, referral from DFS. Category 3 would be determined at each behavioral health center based on referral.</li> </ul>
Issues/questions	<ul style="list-style-type: none"> <li>How would this work with private psychiatric facilities and family income/pay sources? Presumably these kids would be eligible under this statute, but they will be difficult to identify without coming forward.</li> <li>Subcategory C in the statute raises several questions - <ul style="list-style-type: none"> <li>Is eligibility to be referral-based or assessment-based or some combination? Simply using referral could increase the size of the population served under this category, but would get kids into services faster.</li> <li>Should referral sources be limited in statute or rule? I.e., youth crisis shelters, schools, law enforcement.</li> <li>How does “preventing child’s involvement in the judicial system” get evaluated? What kind of assessment is used to measure SED and at-risk of judicial involvement? Potential options: <ul style="list-style-type: none"> <li>- The ECSII (Early Childhood Service Intensity Instrument) for ages 0-5. ECSII and CASI used for Medicaid Children’s Mental Health Waiver.</li> <li>- CASII (Comprehensive Adolescent Severity Inventory) for ages 6-20. Not in public domain; use requires 2-day training.</li> <li>- DISC Predictive Scales (DPS) for ages 9-17</li> <li>- Global Appraisal of Individual Needs–Short Screener (GAIN-SS) for ages 12 and older.</li> <li>- Child and Adolescent Needs and Strengths (CANS) for ages 5 - 20.</li> </ul> </li> </ul> </li> <li>Generally speaking for Subcategory C, there is a tradeoff between comprehensive eligibility screening / processes and getting people treatment quickly. Potential options: <ul style="list-style-type: none"> <li>Trust that, based on referral source (e.g. school, crisis shelter,</li> </ul> </li> </ul>

	<p>SRO, group home, law enforcement), the assessments will bear out eligibility later.</p> <ul style="list-style-type: none"> <li>○ Potential period of presumptive eligibility for initial treatment in case of crisis. Similar to Screening Brief Intervention and Treatment (SBIRT).</li> <li>○ Take hard look at the upfront bureaucracy, eligibility processes.</li> </ul>
Working group recommended statute changes	
Steering Committee modifications	<p>The Steering Committee recommends that the suggestion from the working group regarding referral sources be adopted in statute, in order to narrow the scope of this population somewhat:</p> <p>C. A child who has been referred to a behavioral health center <u>by a youth crisis shelter, school, primary care provider, or law enforcement officer</u> for treatment for mental illness or a substance use disorder that impacts the child's life and the treatment is necessary to prevent child's involvement in the judicial system.</p>

Tier 1(D) - Adults with acute mental illness (Title 25)	
Statutory definition	<p>W.S. § 35-1-613(a)(xiv)</p> <p>"Adults with acute mental illness" means persons who are subject to an emergency detention under W.S. 25-10-109, an involuntary hospitalization order under W.S. 25-10-110 or a directed outpatient commitment order under W.S. 25-10-110.1, or who were released from an emergency detention or were discharged from an involuntary hospitalization or directed outpatient commitment order within the last six (6) months</p>
Plain language interpretation	<p>This means an adult who is detained or involuntarily hospitalized (IH), or under a directed outpatient commitment, or who were released from detention, IH, or directed outpatient commitment within the last 6 months.</p>
Eligibility criteria	<ul style="list-style-type: none"> <li>▪ Timeframe - 6 months from date of latest 3.81 or related examination or court order. The timeframe could be a moving target as the person progresses through the process.</li> <li>▪ Eligibility Criteria - Either someone had been detained/court ordered or not. Referred by State Hospital or Gatekeeper.</li> <li>▪ Documentation - 3.81 detention document for T25 and/or court order.</li> </ul>

Issues/questions	<ul style="list-style-type: none"> <li>▪ If lower level individuals who have a 3.81 detention document and are then released, the bar for this priority population group may be too low. Potentially require a higher level in the process; i.e., referral from gatekeeper.</li> <li>▪ How are tribal members adjudicated in Tribal Court under tribal code to be handled?</li> </ul>
Working group recommended statute changes	(a)(xiv) “Adults <u>subject to Title 25 with acute mental illness</u> ” means persons who are subject to an emergency detention under W.S. 25-10-109, an involuntary hospitalization order under W.S. 25-10-110 or a directed outpatient commitment order under W.S. 25-10-110.1, or who were released from an emergency detention or were discharged from an involuntary hospitalization or directed outpatient commitment order within the last six (6) months.
Steering Committee modifications	The Steering Committee <b>concurs</b> with this recommendation.

Tier 1(E) - Adults with severe mental illness	
Statutory definition	<p>W.S. § 35-1-613(a)(xv)</p> <p>"Adults with severe mental illness" means persons who, based on diagnosis and history, have a substantial probability of being unable to meet their needs for food, shelter and medical care if they do not receive regular mental health treatment or case management;</p>
Plain language interpretation	Someone not formally in the Title 25 process, but could end up there without treatment.
Eligibility criteria	<ul style="list-style-type: none"> <li>▪ Could use the old Severe and Persistent Mental Illness (SPMI) definition and eligibility checklist as a framework.</li> <li>▪ The Daily Living Activities-20 (DLA-20) score to substantiate functional impairment.</li> </ul>
Issues/questions	<ul style="list-style-type: none"> <li>▪ The title of this category does not fit into the standard federal definitions of “severe and persistent mental illness” (SPMI) or “serious mental illness” (SMI). The text of the definition comports with the SPMI category, but it may be OK to keep a state-specific definition.</li> <li>▪ Consider adding language from T25 here - “destabilization from lack of or refusal to take prescribed psychotropic medications for a diagnosed condition or serious physical disease will imminently ensue, unless the individual receives prompt and adequate treatment for this mental illness.”</li> </ul>

Working group recommended statute changes	"Adults with severe mental illness" means persons who, based on diagnosis and history, have a substantial probability of being unable to meet their needs for food, shelter and medical care <u>or are at risk of emergency detention under W.S. 25-10-109</u> if they do not receive regular mental health treatment or case management.
Steering Committee modifications	<p>The Steering Committee <b>does not concur</b> with this recommended change, for three reasons:</p> <ul style="list-style-type: none"> <li>▪ This addition would blur the line with the preceding category;</li> <li>▪ Defining how “substantial probability of being unable to meet their needs ...” will be complex enough without needing to specify an alternate pathway.</li> <li>▪ Subsequent tiers are likely to “catch” anyone falling through cracks in Tier 1.</li> </ul>

Tier 2 - Indigent clients with high needs	
Statutory definition	<p>W.S. § 35-1-613(a)(xx)</p> <p>Indigent clients with high needs" means persons who meet the definition of indigent general access clients under paragraph (xix) of this subsection and who have a mental illness or substance use disorder that substantially impairs their ability to function in society.</p>
Plain language interpretation	<ul style="list-style-type: none"> <li>▪ The definition regarding mental illness is very close to the federal definition of Severe Mental Illness (SMI), where the diagnosis substantially interferes with either work or home life.</li> <li>▪ A similar assessment for functional impairment of substance use disorder would be required.</li> <li>▪ In all cases, clients must be at or below 150% FPL, per indigent general access definition. The 2021 100% Federal Poverty Level (FPL) threshold for a single individual is \$12,880, so 150% FPL would correspond to an income of \$19,320.</li> </ul>
Eligibility criteria	<ul style="list-style-type: none"> <li>▪ The SMI diagnosis is more straightforward; need assessment for Substance Use Disorder (SUD) that offers the ability to measure substantial impairment to functioning in society. Options include: <ul style="list-style-type: none"> <li>○ The Addiction Severity Index (ASI) or American Society of Addiction Medicine (ASAM) placement criteria.</li> <li>○ PHQ 9.</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>○ SASSI-4. A positive indication on the SASSI is related to <i>likelihood of substance use disorders</i>. Accuracy is 92% based on studies. Does not require clinical assessment, but does require interpretation. Takes about 15-20 minutes to complete.</li> <li>○ TCU Drug Screen 5 - scoring relates to DSM criteria for substance use disorders. Appears to be inclusive of alcohol use disorders, and has an opioid supplement set of questions</li> <li>○ DAST-20 (Drug Abuse Screening Test) - 20 questions, scores of 1-5 suggests mild disorders and 6+ suggest moderate/severe. Self-administered, requires interpretation.</li> <li>○ Michigan Alcohol Screening Test (MAST) - 25 questions, scores of 1-3 normal, 4 indicates possible problem, 5-7 suggests substance use disorder, 8+ suggests dependence.</li> <li>○ ASSIST (from World Health Organization) - administered by a screener. Used for both alcohol and other substances and is specific to substance. Distinguishes between low risk of health problems related to substance use and moderate-high risk.</li> </ul> <ul style="list-style-type: none"> <li>▪ For clients continuing in treatment, a biopsychosocial assessment would still need to be completed.</li> </ul>
Issues/questions	As with other groups, there is a tension between conducting eligibility processes/intake and getting individuals into treatment quickly.
Working group recommended statute changes	<p>No statute changes, but recommend in policy/rule:</p> <ul style="list-style-type: none"> <li>▪ An ability to begin treatment with a quick screen (e.g., SBIRT-like process) before a full-blown assessment.</li> <li>▪ Need to identify a quick screener for mental health.</li> </ul>
Steering Committee modifications	The Steering Committee <b>concurs</b> with these recommendations.

Tier 3 - Indigent general access clients	
Statutory definition	<p>W.S. § 35-1-613(a)(xix)</p> <p>"Indigent general access clients" means persons who do not have private or public health insurance that provides coverage for mental illness or substance use disorder treatment and whose total household income is not more than one hundred fifty percent (150%) of the federal poverty level</p>
Plain language interpretation	The rationale for the 150% FPL cutoff was that, between 100% - 200% of the FPL, individuals are eligible for Cost Sharing Reduction (CSR) subsidies as well as Advance Premium Tax Credits (APTCs).

Eligibility criteria	Straightforward income verification through consolidated eligibility applications. Documentation similar to Medicaid application.
Issues/questions	<ul style="list-style-type: none"> <li>▪ The working group had some concerns with the 150% cutoff. For Behavioral Health Centers, a sliding fee scale must be available for individuals below 200% to qualify as a National Health Service Corps site, as well as Certified Community Behavioral Health Center.</li> <li>▪ There were also concerns about how generous (or not) insurance coverage may be, given cost sharing requirements.</li> </ul>

# TRANSITIONS

The objective of the transitions workgroup was to outline how various priority populations would enter into the community behavioral health system.

Figure 7, below, illustrates the four different types of transitions that might occur in the new system: (1) planned discharges from State-operated institutions, (2) planned discharges from non-State institutional settings, (3) “drop offs” during a crisis and (4) routine “walk ins”.

**Figure 7:** Transitions flowchart

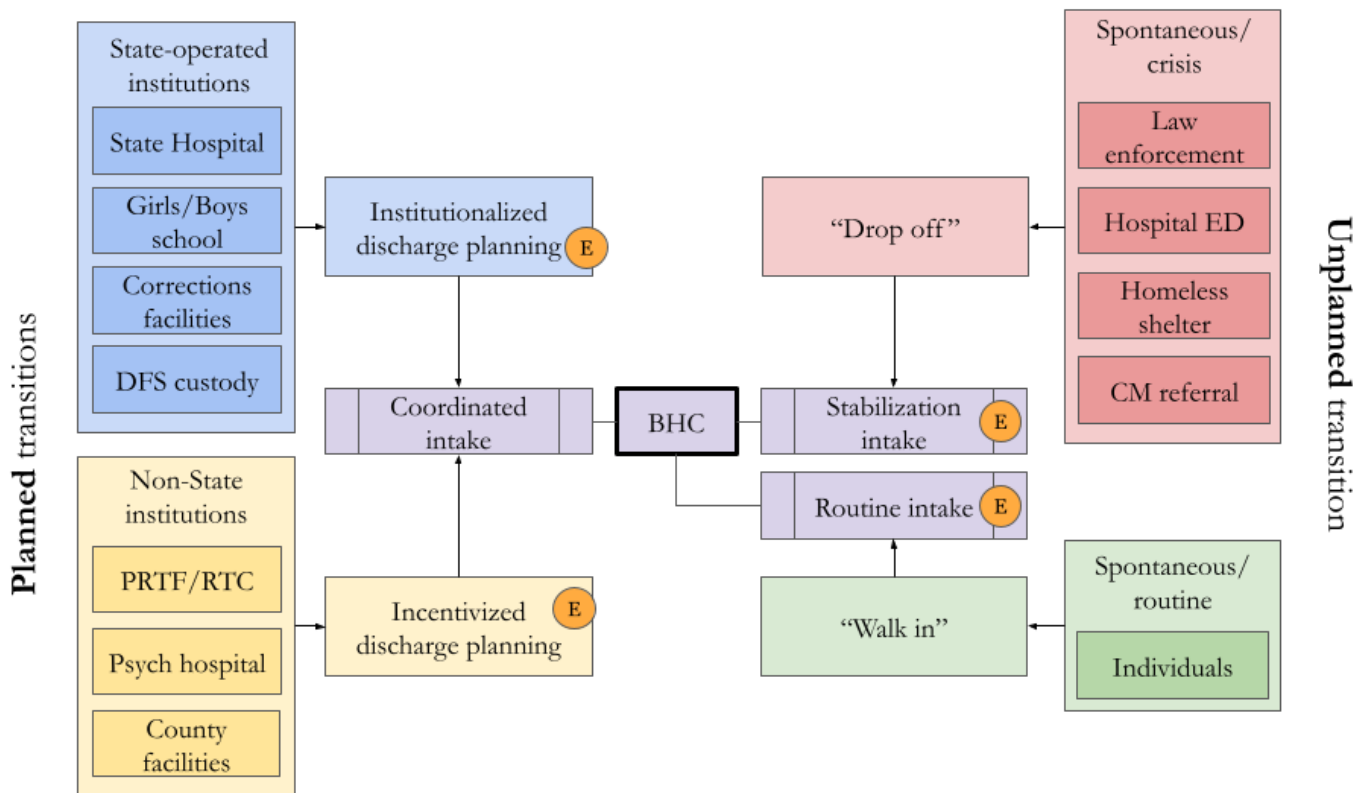


Table 10, on the next page, describes the types of transitions and the corresponding intake procedures at the Behavioral Health Center (BHC) shown above.

Note, in orange on both the figure above and the table on the next page, where **eligibility processes** will take place. For planned discharges, for example, eligibility paperwork would be completed while the person is still in the institution. Crisis eligibility would be done by the Center after the person was stabilized, and eligibility for routine ‘walk-ins’ would be done during intake.

**Table 10:** Types of transitions

Transition type			Intake type	
Planned	Institutionalized	<ul style="list-style-type: none"> <li>State staff at DOC/WDH/DFS institutions initiates discharge planning.</li> <li>Most appropriate (e.g., closest, availability, what person prefers) BHC arranged as “preferred provider”.</li> <li>State staff coordinates <b>eligibility application</b> before discharge.</li> </ul>	Coordinated	<ul style="list-style-type: none"> <li>BHC involved with institution in discharge planning at least 2 weeks before discharge.</li> <li>Records transfer, intake and eligibility processes happen while member still institutionalized.</li> <li>Warm handoff upon discharge; intake should already be complete.</li> </ul>
	Incentivized	<ul style="list-style-type: none"> <li>Private providers required to initiate discharge planning and notify State for eligibility processing as part of payment for episode.</li> <li>State staff coordinates <b>eligibility application</b> before discharge.</li> </ul>		
Spontaneous	“Drop-off”	<ul style="list-style-type: none"> <li>Short/no notice, often in crisis</li> <li>Want to make it as easy as possible for community partners (e.g. law enforcement) to use BHC.</li> </ul>	Stabilization	<ul style="list-style-type: none"> <li>Immediate treatment and discharge planning in facility (ED/jail) or at BHC facility.</li> <li>Comprehensive and rapid case management to de-escalate crisis, with assigned person responsible</li> <li>BHC coordinates <b>eligibility application</b>.</li> </ul>
	“Walk-in”	<ul style="list-style-type: none"> <li>Similar to status quo with non-priority clients</li> </ul>	Routine	<ul style="list-style-type: none"> <li>Whatever BHC does for other clients, except BHC coordinates <b>eligibility application</b> for State clients.</li> </ul>



# OUTCOMES

The primary deliverable of the outcomes working group was to develop a framework of indicators that might allow the State to measure the potential benefit its dollars are providing.

Figure 8, below, shows the logic model for thinking about the different types of indicators. The diagram is intended to be read from left to right, with structural and process indicators supporting intermediate outcomes of client engagement and symptom reduction, with the ultimate goal of supporting outcomes related to community integration.

**Figure 8:** Logical framework for thinking about outcomes

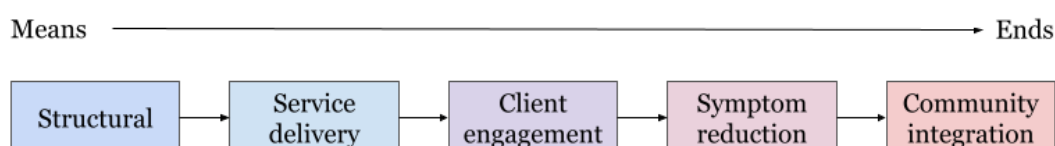


Table 11, below, shows the list of outcomes developed and agreed to by this working group. The outcomes are listed by the categories shown in the figure above, and are meant to indicate the measurements that the working group believed were important for the State to capture.

The details of how these might be measured, who would measure them, for which populations and at what frequency they'd be measured, and how payment might be connected were not settled by the time of this report.

**Table 11:** Recommended outcomes to be tracked

Outcome	Category	Notes
Accreditation (CARF)	Structural	Simple yes/no for each center, each contract period.
Availability / Accessibility		Verification of hours of operation (telehealth and in-person) for each contract period.
Wait time before first actual treatment	Service delivery	This could be calculated by collecting referral date, first visit date, assessment date and first treatment dates (outpatient / residential), either in outcomes tracking system or utilization/claims data.
Emergency Department (ED) visits	Client engagement	This will be more difficult to measure, but could be captured by the State through administrative claims data (e.g. Medicaid) or an Admit-Discharge-Transfer

		(ADT) system feed.
Consumer satisfaction		Currently required in State contracts. Instrument to measure this to be determined.
Functional assessment	Symptom reduction and functional improvement	Instrument to be determined, but DLA-20 is good candidate.
Residential level of care		Instrument to be determined, but LOCUS is a good candidate
Employment / volunteering status	Community integration	Measured in discrete categories (e.g. part-time, full-time, full-time competitive/integrated, unemployed, volunteering, not in labor force, etc.)
Housing status		Measured in discrete categories (homeless, supported housing, fully-independent)
School attendance		Similar to employment measures, but for children.
Court involvement in child placement		DFS identification/referral, assessed at the family unit (i.e., including parents and children).
Re-incarceration		Tracked by Department of Corrections
Probation/parole incidents		Sanctions short of re-incarceration. Tracked by Department of Corrections
Psychiatric hospitalization (adults) or residential treatment (adolescents)		Tracked by Department of Health

# NEXT STEPS AND RECOMMENDATIONS

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Obviously, the work required by HEA 56 is incomplete at this point. Despite the aggressive meeting schedule and acknowledgement that the work will continue throughout the remainder of the year, there was not enough time in this summer's meetings with affected stakeholders to address some of the most important questions of the redesign, including:

- How the "Essential Subsidy Payments" would be allocated;
- How the "pay for performance" (i.e., outcomes-based payments) would function;
- How residential services would be integrated into the design; and,
- How existing funding could be re-purposed.

The redesign groups did have some initial discussions on overall payment allocations. During July, the Department conducted a survey of workgroup members, and received 27 responses. The survey asked members to allocate a hypothetical total funding of \$100 among three different buckets:

1. **Fixed, or "base", payments** would be block grants made to centers for "keeping the lights on and doors open." In other words, if the center contracts with the State, we would pay them a lump sum of money for the year just to be open. The payment would not be connected to the amount of people they see or services they provide. In many cases, fixed payments would be used to subsidize the operations of providers in very rural areas, where patient volume may not be high enough by itself.

Advantages of fixed payments include:

- Fixed payments are predictable (i.e., "fixed") for both the State and providers.
- They require little administration (i.e., no billing).
- They create incentives against over-provision of services.

Disadvantages include:

- The incentive against volume cuts both ways. Since they are made regardless of patients seen or services provided, fixed payments do not incentivize the actual provision of care.

2. **Service-based payments** are the traditional way we reimburse medical providers. There are a range of payment models, with various advantages and disadvantages. The most common model is "fee-for-service" (FFS): you go to the doctor, your insurance pays \$120 for the visit. The doctor orders a test, your insurance pays another \$100. You pick up a prescription, and your insurance pays \$200. Drop in a token, look at a duck. Etc.

Advantages of service-based payments, in this case, fee-for-service, include:

- Strong incentives for service delivery, so people with high needs will usually receive adequate care.
- Fee-for-service billing data for services is very granular, and can provide a lot of data on patient diagnoses, services provided, etc. Data collected this way (e.g., tied to a payment) tends to be more reliable than data gathered in other ways.

Disadvantages include:

- The incentives towards volume can encourage overutilization. Different service-based payment methods may reduce this incentive, but bring their own issues.
- Billing and processing claims creates significant administrative overhead for both provider and payer.

3. **Outcomes-based payments** are relatively uncommon in health care. These would reward providers for achieving pre-defined outcomes in their clients. Examples include: being housed, not being in jail, going to school, being employed. Other outcome measures might reward providers for achieving process measures.

Advantages of outcomes-based payments include:

- They obviously incentivize performance towards achieving patient outcomes, which is, in theory, what the State wants.

Disadvantages include:

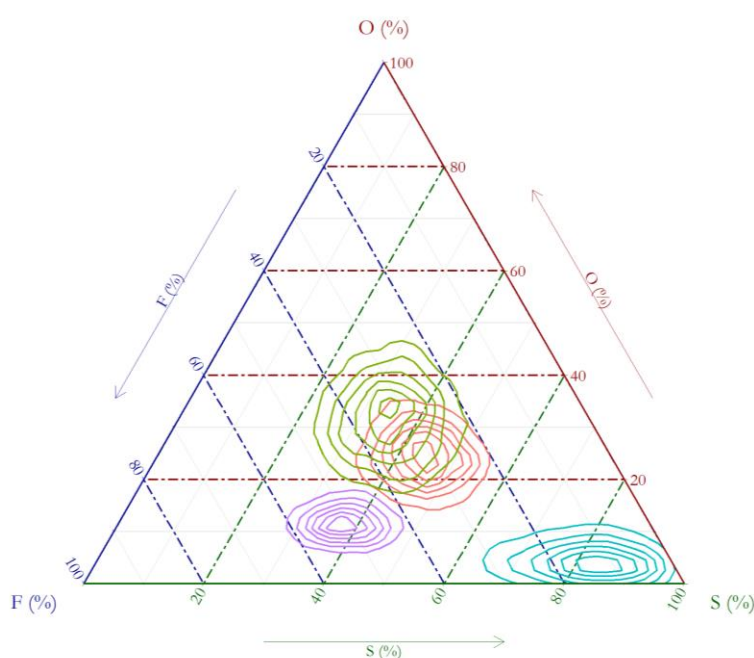
- These payments put significant risk on providers. Many outcomes that the State may care about (e.g., being housed) may not be fully under the provider's control.
- Defining and measuring the outcomes can be very complex.

The average for all 27 survey responses was a mix of 40% fixed payments, 40% service payments and 20% outcomes payments. These responses, however, differed by group. And these differences are shown on Figure 9, on the next page.

Figure 9 is known as a “ternary plot.” It graphically depicts an allocation of three variables that sum to a constant 100% (i.e., 40% + 40% + 20% = 100%). These plots are often used in metallurgy, geology, chemistry and soil science to show how various materials are made up of certain elements. In this case, it depicts the allocation of funding for the behavioral health system among the fixed (“F%”), service-based (“S%”), and outcomes (“O%”) payments.

The way to read Figure 9 is to look at how the axis colors (red, blue and green) correspond to the points of the triangle. The outcomes percent (“O%”) at the top of the triangle, for example, is read from the red axis starting on the bottom right corner.

**Figure 9:** Survey responses for overall payment allocation for legislative committee members (green), executive branch members (red), WAMHSAC provider members (purple) and other non-WAMHSAC providers (blue).



Note on the figure that the average for all responses -- 40% fixed (blue), 40% service (green) and 20% outcomes (red) is bracketed by the three main stakeholder groups that participated in the survey. Generally speaking, WAMHSAC members preferred more fixed, legislators preferred more outcomes, and executive branch members preferred more service-based payments. The two non-WAMHSAC providers that responded (blue) preferred almost entirely service-based payments.

Accordingly, the Department of Health makes the following recommendations for structuring future redesign efforts:

1. **The overall allocation of funding for the behavioral health system should be split according to the survey average: 40% fixed, 40% service and 20% outcomes.** For a system currently funded with approximately \$45 million annually, this would mean \$18 million in fixed payments, \$18 million in service-based payments, and \$9 million in outcomes-based payments.
2. **Fixed payments should include both Essential Subsidy Payments for a limited set of providers and base payments for all providers.**

- The distribution of Essential Subsidy Payments should be determined according to to-be-determined criteria based on the requirements of W.S. § 35-1-620(b)(x).
- The amount of Essential Subsidy Payments for each site location should be prospective (i.e., not based on specific site costs) and reflect the following factors:
  - The average annual overhead cost for sites to “keep the lights on and the doors open”, multiplied by:
  - An independently-determined and standardized regional cost adjustment (e.g., from the Economic Analysis Division or Department of Education).
- The total amount allocated for Essential Subsidy Payments would reflect the number of sites eligible times the per-site amount. Base payments would then be the amount remaining after Essential Subsidy Payments are taken out of the \$18 million “fixed payment” bucket.

**3. Service-based payments should be implemented along the following principles:**

- Payments should be processed using existing State infrastructure that can be modified relatively easily;
- Service rates should not create incentives for skewed utilization; i.e., the rates should be proportional to the relative cost of providing each service.
- Payment administration should minimize duplication and burden on providers;
- Payments should maximize other pay sources, including Medicaid and private insurance, in order to stretch State General Fund dollars.

**4. Outcomes-based payments should be implemented gradually and rigorously evaluated.**

- Instead of beginning with a 20% allocation, the Department would propose making this 10% initially (reverting the other 10% to service or fixed), and using these funds to conduct a pilot study on the effectiveness of paying for outcomes.
- The pilot should use a limited set of easily-collected outcomes data (e.g., recidivism or involuntary hospitalizations are already known to the State), be limited to a subset of priority populations; and be conducted in a randomized controlled way (e.g., splitting the eligible priority populations in half) in order to ensure we can interpret results as **causing** the observed effects, not merely **associated** with them.

# PROPOSED LEGISLATION

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During the Behavioral Health Redesign effort over the summer, workgroups noted areas in statute that would benefit from minor revisions in the eligibility definitions.

Additionally, both the Steering Committee and Affected Stakeholder groups recognized that the Redesign will require additional time for discussions before statutory changes and rules should be implemented.

The Steering Committee also suggests that the Legislature be offered an opportunity to concur with (or reject or modify) the recommendations contained in this report.

The proposed bill draft below therefore attempts to capture these three requirements. Section 1 carries out the amendments to the statutory definitions of priority populations, Section 2 amends the implementation date requirements from HEA 56, now in Session Law, Section 3 provides concurrence with this report, and Section 4 requires the Department of Health to develop and provide cost estimates for system implementation (using ARPA dollars) for consideration in the 2023 General Session.

Behavioral health redesign

Sponsored by: Joint Labor, Health and Social Services Committee

## A BILL for

AN ACT relating to public health and safety; amending provisions related to community health services; amending the categories of persons to receive state funded mental illness and substance use disorder services; continuing the select committee on mental health and substance abuse; requiring reports; and providing for effective dates.

Be It Enacted by the Legislature of the State of Wyoming:

**Section 1.** W.S. 35-1-613(a) (xiv), (xvii), (xxi), and (xxiii) are amended to read:

35-1-613. Definitions.

(a) As used in this act:

(xiv) "Adults subject to Title 25 with acute mental illness" means persons who are subject to an emergency detention under W.S. 25-10-109, an involuntary hospitalization order under W.S. 25-10-110 or a directed outpatient commitment order under W.S. 25-10-110.1, or who were released from an emergency detention or were discharged from an involuntary hospitalization or directed outpatient commitment order within the last six (6) months.

(xvii) "Families at high risk" means:

(A) Children who have been discharged from an acute psychiatric facility or a psychiatric residential treatment facility within the previous six (6) months, and their immediate family members as defined by rule of the department of family services;

(B) A child or the parent, legal guardian or other immediate family member of a child, as defined by rule of the department of family services, who has been referred to a behavioral health center by the department of family services for treatment for a mental illness or a substance use disorder and the treatment is necessary to prevent the removal of the child from the child's home or to reunify the child with the child's family;

C. A child who has been referred to a behavioral health center by a youth crisis shelter, school, primary care provider, or law enforcement officer for treatment for mental illness or a substance use disorder that impacts the child's life and the treatment is necessary to prevent child's involvement in the judicial system.

(xxi) "Nonstate level justice involved" means:

(A) Persons who within the previous six (6) months have been placed on probation and made subject to an intensive supervision program under W.S. 7-13-1102 that includes treatment for a mental illness or a substance use disorder;

(B) Persons who within the previous six (6) months have been convicted of or pled nolo contendere to a criminal offense and ordered to enroll in an ~~intensive outpatient~~ treatment program for a mental illness or substance use disorder as part of their sentence;

(xxiii) "State level justice involved" means persons that within the previous six (6) months who have been released or paroled from an institution as defined by W.S. 7-13-401(a)(vi), ~~released~~ or are awaiting admission or evaluation from or have been evaluated by discharged from a facility as defined under W.S. 7-11-301(a)(ii) and who require continuing treatment for a mental illness or substance use disorder;

## **Section 2.**

Section 3(d) of Chapter 79 of the Session Laws from the 2021 General Session is amended to read:

(d) The department of health and department of family services shall promulgate rules and regulations necessary to implement section 1 of this act by July 1, 202~~2~~<sup>3</sup>.

Section 4(a) of Chapter 79 of the Session Laws from the 2021 General Session is amended to read:



(a) Except as otherwise provided by subsection (b) of this section, this act is effective July 1, 202~~2~~3.

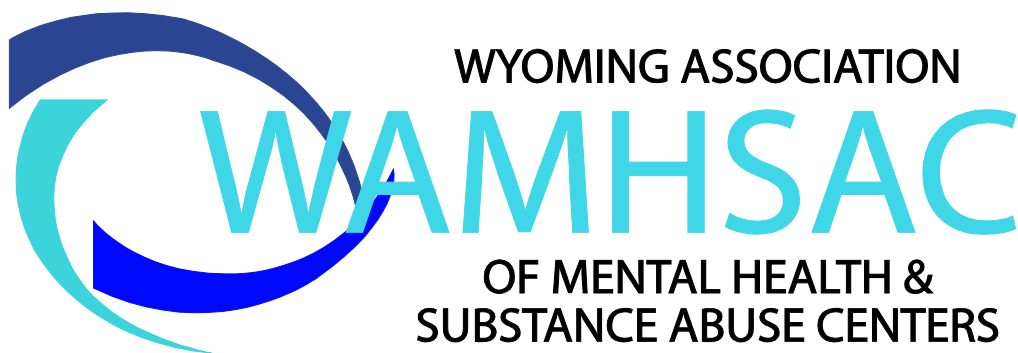
### **Section 3.**

The legislature concurs with the recommendations of the September 1, 2021 Behavioral Health Redesign Initial Report, on file with the legislative service office.

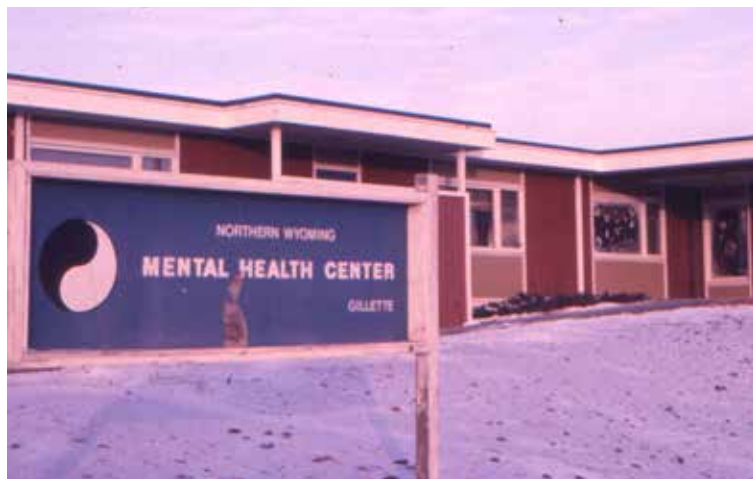
### **Section 4.**

It is the intent of the legislature that the department of health submits exception requests from federal funds made available from the American Rescue Plan Act, P.L. 117-2, to develop the provider capabilities, claims processing, eligibility determination, and outcomes infrastructure capabilities required to implement the behavioral health redesign.

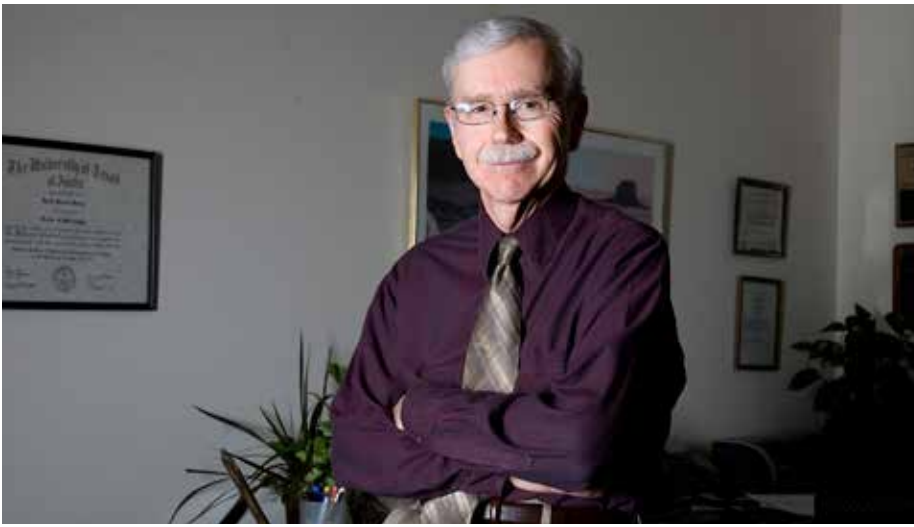
# Attachment A



## A 60 YEAR HISTORY 1950-2010







# President's Message

*Photo by Wyoming Tribune-Eagle*

Dear Friends,

The member centers of the Wyoming Association of Mental Health and Substance Abuse Centers (WAMHSAC) have been serving the people of Wyoming for over 50 years. Our members serve over 25,000 people each year and are the foundation for mental health and substance abuse care in Wyoming. However, it has not always been so. Each of our centers began as small organizations that grew into our current system through the united strength that has been WAMHSAC. Mental health care has always been a “hard sell” and we have not come to where we are by accident.

A while back, many of us came to realize that the history of Wyoming’s mental health care system was being lost as those who lived it were retiring. So we compiled this document to capture some of what has happened over the years, as well as some of the stories of those who were most instrumental. This is primarily an anecdotal history. Our goal was to capture not just the facts, but also the flavor of what has occurred. Our history is rich with personal stories. Our hope is that as mental health care continues to develop, future members will be able to use this document to reflect back and better understand how we got here.

My own experience with WAMHSAC began in 1990. I had just become Director of Southeast Wyoming Mental Health Center (later Peak Wellness Center). A colleague at Southeast, Bill Quinn, told me I needed to attend the next WAMHSAC meeting in Casper. The former Director, Ray Muhr, had been a very active member and felt that WAMHSAC participation was essential for our center. So, I pulled out a map and found Casper on it. I was appalled to discover it was 180 miles away. I would later learn that in Wyoming that was a short drive. I really don’t remember very much about the meeting except its tone. Mike Huston, the Director in Casper, was the chair. Whatever was being discussed was contentious in some way and he was cussing with an “energy” that I had rarely witnessed. I remember not understanding why the conversation was so heated.

I later came to understand that what I was seeing was commitment – a passionate commitment for the work, for the clients, for the system of care. A lot of people have really, really cared about what we do and worked very, very hard to get us where we are today. I now understand that commitment was essential for the long uphill climb that has been mental health care in Wyoming.

**David Birney, Ph.D.**  
**WAMHSAC President**





Some of the brains behind this project at a Sept. 16, 2011 meeting in Casper. The meeting with WAMHSAC on this history project included: Allan Braaten, Dr. Don Rardin, Carol Day, John C. McMahan, Mike Huston, and Jerry Iekel. Dr. David Birney is not pictured. *Photo by Rachel Girt.*

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**At one time, the Wyoming State Hospital served over 500 patients a day because there was nowhere else to go for mental health services in the state. *Photo from WAMHSAC archives.***

## 1955

Gov. Milward L. Simpson appointed members to the Mental Health Survey Committee

## 1956

The Mental Health Survey results painted a picture of marked deficiencies in mental health services available in Wyoming.

## 1957

Wyoming Statutes provided for the establishment and operation of joint community health boards.

## 1961

Wyoming Legislature passed the Community Mental Health Services Act establishing community mental health services with state funding not to exceed 50 percent of total expenditures.

## Setting the Stage for Community-Based Care

**W**hile much of the impetus for community-based care can be attributed to a grassroots push by Wyoming residents from a number of communities, events in the 1950s and the 1960s, some on the national level and some in Wyoming, sparked the development of community mental health centers in the state.

In the 1950s, a national push to better address mental health heightened awareness in Wyoming. That, combined with advances in psychopharmacology and the introduction of more effective antipsychotic and anti-depressant medications, helped start changing the lives of people with mental health disorders for the better.

To better evaluate the status of mental health needs and services, Gov. Milward L. Simpson appointed members to the Mental Health Survey Committee with Dr. Franklin D. Yoder, then director of the Wyoming State Department of Public Health as chairman, in May

*Continued on page 5.....*

# 1960s

**“Before the community mental health centers, seriously mentally ill were sent to the Wyoming State Hospital to live out their lives. The State Hospital then had a lot of people, around 500, but now it is around 80.”**

***-Dr. Don Rardin, former director of Fremont Counseling Center***

of 1955. The committee conducted a survey to seek the facts and opinions regarding mental health from citizen clubs and organizations and local public school personnel.

The survey results, published in a 1956 report, painted a picture of marked deficiencies in mental health services available in Wyoming. The survey highlighted that no single agency in the state was responsible for planning the state's treatment and prevention programs, encouraging and coordinating mental health research, and meeting the state's needs for mental health services overall.<sup>1</sup>

At the time, mental health services were very limited in the state. The Board of Charities and Reform had administrative control of the Wyoming State Hospital, the Wyoming State Training School, the Wyoming Industrial Institute and the Wyoming Girl's School. The Wyoming Department of Public Health offered the only prevention and clinical service type of mental health program in the state. The one privately practicing psychiatrist in Wyoming worked part-time for the Department of Public Health in the Mental Health Program. Additionally, the State Hospital, the State Training School and the Veterans Administration Hospital in Sheridan were the only three institutions offering diagnosis and treatment for the “mentally ill or mentally defective.”<sup>2</sup>

In the survey, the majority of the professional respondents agreed that mental health was the state's most pressing health need. They also identified three main problems: a general unawareness of the mental health problem; a serious shortage of social workers, lay workers and voluntary workers in the state; and no outpatient clinics for the follow-up of discharged mental patients from the state hospital.<sup>2</sup>

The survey set the stage for a push for efforts to establish a system of care in communities. In 1957, Wyoming legislation provided for the establishment and operation of joint community mental health boards. In 1958 the Sheridan Mental Hygiene Clinic was opened as an evening clinic as a result of the funding efforts of the Sheridan Mental Health

## 1963

When President John F. Kennedy signed the Community Mental Health Act of 1963, Congress appropriated federal funding to initiate a community mental health system, as an alternative to institutionalization.

Gov. Clifford Hansen appointed members to the Governor's Planning Commission on Mental Health to appraise the state's mental health needs and develop recommendations.

## 1965

Regionalization came out of *As Wyoming Sows*, published in 1965, as did funding prioritization based on need and population.

## 1966

Sheridan, Johnson, Campbell, Weston and Crook counties signed a cooperative multi-county agreement with the Northern Wyoming Mental Health Center for mental health services in the northeast region.

## 1969

The legislature created the Department of Health and Social Services which included Mental Health and Mental Retardation Services under the Division of Health and Medical Services.

*Continued on page 6.....*



## Wyoming First Lady Win Hickey



*Photo from State of Wyoming Archives.*

First Lady Win Hickey was very instrumental in getting mental health centers going in Wyoming, said John McMahan, who joined Northern Wyoming Mental Health Center in 1967.<sup>3</sup> She was such a strong advocate and educator who raised public awareness about mental health and the need for a strong state mental health association. She served as one of the early presidents of the Wyoming Association for Mental Health.

Hickey's husband Joe Hickey was elected governor of Wyoming in 1958, serving until 1961 when he was appointed to the U.S. Senate. After her husband died in 1970, Hickey, a Democrat, pursued politics. She was the first woman elected Laramie County commissioner and also the first woman elected to the state senate from the county. "Her life reflected the true values of commitment to God, country and family," her son Paul Hickey said in an interview after her death in April 2007. "If she took on a cause, she took it on with great passion."<sup>8</sup>(Associated Press, 2007)

**"For Wyoming, deinstitutionalization meant returning patients to small, rural communities, most of which didn't have much in terms of trained mental health providers."**

**-Mike Huston, former director of Central Wyoming Counseling Center**

Association, according to John McMahan, former director Northern Wyoming Mental Health Center.<sup>3</sup> In 1959, Central Wyoming Counseling Center opened.

By 1961, those efforts along with other initiatives in the state culminated in the Wyoming Legislature passing the Community Mental Health Services Act, which established community mental health services. The act authorized the Wyoming Department of Public Health through the Division of Mental Health to enter into contractual agreements for services and defined community mental health boards as agencies of county or municipal governments.<sup>4</sup>

The Division of Mental Health created a manual *Establishing and Financing Community Mental Health Services in Wyoming* to assist individuals or groups who had an interest in establishing a local community mental health center. In the manual, the division outlined that its philosophy of local participation "is that the most effective mental health programs are those that are community-based; community-administered; and, community-financed."<sup>5</sup>

Federal funding soon came Wyoming's way to help grow community mental health centers. When President John F. Kennedy signed the Community Mental Health Act of 1963, Congress appropriated federal funding to initiate a community mental health system, as an alternative to institutionalization. The Northern Wyoming Mental Health Center was the first multi-county center in Wyoming to be federally funded under the staffing grants, said Jerry Iekel, former director of the center. Southeast Wyoming

*Continued on page 7.....*



# 1960s

Mental Health Center, now known as Peak Wellness Center, also received some of those initial funds. Central Wyoming Counseling Center refused the federal staffing grant.<sup>6</sup>

“The federal staffing grants provided Wyoming with the guidelines for what a mental health center should look like and what services should be offered,” said Dr. Don Rardin, former director of Fremont Counseling Center in Lander. “When Fremont County received the first staffing grant, which lasted for eight years, our center became more than a part-time office with limited services,” he said.<sup>7</sup> Eventually, these grants had a lot of influence on those centers that received the funds, on the structure of those centers that didn’t receive the funds and on the state offices thinking about the structure.

At the time, the Wyoming State Hospital served over 500 patients a day, said Mike Huston, former director of Central Wyoming Counseling Center. “For Wyoming, deinstitutionalization meant returning patients to small, rural communities, most of which didn’t have much in terms of trained mental health providers. Often these patients turned to family doctors, did not receive help or, in extreme cases, became homeless.”<sup>9</sup>

In 1963, the Sheridan Mental Hygiene Clinic signed a small start-up contract with the State of Wyoming to support the delivery of services and the development of a regional consortium in northern Wyoming that included Sheridan, Crook, Weston, Johnson and Campbell counties.

With Wyoming having the second highest suicide rate in the nation and a growing number of patients with psychiatric problems, key physicians in the northern region became strong advocates for the development of mental health services. They were concerned about sending patients in need of psychiatric services away from their home communities and over long distances to the Wyoming State Hospital or to private services in Denver or Billings, MT.<sup>10</sup>

Although representative physicians from each of the counties in the northeastern region were actively supporting the development of regional mental health services, as were physicians in other areas of the state, support was not universal, and initially the Wyoming

**“During the 1960s, people didn’t always seek help because of the stigma and adherence to an individualistic philosophy of taking care of ourselves and not seeking help dealing with depression or when things fall apart. When I used to have a tinderbox office just off of Main Street in Newcastle in 1971, many patients used to enter the office through the alley and through the janitor’s closet to avoid being seen coming in the front door.”**

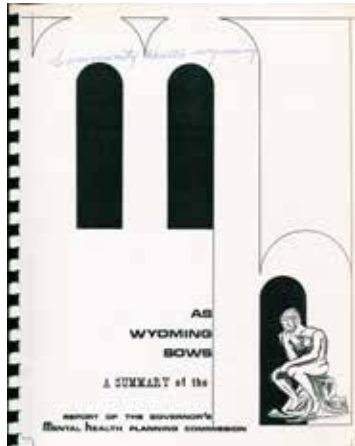
**- Jerry Iekel, former director of Northern Wyoming Mental Health Center<sup>6</sup>**

Medical Society lobbied against public support of programs for the mental health clinics. This resistance abated over time as successful programs were established.<sup>3</sup>

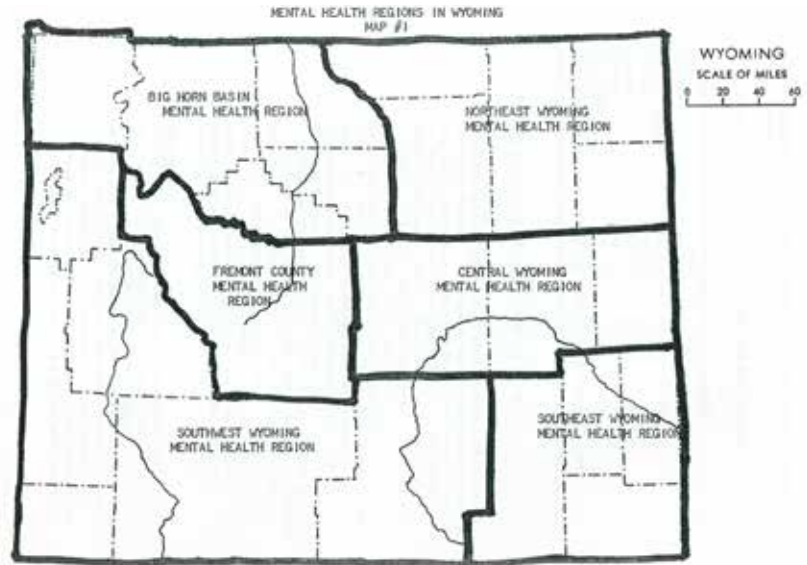
McMahan discussed the challenges faced by those starting mental health services in the communities. In the early developmental years of the community mental health centers in Wyoming, outpatient services were housed in side-street, store-front locations, office buildings, county court houses, medical clinics and residential dwellings. Offices were located in the county-seat, with outreach to towns and smaller communities offered on an intermittent basis in school facilities or churches.

McMahan explained that professional relationships tended to become very personal and based upon the trust and respect level that the mental health professional was able to establish within the community with law enforcement, physicians, hospital staff, judges, school teachers, and Wyoming Department of Public Assistance (what is currently known as Department of Family Services), etc.

*Continued on page 8.....*



**Regionalization came out of the report *As Wyoming Sows*. The map shows the six regions that were established in 1965.**



"This was one of the most daunting and greatest challenges confronting the community-based clinician hired to establish a mental health service in the community," McMahan said. "Clinicians were called upon to deal with mental health emergencies in private homes, jails, hospitals, and emergency room settings. They responded to night and weekend calls on a demanding and sometimes no-relief schedule. Over time, the addition of staff allowed for sharing the on-call responsibilities with other clinicians on a rotation basis. The psychiatric emergency service went a long way to establish the credibility of the mental health center and garner support from many agencies in the community."<sup>3</sup>

In 1963, Gov. Clifford Hansen appointed the Governor's Planning Commission on Mental Health to review the state's mental health needs and develop recommendations to meet those needs. Sheridan physician Dr. Seymour Thickman chaired the committee which published the summary report, *As Wyoming Sows*, on Aug. 15, 1965.<sup>11</sup>

Regionalization came out of *As Wyoming Sows*, as did funding prioritization based on need and population, McMahan said, noting that the northeastern region had the lowest priority at the time because of a rank ordering associated with the population density and service demands in the region at the time. The report set forth

the mental health regions as: Big Horn Basin Region for Big Horn, Hot Springs, Park and Washakie, Yellowstone Park counties; Northern Region for Campbell, Crook, Johnson, Sheridan and Weston counties; Fremont Region for Fremont County; Central Region for Natrona, Converse and Niobrara counties; Southwest Region for Carbon, Lincoln, Sublette, Sweetwater, Teton and Uinta counties; and Southeast Region for Albany, Goshen, Laramie and Platte counties.

In May 1966, the Northern Wyoming Mental Health Center was officially established as a multi-county center serving Sheridan, Johnson, Campbell, Weston and Crook counties and signed a cooperative agreement for mental health services in the northeast region with the county commissioners in each of the five counties. This formation of the first multi-county regional consortium was a historical first, developing a commitment to a common vision, a formula for some financial support, and appointing the first board directors, McMahan said. In 1968, federal support of a five county agreement led to Northern Wyoming Mental Health receiving a federal staffing grant.

Recognition of the lack of community mental health centers led the legislature to appropriate general funds

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# 1960s

to assist community-based mental health treatment centers in 1967. In 1969, the legislature created the Department of Health and Social Services which included Mental Health and Mental Retardation Services under the Division of Health and Medical Services.

With federal staffing grants, state funding started increasing but there was no state office, Rardin said. The centers helped lobby and sponsor the bill that created the state office. Rardin called the creation of a state office “a mixed blessing,” as the community mental health centers have struggled with the state office over the appropriate roles and boundaries since the 1960s. He conceded that the state has a very legitimate interest making sure that the public money is spent appropriately. “If you talked to state people, I am sure they would say that the centers do not want to live with any rules and just want to do what they want to do.”<sup>7</sup>

Problems generated by deinstitutionalization combined with the insufficiency of services overall ignited Wyoming’s residents on what would be the start of a strong grassroots push to develop community based mental health centers in the state. It began simply and quietly with communities forming local boards to administer the mixture of federal, state and local funds. These boards would later become the heart of the movement to improve mental health and substance abuse care in communities that continues to this day. “Wyoming should be proud of the courage, passion and commitment of the center boards, center directors, legislators and devoted citizens for bringing about the initiatives that have resulted in mental health and substance abuse treatment services in Wyoming,” McMahan said.<sup>3</sup>

The directors of mental health centers started meeting informally around this time with occasional meetings in Cheyenne or Casper, Iekel said. The association had no legal status, no dues and no minutes.

**“In those very early formative years of the center, because of the perceived stigma of mental health treatment, clinical staff spent at least 50 percent of their time doing clinical work in the community, conducting family therapy in the home, providing couples’ therapy at evening clinics, seeing individuals and families in the hospital ER, and breaking down barriers to seeking services.”**

***- John McMahan, former director of Northern Wyoming Mental Health Center<sup>3</sup>***



**Southeast Wyoming Mental Health Center in the early days. Photo from Peak Wellness Center’s 50th Anniversary PowerPoint in 2009**



John C. McMahan discusses the impact of mental health centers while at a 2011 meeting. *Photo by Mike Huston.*

## JOHN C. MCMAHAN

# Mental health centers significantly changed the way individuals were helped

**J**ohn McMahan joined Northern Wyoming Mental Health Center in 1967, serving as a clinician and program manager until 1987 when he took over as executive director until 2008. McMahan pointed out that the arrival of mental health clinics and services in northern Wyoming, and in many other regions of the state, significantly changed the way in which individuals and families were helped with emotional crises and disabling psychological problems and psychiatric disorders.<sup>12</sup>

Prior to the establishment of these clinics and services, persons struggling with psychiatric and psychological problems such as major depressive disorders, schizophrenia, or bi-polar disorders as well as substance abuse problems, would usually present at the county hospital ER, to their family practice physician, a minister, or in cases where an individual had no support system, at the police department or county law enforcement center.

More often than not, the behaviors and symptoms of these individuals were not understood and therefore perceived as “unmanageable” and sometimes even “scary.” Family members and care givers felt helpless to deal with these individuals and situations. As a result, such persons were referred to private psychiatric hospitals outside Wyoming in either Billings, Denver, Salt Lake City or other large urban area, providing the family had the financial resources to cover the cost of hospitalization.

Otherwise, the patient was involuntarily committed to the Wyoming State Hospital and consequently removed great distances from the

community and family support. In those early years, family physicians were generally reluctant to treat these individuals in the local hospital as they were not sufficiently familiar with or comfortable administering psychotropic medications and dealing with the patient’s psychiatric disorder. Additionally, nursing staff in general hospitals were not trained to deal with patients suffering from a psychiatric disorder or a mental illness and were apprehensive about caring for patients with serious conditions.

In northern Wyoming, the establishment of the community mental health center in the mid-60s and early 1970s introduced the mental health team which was comprised of a psychiatrist, a psychiatric nurse and a psychiatric social worker. The psychiatrist and psychiatric nurse were circuit riders traveling to each of the five northern counties while a psychiatric social worker was based in each of the counties. This team collectively and individually provided consultation and training to local physicians, hospital nursing staffs and law enforcement on the diagnosis and

*Continued on page 11.....*





**Photo of Northern Wyoming Mental Health Center Buffalo Outpatient Clinic. Photo provided by John McMahan.**

**“The presence of community mental health centers “quietly” and unpretentiously made a difference in the lives of many Wyoming individuals and families.”**

***-John McMahan***

treatment of psychiatric patients including the care and pharmacological management of the patient.

As a result, many local physicians and hospitals were willing to work with the mental health team in treating and managing the patient in the local hospital. Persons, who would have historically been “shipped-off” to a facility outside Wyoming or the State Hospital at considerable expense and emotional distress to the individual and the family, were pharmacologically treated jointly by the psychiatrist and family physician. The patient was stabilized in the local hospital sometimes in as little as 72 hours with daily inpatient counseling provided by the psychiatric social worker or other mental health professional. This also included work with the family to facilitate reintegration of the patient back into the community and or home environment.

In many cases the team traveled to patients unwilling or fearful of seeking help. An example of one such case involved traveling to a remote ranch some 80 miles from town to help a young mother who was in the throes of an acute bi-polar episode. She was extremely agitated and delusional. Her behavior was alarming to her husband and frightening to her family. The psychiatric nurse

and psychiatric social worker traveled to the ranch and were able to engage the mother and administer medication ordered by the psychiatrist via phone consults which calmed and stabilized her and set the stage for follow-up care without hospitalization. Historically this woman would have been committed to the State Hospital.

In another case, an “old time” cowboy and established rancher had become morbidly depressed following a major set-back in his ranching operation and resulting major financial losses. He withdrew and ceased to function. His wife was upset and worried because he was threatening to hang himself in the barn. He refused to come to town to see his doctor or get help. At the urging of his family physician, wife and son, he finally agreed to let the psychiatric social worker come to the ranch to talk with him. This resulted in his consent to begin an antidepressant medication regimen and follow-up counseling initially at the ranch, and later at the clinic. His suicidal preoccupation ceased and his depression abated.

There are wide ranging examples, of course too numerous to mention, of how the presence of community mental health centers “quietly” and unpretentiously made a difference in the lives of many Wyoming individuals and families.

The presence of mental health center professional staff and services pre-date the existence of “private practice” professionals that are now abundant throughout the state of Wyoming. A large number of these professionals now in private practice started in community mental health centers either as program staff or clinical interns.



**This building was Central Wyoming Counseling Center's location when Mike Huston started to work for them in 1972. The center had been there for about 7-8 years. *Photo by Mike Huston.***

## 1971

The Mental Health-Mental Retardation Advisory Council was created to make recommendations on facilities, programs and other matters pertaining to mental health and mental retardation services provided by the state and federal governments.

## 1972

The first joint association meeting between the directors and boards was held in Casper at the Holiday Inn.

## 1973

The Mental Health Advisory Council was created to advise the state Board of Health in carrying out the administration of statutes relating to mental health issues.

Federal funding became available under Public Law 88-164 to Wyoming for the construction of mental health facilities.

## Growing the Community-Based System

**The 1970s were a growing period as mental health centers started sprouting up in the smaller communities and as the local boards for the centers recognized the need to organize on a statewide level. These local boards were evolving into passionate, powerful advocates for change that had, quite simply, the best contacts in state government.**

In 1972, Gov. Stan Hathaway addressed a joint conference of the Wyoming Association of Mental Health and the Wyoming State Mental Health Boards Association at the Hitching Post in Cheyenne. Mrs. Mary Stark was the president of the Wyoming State Mental Health Association. She described the governor as the strongest supporter and always aware of the needs of mental health programs in a Wyoming Eagle newspaper article in 1972.<sup>13</sup>

Governor Hathaway called mental health a fundamental human problem. He commented that he was not ready to abolish the Wyoming State Hospital, but noted that progress has been made in the previous ten years. The governor attributed the change in part to the efforts by the seven mental health centers. The centers reached out to help those who might have once been committed to the State Hospital, allowing them to return to society to assume their role.<sup>13</sup>

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# 1970s

The group for directors of mental health centers started to meet more regularly when Mike Huston started his job at the Central Wyoming Counseling Center in 1972. “We would meet quarterly at the time, because there were not many of us. Most of the time, we talked about administrative, clinical, and budget stuff. We really did not have a strong legislative presence in those days.”

The state association for the local boards evolved from conversations between some of his board members and their counterparts at Southeast Wyoming Mental Health Center, now called Peak Wellness Center, Huston recalled. He explained that the boards saw a need for a state association where the boards of the community mental health centers got together.

Very active in the early development of the association for the local boards, Lucille Dumbille of Newcastle served as the president/chairperson of the boards association from 1970 -1974. She initially served as a board member and board president for the Northern Wyoming Mental Health Center. “Her services were especially valuable in the development and passage of legislation bringing about the reorganization of health and human services and statewide standards for mental health centers,” said John McMahan, former director of the Northern Wyoming Mental Health Center.

While the directors still held separate meetings, the directors also attended the board association meeting to provide support and their expertise. The two groups came together, holding the first joint association meeting between the directors and boards in Casper during the fall of 1972 at the Holiday Inn. However, the groups only came together for that meeting, going their own way afterward.

Meanwhile substance abuse services started to evolve in the 1970s. In those early days, Huston noted that centers provided some level of substance abuse services, which at the time was comprised mostly of alcohol abuse, but the overall emphasis was on mental health. On the federal level, funding became available in the early 1970s when Congress amended the Community Mental Health Centers Act to include the prevention and treatment of alcohol abuse and alcoholism. While still working for the Department of Health, Huston wrote the first alcohol treatment plan required in order for Wyoming to be eligible for \$200,000 in federal funding for alcohol treatment services.

The Governor’s Advisory Committee on Drug Abuse and Alcoholism gave the federal grants to the centers. In order to receive funds, the centers had to complete applications and give a presentation before the committee. Central Wyoming Counseling Center received a grant to hire its first alcohol treatment professional while Northern Wyoming Mental Health Center used its \$32,000 to create a counseling position to help drug and alcohol abusing clients.

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## 1975

Expanding core services from the 1963 mandated levels in 1975, Congress mandated eight additional services, emphasizing comprehensiveness and accessibility to all persons regardless of ability to pay.

## 1977

President Carter established the President’s Commission on Mental Health, the first comprehensive survey of mental healthcare since the 1950s.

Congress passed Public Law 94-63 requiring the expansion of services to meet new minimums for screening of residents being considered for referral to the state hospital, follow-up of those discharged, transitional halfway house services, and programs of specialized services for the elderly, children, substance abusers and rape victims.

Wyoming Protection & Advocacy System, Inc. was established to provide protection of the rights of persons with disabilities through legally based advocacy.

## 1978

The original federal staffing grants ended.

The legislature passed Wyoming Statute 9-5-227 to establish new mechanisms and formula for state and local funding of mental health programs.

## 1979

Behavioral Health Division in the Wyoming Department of Health was established.

The Mental Health Systems Act replaced the Community Mental Health Centers Act, making state government more involved in community mental health center programs.

## WYOMING FIRST LADY BOBBY HATHAWAY



**Mrs. Hathaway.** *Photo provided by her daughter Sue Garrett.*

**First Lady Bobby Hathaway was an advocate for mental health and substance abuse services in Wyoming. She served as the first vice president of the State Mental Health Association, which was a mental health advocacy group. She wanted to change the lack of substance abuse services and pushed very hard for communities to develop alcohol treatment programs, said Mike Huston, former director of Central Wyoming Counseling Center.<sup>9</sup>**

**Ms. Hathaway's daughter Sue Garrett was instrumental in developing recovery services for people with serious mental illness in Wyoming during her 30 years of work with Peak Wellness Center in Cheyenne.**

An economic boon in the early 1970s opened up new state revenue streams for mental health centers. Wyoming had become the energy breadbasket of the nation, having at times the lowest unemployment rate and among the highest per capita income in the nation. Seeking to fill the state's coffers, legislators passed legislation creating the mineral severance taxes in 1974. That system increased available state funding. Also in 1974, the state passed legislation increasing the proportion of sales and use tax revenues returned to municipal government.

In order to obtain funding, each mental health center individually went before the Ways and Means Committee, a precursor to today's Joint Appropriation Committee, to plead their case. At that time, legislators wanted to see local buy-in for the centers' efforts and the state would, within reason, match almost every local dollar the centers received.

Huston recalls going before the committee with a couple of his board members. "The Ways and Means Committee treated us like they would treat any state agency. There would be questions about why we need this and we had to show our budget. They wanted to know about what salaries we paid. We had to give them a complete budget request in terms of how much money we needed, how much local money we had and what we were going to do with the money."<sup>9</sup>

Many legislators were apprehensive of federal funding and leery of any requirements that made the state step up with matching funds. He said the centers received funding not to exceed 50 percent of operating expenditures in the early years. Even back then, legislators wanted due diligence that funds were being spent how they were supposed to be and that funding such efforts made a difference, he said. "Legislators were concerned about whether they were going to get their bang for the buck."<sup>9</sup>

However, Huston explained that the funding operated more like a grant; initially, there were no requirements for data compliance or performance measures.

McMahan was quick to point out that the community-based mental health movement had many legislative supporters. Among the many legislators who supported the movement, McMahan said, "Senator Rex Arney was a strong supporter and advocate of community mental health in the early years and helped pass, and probably cosponsored, legislation beneficial to the centers."<sup>3</sup>

To build the facilities, federal funding played an important role in the local communities. In the early years, outpatient offices were housed at various available sites including office buildings, the basements of hospitals, churches, schools, store-fronts on Main Street, nursing homes and courthouses. That changed when federal

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# 1970s

funding became available in 1973 under Public Law 88-164, to Wyoming for the construction of mental health facilities. For northeast Wyoming, the funding led to new office buildings in each of its five counties.<sup>10</sup>

During Governor Stan Hathaway's term, there was an attempt to reorganize the Department of Health and Social Services in 1975. Chairing the legislative Mental Health Subcommittee, Sen. Malcolm Wallop sponsored the Human Services Reorganization Act, which tried to remove the control over the institutions by the Board of Charities and Reform. The bill was drafted in the wake of a legislative staff report on mental health care services in the state. The bill died but set the stage for future changes, Huston said.

In 1975 core services were expanded from the 1963 mandated levels, Congress mandated eight additional services, emphasizing comprehensiveness and accessibility to all persons regardless of ability to pay. The required services expanded to include children

and elderly services, screening services, follow-up care, transitional services, alcohol abuse services and drug abuse services.<sup>10</sup>

Southeast Mental Health Center, now Peak Wellness Center, added the following services: alcohol, drug, rape counseling and prevention, screening of institutional patients, follow-up of institutional patients, care for children, transitional care and elderly care.

Starting his first term in January 1975, Gov. Ed Herschler called the implementation of the 1975 federal mental health law "a whole new ballgame." During his term as governor, he appointed a task force to plan for a statewide mental health set up under the new federal law. He made this announcement while speaking at a banquet honoring board members of the Mental Health Center of Northern Wyoming.<sup>15</sup> "I hope that through the work of this task force, we are going to get you technical,

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## Dr. Raymond Muhr

In 1970, Raymond Muhr, Th.D., became the executive director of Southeast Wyoming Mental Health Center. He served in that position for over 20 years. "When Ray Muhr saw unmet needs in the community, he went about finding ways to meet them," said Al Wiederspahn, who served as a board member for Southeast Wyoming Mental Health Center from 1978-1988, in the PowerPoint for the 50th anniversary celebration for Peak Wellness Center. "There were challenges; he was always equal to them."<sup>14</sup>



**TOP PHOTO: Dr. Ray Muhr; RIGHT PHOTO: Jewel Tomanek and Dr. Muhr**  
*Photos from Peak Wellness Center's 50th Anniversary PowerPoint in 2009.*

financial and professional assistance that you may need,” Governor Herschler said.<sup>15</sup>

An increased emphasis on mental health led to the creation of a series of statewide councils. From 1971-1977, the Mental Health-Mental Retardation Advisory Council was created to make recommendations on facilities, programs and other matters pertaining to mental health and mental retardation services provided by the state and federal governments. The Mental Health Advisory Council was created in 1973 to advise the state Board of Health in carrying out the administration of statutes relating to mental health issues, but was terminated in 1977. Working from 1977-79, the Council on Mental Health, Alcohol Abuse and Drug Abuse promoted citizen and agency participation in the advisement of the state Mental Health, Alcohol and Drug Abuse Authority on planning and policy and serve as a liaison between communities and the agency.<sup>16</sup>

In 1977, Congress passed Public Law 94-63 requiring the expansion of services to meet new minimums for screening of residents being considered for referral to the state hospital, follow-up of those discharged, transitional halfway house services, and programs of specialized services for the elderly, children, substance abusers and rape victims. Northern Mental Health Center received \$332,003 in federal funding for fiscal year 1978 to expand services to meet these new requirements.<sup>10</sup>

By 1978, the original federal staffing grants ended and funding by the state and local sources became much more

critical. Up to that point, the growth and development of community mental health centers was largely funded by these federal grants and increases in state funding. However, it is important to note that county and city government provided the initial and critical funding base for all the centers, Huston said.

In place of the staffing grants to the centers, the federal government started to give large block grants to the state to distribute, Huston explained. In 1978, the legislature passed Wyoming Statute 9-5-227 to establish new mechanisms and formula for state and local funding of mental health programs.

Toward the end of the 1970s, the Wyoming Attorney General’s Office also determined that cutting a check directly to the centers stretched the limits of the law and that funding needed to be awarded through a state agency, Huston said. That charge fell to the Wyoming Department of Health and Social Services’ Behavioral Health Division, which was established in 1979. Under the change, the Department of Health and Social Services developed contracts with the individual centers to provide services. The centers still had to attend the legislative budget hearings but they did not have to do the individual presentations.

Carol Day, a substance abuse counselor at the time, started with the department a month before the Division was created. She recalled that the centers “drove the

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**Cheyenne Halfway House for Alcoholics. Photo from Peak Wellness Center’s 50th Anniversary PowerPoint in 2009.**

# 1970s

boat at the time,” supporting the development of the Division and directing the process. “There was a lot of ownership with the directors. They owned it and created it.”<sup>17</sup>

Among the Division’s first steps was developing how the contracting worked. In the beginning, the centers did not have standards just contracts with the Department, Day said. “Initially, we mirrored those pre-Division contracts and tried to approve them. However, that slowly changed as there became an expectation with state funding that you would know more clearly what you were purchasing.”<sup>17</sup>

With the assignment of funding to the Behavioral Health Division also came the struggle of what was the appropriate level of state control versus local autonomy. For example, Ikel said that the Division, at the time, believed that it had the authority to approve mental health center staff hires, even though the centers were nonprofit organizations with a contract to provide mental health services with the state government. When Ikel applied at Northern Wyoming Mental Health Center for the position in Newcastle, the state office demanded that he drive down to Cheyenne so the state office could check him out, Ikel said. That of course raised the ire of the mental health centers who wanted to hire their own employees and not be beholden to state government for basic decisions.

In 1979, the Mental Health Systems Act replaced the Community Mental Health Centers Act, making state government more involved in community mental health center programs and focused on underserved populations, especially the chronically mentally ill. Although retaining the philosophy of comprehensiveness, the new act allowed for more flexibility in the development of programs with less than the five of the 13 elements of services required by previous laws.<sup>10</sup>



**Albany County Clinic in Memorial Hospital. Photo from Peak Wellness Center’s 50th Anniversary PowerPoint in 2009.**



**Platte County Clinic. Photo from Peak Wellness Center’s 50th Anniversary PowerPoint in 2009.**

## DON RARDIN, PH.D.

# Nine trends that impacted mental health services

**D**r. Don Rardin worked at the Fremont Counseling Center in Lander for 25 years, the majority of which he served as director. He also worked at the Wyoming State Hospital running its psychology services for ten years. Looking back over the last 40 years, Rardin has seen nine trends that led to the improvement of mental health services.<sup>7</sup>



Dr. Rardin discusses the impacts on mental health services while at a 2011 meeting.  
*Photo by Mike Huston.*

1. **MEDICATIONS** - Improving medications came from the development of Thorazine, which was the original drug that had an antipsychotic quality to it but some nasty side effects. Over time, medications have become more effective in terms of antipsychotic part and reducing the side effects. However, these are not curative medications but rather meant to be more effective management tools. When the centers started, typically there would be a general practitioner willing to work with the mental health center staff on prescribing medications. Outside Cheyenne and Casper and the State Hospital, there were no psychiatrists, just general practitioners. The development and use of antidepressant medications came closer to curative things for some clients. Today, the role of medication is huge and every center has access either to psychiatrist or psychiatric nurse practitioner.
2. **INPATIENT CARE** - Initially, the State Hospital was the only place for inpatient care and then Cheyenne and Casper began to offer some inpatient care. Because of this situation, we used to hold patients in the hospital when we felt they were severely mentally ill and needed to be hospitalized. The Sheriff's Office provided a sitter, who was an off duty deputy or a deputy's wife. People were held there until a court hearing and transportation to the State Hospital.
- Before medications, for many years, smaller communities held mentally ill in jails so that they could not hurt other people and were watched close so they could not hurt themselves. One thing the centers still struggle with is involuntary commitments where people are danger to themselves or others. Every county has worked its own way of doing it, but today's methods are still very expensive, not very efficient and typically it is not very integrated.
3. **SPECIALIZATION** - Related to medications, in the beginning mental health centers were staffed by generalists who could work with anyone walking in the door. In many small communities, you could not really specialize because there was not enough staffing and enough of a population to warrant specialization. Over the years, the centers have grown more specialized. The public has become more aware of community mental health and there is a lot more specialized care available for children and adults, severely mentally ill and substance abuse. Mental health care has become a lot more individualized.
4. **SUBSTANCE ABUSE** - When I came into the system in 1974/1975, substance abuse was the small homemade residential treatment program and AA. When they went well, they were these

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**HUMANIZATION OF PATIENTS:** The humanization of mental health patients could be the tenth trend. Dr. Karns, who was the superintendent of the State Hospital, began changing the hospital from the old asylum model to an actual hospital and treating mental health patients as people. Among the changes during his tenure were getting rid of the uniforms that patients used to wear and removing the bars from the windows. Those bars were given away and used as BBQ grills. *Photo from WAMHSAC archives.*



warm, homey little places where the alcohol community would gather together to figure out a program of intervention and they would stay there until they were better. There was very little structure and hardly any formality. When a study reported that there was no point in treating people for more than a 30-day stay, state funding would no longer pay for stay over 30 days, even if the center strongly advocated for it. Treatment became a little cookie cutter after that study and some programs were terrible.

**5. SERIOUSLY PERSISTENTLY MENTALLY ILL-**

Initially, treatment and intervention for the seriously persistently mentally ill would be limited to an office visit called counseling. When people heard voices and you were trying to carry on a conversation, counseling sessions were a little bizarre. The medication started being helpful. Over time, the centers have made huge gains in terms of their ability to intervene with the seriously mentally ill population. I tie some of the gains in that to national trends of learning how to provide effective services. Some of the credit also falls to Dr. Pablo Hernandez, who headed up the State Hospital for many years. He initiated quality of life funding money. All of a sudden we had money that we could spend for the seriously persistently mentally ill for dentures, mattresses, food, gas, whatever they needed that we felt fit. This little pool of money changed our perspective on how we go about providing quality services to this population. Now the centers provide a lot of active outreach, advocacy, help people get jobs, housing and a real rich range of services. In my

opinion, this is the area that has had the most gains.

**6. COMMUNITY BOARDS-** The community boards have been an incredible resource in terms of time and effort and genuine interest. Most of the board members have some personal tie that caused them to be interested in mental health. I remember a board member who was a local minister who had two brothers who were schizophrenic. One of them died from exposure. He dedicated his time on the board to his brothers. I think that we have not done a good job on a state level of encouraging, recognizing and supporting our boards. They have been such a dedicated folks.

**7. FUNDING** - Funding started out locally and then a little bit of state funds. Then the federal staffing grants were added, helping generate the political support to increase state funding. The huge third leg of funding became Medicaid. Medicare never has played much of a role for kids and adults.

**8. ALCOHOL USE AND SUICIDE** - Wyoming had persistent history of leading alcohol use and suicide. There are a lot of different theories about the causes. I think that the availability of guns and alcohol are part of the idea of being a very independent person who will do what they want to do.

**9. CHRIS S. LAWSUIT** - Chris S. Lawsuit, see pg. 29 for more details, has been politically a critical piece that increased the effectiveness of community mental health programs and addressed the appropriateness of keeping people in the State Hospital.



**LEFT: BHBHS Director Darwin Irvin RIGHT PHOTO: Big Horn Behavioral building. Photos provided by WAMHSAC archives.**

## 1980

The Wyoming Mental Health Boards Association wrote a constitution.

## 1981

Congress enacted the Alcohol, Drug Abuse and Mental Health (ADM) Block Grant which was a part of the Omnibus Reconciliation Act.

On April 1, over 100 people attended a public hearing about the new standards in the basement of the Hathaway Building down in the basement.

## 1983

The Board Association updated its constitution to include substance abuse governing advisory board members.

## 1984

The Division of Community Programs created the Rules and Regulations for the division to establish minimum standards.

## 1985

The National Association of Mentally Ill was organized in the state.

## Defining Standards of Care

**D**uring the 1980s, the association for the local boards started to gain momentum and develop a legislative agenda, which came in handy as state government tried to define standards of care.

In 1980 after becoming incorporated, Wyoming Mental Health Boards Association wrote a constitution, probably in reaction to the formation of the state division, Huston said. The membership of the Association just included mental health board members, but directors still went to the meetings to provide support and knowledge.

According to the Association's constitution the purposes were to:

- Provide constant improvement of public mental health services in state of Wyoming
- Provide for closer cooperation among mental health boards of the state
- Provide information and assistance to individual mental health boards and members
- Cooperate to the fullest extent with public officials, mental health directors and employees, to advance the cause of mental health services and to promote constructive mental health legislation
- Promote cooperative working relations with the Department of Public Health and Social Services<sup>18</sup>

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# 1980s

By 1983, the Association updated its constitution to include substance abuse governing advisory board members along with mental health boards and added substance to the services. This was a change, as the residential treatment programs had initially formed their own Substance Abuse Directors Association, but then decided to join with the Mental Health Association, Rardin said.

Substance abuse was not as big a priority at the time as mental health drove the boat, said Carol Day who worked for the Division. Originally, the Behavioral Health Division included mental health, substance abuse, family violence, and developmental disabilities. “I worked at the time under substance abuse. We definitely were the step children in the Division. It is interesting how that flipped over time. There has never been a good balance or even focus between mental health and substance abuse.”<sup>17</sup>

In 1981, Congress enacted the Alcohol, Drug Abuse and Mental Health (ADM) Block Grant which was a part of the Omnibus Reconciliation Act of 1981. This federal legislation repealed the Mental Health Systems Act and consolidated the federal alcohol, drug abuse and mental health programs in to ADM Block Grant. Under ADM, states were given wide discretion in administrating the block grant.

WAMHSAC’s strong political backing both in the Legislature and in Gov. Ed Herschler’s Office proved to be critical when the Department of Health and Social Services pushed for standards of the community mental health centers in the early 1980s. During this time, legislators started advocating for increased accountability for funding overall. While the Department of Health and Social Services was required by statute to have standards, Huston said that the department took this too far with their first proposed standards to govern, oversee or regulate community mental health and substance abuse. “When they first came out, the proposal was over 100 pages. The community people just erupted,” Huston said.<sup>9</sup>

On April 1, 1981, over 100 people attended a public hearing in the basement of the Hathaway Building. There was a big public outcry about overregulation and control by the state. Huston said the proposed regulations “were pretty invasive and controlling kinds of things. Basically it was tantamount to the centers becoming state agencies without enjoying the perks of being state agencies.”<sup>9</sup>

Day, who worked in the division at the time, remarked that the centers had tremendous political clout. “Over time we had a series of administrators, some of whom did a good job and some of whom butted heads with WAMHSAC. The most notable was around the development of standards. The Division proposed standards that directors did not like. They garnered legislators, board members and

## 1986

Governor Herschler ordered a \$7.7 million cut in the budgets of state agencies and institutions.

The Wyoming Association of Mental Health Directors produced its first annual legislative Report on Mental Health Services in Wyoming.

## 1987

Medicaid became available to community mental health centers as a third party service.

## 1989

The association for local boards sought increase in state funding.



**A 1987 jail visit for substance abuse.**  
*Photo provided by WAMHSAC archives.*

*Continued on page 22.....*



anyone else they could think of. The result of that was that the administrator of the Division lost his job. The governor removed him.”<sup>17</sup>

Day remembers working with the center directors early on. “I was pretty young when I started here. They were a formidable group. I was scared of them, not because they were mean but because they had such political power. A couple of them had pretty violent tempers. I remember being in meetings with them when they would start throwing papers across the room, and shouting.”<sup>17</sup>

Day explained that she could not always tell what was upsetting them. The standards were predictable, she said. “They kept telling us that we were overreaching our authority. We didn’t listen to them and they brought their board members and legislators to the April 1 public hearing.”<sup>17</sup>

Even before the standards, the Division had to find ways to better work with the centers when developing processes and procedures even over payment. “If they did not like something or thought that it was onerous, they would let us know in no uncertain terms,” Day said. “The Division would back down and we would go into another direction.”<sup>17</sup>

After the public hearing, Huston explained that Governor Herschler made a decision and reassigned some people. “Some people lost their jobs. He set up another committee comprised of representatives of the state and community centers to develop standards that were more

acceptable and less controlling and invasive. He sent the message that there had to be some accountability for state dollars flowing into the community programs.”<sup>9</sup>

In 1984, the Division of Community Programs of the Department of Health and Social Services created the Rules and Regulations of the Division of Community Programs to establish minimum standards and approve policies and procedures for the establishment and operation of community based programs.<sup>10</sup>

Day said that Julie Robinson who worked in the Division, was instrumental in developing the rules and regulations that guide the contracting process. “There was not a battle like there was over the standards, because Julie was smart enough to garner her own political backing so that there was more of a balance. It was very thoroughly thought-out on her part in terms of the political piece and the local influence that community providers have. She worked with Senator Win Hickey pretty closely in the design of the rules and regulations. Senator Hickey was a proponent of WAMHSAC and a proponent of Julie’s so that Julie would call her up for advice.”<sup>17</sup>

From this time forward, state contracts with the centers became a little more specific. From this, the first data system was developed so that the centers reported to the state demographic information and what services were provided. Prior to that, some data was collected, so the Department of Health and Social Services could compile information from all the various centers around

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**Jerry Iekel reminisces about the past at a 2011 meeting. Photo by Mike Huston.**

**“The directors association was pretty passionate about improving services and the community mental health centers. I remember a directors’ meeting where Ray Muhr, then the director of Southeast Mental Health, threw papers into the air. Our passion was fueled more by the relationship with the state than ourselves. We were seen as mavericks, getting strong and fighting the bureaucratic system.”**

**- Jerry Iekel, former director of Northern Wyoming Mental Health Center and legislator<sup>6</sup>**

# 1980s

the state. Huston said that the system collected pretty rudimentary data. Moreover, much of the early data was lost when flooding destroyed records stored in the basement. A system that captured detailed information about individual clients did not evolve until the late 1980s.

Huston said, “This first client reporting system was a paper and pencil process where you fill out a form of demographic information and data. Each person

was assigned a paste number, a unique identifier. Each center around the state had their block of numbers and they had to fill out this paper form and submit it to the state. That was the first effort in developing a database in terms of how many people were treated and defined by sex, by age and by what kind of diagnoses was starting to be compiled.”<sup>6</sup>

*Continued on page 24.....*

## MIKE HUSTON

### Local mental health boards were key to legislative success

**M**ike Huston, former director of Central Wyoming Counseling Center, said the support the local mental health boards generated was key to the Association’s legislative successes.<sup>9</sup>

Prior to the official formation of WAMHSAC, Pat Henry, a board member of Central Wyoming Counseling Center and an early president of the Association, developed the idea of the legislative breakfast at the Hitching Post, Huston said.

“Back then, there were only a handful of legislators that did not stay at the Hitching Post, which was the center of the universe,” Huston said, pointing out that the Association had really good attendance. “I remember a legislator breakfast that had two-thirds or more of the legislators there. We would do an educational program of some type and give the WAMHSAC legislative report.”

Huston said that legislative support helped initially in the funding arena. “The legislature was willing to increase its participation and support of community programs, but not pay the entire cost. They wanted local buy-in on it. So, until this day, there is a requirement that at least 10 percent of our budget has to come from sources other than the Wyoming Legislature.”

**LEFT: Mike Huston at a 2011 meeting. Photo provided by Mike Huston.**

**RIGHT: Central Wyoming Counseling Center. Photo provided by WAMHSAC archives.**



Meanwhile, the entire state felt the sting as the drop in oil prices led to a devastating bust in the 1980s. The bust impacted the centers in terms of funding cuts and an increased demand in services from a stressed out population.

Huston said, “Everything rippled across Wyoming. It devastated Wyoming and it devastated Casper. I was living here at the time and thousands of people just left. People lost their jobs and walked away from their repossessed houses in droves.”<sup>9</sup> He explained that the bust had a significant impact on people and the centers saw an increase of alcohol abuse to depression.

Discouraged by the lack of services available to their mentally ill children, a group of parents started NAMI Wyoming in 1985. Iekel called NAMI Wyoming a high level advocacy group that had a very effective lobby during legislature.

By 1986, the drop in oil prices cut state revenues, causing Governor Herschler to order a \$7.7 million cut in the budgets of state agencies and institutions.<sup>16</sup>

“We got an overnight call from the Herschler administration that budgets would be reduced by 10 percent effective immediately,” Huston recalls, explaining that the cuts impacted every center. “We had just hired a husband and wife team from Nebraska. We had offered them a job and they had accepted it. I had to call them the next day and say whoops we just had a ten percent cut by the governor. I am going to have to withdraw my offers. I probably could have still kept one of them, but one of them didn’t want to be here with the other in Nebraska.”<sup>9</sup>

**“Everything rippled across Wyoming. It devastated Wyoming and it devastated Casper. I was living here at the time and thousands of people just left. People lost their jobs and walked away from their repossessed houses in droves.”**

**-Mike Huston,  
Former director of Central Wyoming Counseling  
Services<sup>9</sup>**

The legislature, of course, drew back severely on overall state expenditures; however, community mental health and substance abuse did not experience a direct decrease. “It was basically just don’t let them cut us anymore,” Huston said.<sup>9</sup>

However, the bust had a big impact in the communities as a lot of local funding dried up, hurting centers, said Allan Braaten, executive director at Hot Springs County Counseling Services.

In 1986, the Wyoming Association of Mental Health Directors produced its first annual *Legislative Report on Mental Health Services in Wyoming* to look at services being provided. The report discussed its commitment to work cooperatively with the Division of Community Programs in responding on a statewide level to the mental health needs of Wyoming citizens.

According to the legislative report, mental health centers served 16,435 individuals across the state during fiscal year 1987. The hours delivered in service to these individuals totaled 108,985 during that year, which was 37,485 hours beyond the 71,500 hours made available through legislative funding.<sup>19</sup>

By 1987, Medicaid became available to community mental health centers. “Medicaid expanded our funding dramatically,” Rardin said. “Though, the state would not pay the match. We had to pay the match out of our coverage through our state funding.”<sup>7</sup>

Centers were also expanding services available in the communities. In 1987, Southeast Mental Health Center (Peak Wellness Center) developed the following programs: Anger Control Group; Therapeutic Foster Care; Case Management for the Chronically Mentally Ill; Family Sexual Abuse Treatment Program; Divorce Groups; School Suicide Prevention in cooperation with Laramie County School District #1; and continuing consultation and education services for over 50 local agencies.<sup>14</sup>

In 1988, the Wyoming Association of Mental Health Directors and Wyoming Mental Health Center Boards Association joined together to issue the *Report on Mental Health Services in Wyoming FY87*. During fiscal year 1987, mental health centers served 19,707 children, adults and elderly with 119,386 hours of services.<sup>20</sup>

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# 1980s

The report highlighted that the majority of treatment had to be subsidized by state funds. Of those clients receiving treatment, 51 percent had household incomes of \$10,000 per year or less, 38 percent had household incomes of \$5,000 per year or less, 70 percent had household incomes under \$19,990 annually. Additionally, the report noted that 64 percent of all clients were students, disabled, and unemployed or employed less than full time while 11 percent were chronically mentally ill.<sup>20</sup>

In addition to spending time providing education about mental health, the centers placed considerable emphasis on working with the chronically mentally ill in fiscal year 1987. According to the report, nine mental health centers had case management services for the chronically mentally ill and one center was developing a residential program for the population.

The issue of standards was raised again during the summer of 1989. The Division of Community Programs started a joint venture with both the local boards and directors associations to revise the Standards for the Operation of Community Mental Health and Substance Abuse Program, which were originally developed in 1981.<sup>21</sup> Similar to past concerns, associations were paying close attention to the standards and their impact on the local centers' ability to run operations.

Also that year, feeling the pinch of state and local budget cuts and facing client waiting lists, the Mental Health Boards Association urged Gov. Mike Sullivan to increase funding for mental health centers in his budget recommendation. In an Oct. 16, 1989 letter to the governor, Association President Dawna Rookstool pointed out that state funding was reduced by 7 percent in 1987 and 2.5 percent in 1989. Further, local funding was reduced by 8 percent due to the termination of federal revenue sharing.<sup>22</sup>

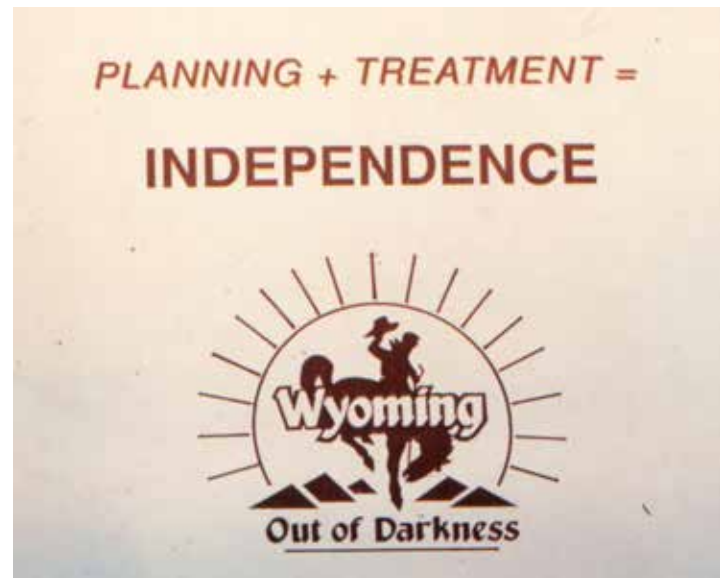
In a Dec. 27, 1989 letter to Rookstool, Governor Sullivan explained that such an increase was not included because "state resources are finite, and the department had not recommended this expansion."<sup>23</sup> However, upon learning of Rep. Lynn Dickey's plans to seek additional funding, the governor said he would have no problem with additional money being made available.

**"The state had difficulty dealing with community-based mental health centers, because we were not state employees."**

**-Dr. Don Rardin,  
Former director of Fremont Counseling Center<sup>7</sup>**



**Mike Huston back in the day. Photo provided by WAMHSAC archives.**



**An old logo for WAMHSAC. Photo provided by WAMHSAC archives.**



**LEFT PHOTO:** The Mercer House in Natrona County; **RIGHT PHOTO:** Susie True on the right talks to another WAMHSAC member. *Photos provided from WAMHSAC archives.*

## 1990

The reorganization of the Department of Health was a topic of conversation at the Wyoming Mental Health and Substance Abuse Boards Association meeting in Jackson on August 25.

## 1991

The Wyoming Association of Mental Health and Substance Abuse (WAMHSAC) formed as an official association in 1991, filing its nonprofit status.

Two bills supported by WAMHSAC passed in the 1991 session. The first, Senate File 16 allowed contract agency employees to participate in the state retirement system. The second, House Bill 5, included a footnote, increasing Division of Community Programs budget.

## Expanding Services

**E**fforts in the 1990s stressed expanding care to adults and children with serious and persistent illness, highlighting substance abuse problems in communities and adding quality of life funding. To do that, the directors and the local boards agreed to become one association to better communicate to the legislature and the public.

Kicking off the 1990s, the *Casper Star Tribune* ran a series of articles in February, questioning the role of community mental health services and their right to be competitive in providing mental health services. In one of the articles, Sen. Kelly Mader even commented on whether the competition between mental health centers and private-for-profit providers was proper.

In response, Steve Zimmerman with the Division of Community Programs in the Wyoming Department of Health and Social Services wrote in an April 25, 1990 letter to both the boards and directors associations: "Community mental health centers are not subsidized by the state but rather earn contract dollars based on the units of service that are provided to citizens of the community. The Division

*Continued on page 27.....*

# 1990s

of Community Programs recognizes that the services purchased by the state are a minimum core to which individual patient resources are billed on ‘an ability to pay basis.’”<sup>24</sup>

As experienced in past decades, state government continued to struggle on the best place to put mental health and substance abuse. In 1990, the Department of Health and Social Services underwent reorganization. The reorganization of the Department of Health was a topic of conversation at the WAMHSAC local boards association meeting in Jackson on Aug. 25, 1990. According to the Aug. 25 meeting minutes, Huston reported to the association that the directors voted to recommend that mental health, substance abuse, the state hospital and family violence all be in one division.<sup>25</sup> Eventually, this reorganization came to pass when the Behavioral Health Division was formed to work with mental health and substance abuse issues.<sup>16</sup>

More importantly, during the Aug. 25 meeting, the boards association voted to formally merge with the directors association. According to the draft proposal, the purpose of forming one association was “to create a more formal, organized, and visible association intended to promote the cause of community mental health and substance abuse programs in Wyoming.” The Wyoming Association of Mental Health and Substance Abuse (WAMHSAC) formed as an official association in 1991, but did not file its nonprofit status until 1994.

The Nonprofit Corporation Articles of Incorporation for WAMHSAC were first filed with the Wyoming Secretary of State Kathy Karpan in September 1994. Linda Dixon, who was the WAMHSAC President and Northern Wyoming Mental Health Center Board President at that time, was the signator. On a side note, her husband Jerry Dixon served in the Wyoming Senate for 11 years, including being Senate President. The articles were amended and resubmitted in November 1995.

In December 1995 the IRS ruled that WAMHSAC would be classified as a 501(c)(6) as the association more resembled “a professional organization established to promote, develop and coordinate the mental health and substance abuse program and service activity of its member centers.” The application was signed by WAMHSAC president Deborah Alden<sup>26</sup> WAMHSAC officers at the time of the application were:

- President: Deborah Alden, Board Member, Southeast Wyoming Mental Health Center
- President-Elect: Rick Luchsinger, Board Member, Eastern Wyoming Mental Health Center
- Secretary: David Birney, Executive Director, Southeast Wyoming Mental Health Center

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## 1992

Primarily during the 1992 budget session, the legislature authorized funding to open five Supported Independent Programs (SIP) for the chronic and seriously mentally ill and to develop a community living program for some longer term patients from the Wyoming State Hospital.

## 1993

The Division of Behavioral Health developed a Five Year Plan for Statewide Behavioral Health Services.

WAMHSAC worked on developing an Implementation Plan and Funding Formula designed to relocate services from the State Hospital to the communities.

## 1994

Protection & Advocacy sued the state on behalf of a patient, identified only as Chris S.

## 1996

Community-based mental health centers could reduce their share of the state Medicaid match from the full state match rate to 15 percent match by developing intensive community-based services for children and adolescents who would otherwise be in placement outside their communities.

## 1998

The legislature took an unprecedented step and appropriated \$3.2 million, as part of the Methamphetamine Initiative.

## 1999

U.S. Supreme Court ruled in *Olmstead, et al. v. L.C.* that under the Americans with Disabilities Act, individuals with mental disabilities have the right to live in the community rather than in institution.



**A male with a ten year history of state inpatient hospitalization was discharged from the State Hospital to a Supported Independence Programs (SIP) group residential program. After less than six months in the residence, he obtained and moved into his own apartment. He currently is receiving supportive services from the SIP to assist with daily living activity and has recently begun work in a supported employment setting.**

*- Story from 1995 Legislative WAMHSAC Report<sup>27</sup>*

- Treasurer: Tom Markos, Board Member, Carbon County Counseling Center

Having a strong political base in the legislature also brought WAMHSAC forward. Huston attributed a lot of the support coming from the hard work by the boards of the local community centers. “That didn’t mean that everyone in the legislature thought that was a worthwhile use of state dollars. There were certainly people who thought it was a waste of dollars to try to treat alcohol abuse and that the State Hospital was there to help some of the people with mental problems.”<sup>9</sup>

According to the 1991 report to the legislature, mental health centers provided essential mental health and substance abuse services to 20,366 children, adolescents, adults and elderly persons, totaling 155,082 hours of services provided during fiscal year 1990. The big legislative push for the 1991 legislative session was for an increase of state funding so that the centers could meet the pressing needs of special populations requiring extensive outreach like the chronically mentally ill, severely emotionally disturbed children and adolescents, substance abusers and the elderly. According to the 1991 legislative report, there had not been an increase in state contract funding to mental health centers since 1985<sup>28</sup>

Two bills supported by WAMHSAC were passed in the 1991 session. The first, Senate File 16, allowed contract agency employees to participate in the state retirement system. The second, House Bill 5, included a footnote increasing Division of Community Program budget by 5.7 percent to help offset inflationary costs of doing business and offering some relief to the struggling centers.<sup>29</sup>

During the early 1990s, WAMHSAC hired Wendy Curran as its executive secretary to strengthen their legislative presence. Huston laughed, remembering that Curran used to refer to them as “Wendy and her boys.”<sup>9</sup>

Within the 1992 legislative report, WAMHSAC gave the legislature summaries of concept papers dealing with children and adolescent services, chronically mentally ill services and an integrated substance abuse service system. Further, WAMHSAC stated its agreement with the Management Audit Committee’s recommendations that the Wyoming Department of Health develop a statewide mental health plan and funding be provided for community mental health alternatives to hospital care.<sup>30</sup>

During the 1992 budget session, the legislature authorized funding to open five Supported Independent Programs (SIP) for the chronic and seriously mentally ill and to develop a community living program for some longer term patients from the Wyoming State Hospital. The principle behind SIP funding was that most seriously mentally ill have the capability to live in a normal community setting and manage their own lives if they have access to a broad range of flexible services where they live and work.<sup>10</sup>

Seeking a strong system of care, the Division of Behavioral Health developed its Five Year Plan for Statewide Behavioral Health Services in 1993. Within its 1993 report to the legislature, WAMHSAC expressed its support for the plan, particularly its recommendations to provide ongoing financial support reflecting the increases in the cost of doing business, developing community-based care for troubled children and the

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# 1990s

seriously mentally ill, and expanding treatment options for chemically involved residents.<sup>31</sup>

During 1993, WAMHSAC worked on developing an Implementation Plan and Funding Formula designed to relocate services from the State Hospital to the communities. Under the plan, the funds would provide a gatekeeper function at the community level to help stop inappropriate admissions to the State Hospital, to keep small centers operating, to provide services for seriously emotionally disturbed children in the community, to keep children out of the State Hospital and to provide residential community treatment for the dual diagnoses substance abuser with psychiatric illness.<sup>32</sup>

The state's efforts to provide adequate services at the State Hospital were publicly questioned in 1994 when Protection & Advocacy System, Inc. sued the State of Wyoming on behalf of patients, identified only as Chris S., et al., alleging inadequacy and unavailability of appropriate facilities and services for people with mental illness. The Chris S. lawsuit was critical in increasing effectiveness of services, Rardin said.

Jeanne Thobro was the chief executive office for Protection and Advocacy at the time. Protection and Advocacy serves individuals with a wide range of disabilities. This nonprofit investigates reports of abuse and neglect, seeks systemic change to prevent further incidents and advocates for basic rights.

Thobro explained that Protection and Advocacy received a number of significant complaints from family members with people with mental illness or people with mental illness at the State Hospital calling them directly. "As we started to get significant complaints from our constituents, it became clear to us that all was not well with the State Hospital. As we began our investigations, the facts were that indeed there were very serious conditions at the Wyoming State Hospital requiring our attention."<sup>33</sup>

The complaints primarily pertained to health and safety concerns at the State Hospital, including insufficient staffing. Some complaints focused on patients, who

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## Susie True

With Susie True at the helm, the Wyoming Association of Mental Health and Substance Abuse formed as an official association in 1991, filing its nonprofit status. "Susie was the real leader in moving WAMHSAC forward and making it a real viable meaningful group," Huston said.<sup>9</sup> Her insight helped the association better communicate with legislators. One year, Susie True interviewed couple clients at Central Wyoming who were seriously mentally ill, using the interviews for a video for the legislative presentation. Huston said, "For some legislators, it was the first time they had an understanding of what we do and services we provide and who we deal with."



**LEFT: Susie True. RIGHT: Susie True visits at a meeting with Dr. Vern Cox from High Country Counseling in the background. Photos from WAMHSAC archives.**

were supposed to receive one-on-one supervision in their treatment plans but did not, posing suicide risks. “There were actual near attempts at suicide and actual successful suicides at the Wyoming State Hospital that could be linked to a lack of adequate staffing,” Thobro said.<sup>33</sup> Additionally, Protection and Advocacy received allegations of significant neglect at the State Hospital. For example, if someone was to have certain treatments and psychiatric counseling it was not happening, she said.

The actual treatment of people and staffing issues were some of the driving forces behind the litigation but not the only ones. Thobro explained that the second prong that prompted the litigation was the lack of community alternatives to allow people to succeed in community settings. However, she pointed out that, “It was not complaints about community mental health centers that drove the lawsuit. It was the Wyoming State Hospital.”<sup>33</sup>

Protection & Advocacy was also concerned that there were no certification standards for community mental health centers. “We felt that it was important to have a standard that was uniform among the centers to assure people of good treatment on the community side.”<sup>33</sup> Protection and Advocacy was also concerned with long waiting lists in some communities for services and that people were being inappropriately referred to the State Hospital for treatment, Thobro said.

Part of the Chris S. lawsuit was also driven by emerging case law and the U.S. Supreme Court decision of *Olmstead, et al. v. L.C.* in 1999 that people should have the opportunity to be in less restrictive environments such as community settings if possible. “One of the main goals was to get a ramped-up community system that would not have a person who did not need the Wyoming State Hospital go there. It is the philosophy of this agency that a psychiatric hospital ideally should not be the lifelong home of someone with mental illness.”<sup>33</sup>

Also with the litigation, Protection and Advocacy wanted to ensure that people had opportunities outside of the structured WAMHSAC system to have access to private psychologists and to other forms of support to get help, Thobro said. She noted that ‘choices’ is kind of an operative word in the Olmstead litigation that “people are afforded opportunities so we just don’t offer a one size fits all system.”<sup>33</sup>

Thobro pointed out that the lawsuit was also concerned with the unnecessary jailing of people with mental illness in some communities, because they didn’t have the ability to go into some type of a residential program or whatever treatment was needed. “They have not committed a crime. They should not be part of the criminal justice system. They had mental illness and may have become delusional and found themselves in a jail cell.”<sup>33</sup>

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**LEFT PHOTO: Photo from the legislative session; RIGHT PHOTO: Susie True discusses WAMHSAC issues with Bob Knappenberger, director of Carbon County Counseling. Photos from WAMHSAC archives.**



## WENDY CURRAN: WAMHSAC built the system

**Wendy Curran was hired as WAMHSAC's first official staff member in the early 1990s. She served in a part-time position as executive secretary, operating as a lobbyist and liaison for the group until leaving to become the executive director of the Wyoming Medical Society in 1998. She left that position to work for Gov. Dave Freudenthal.<sup>34</sup>**



Wendy Curran

I received a call from WAMHSAC president Susie True, inviting me to lunch with Mike Huston. Mike and Susie shared with me the background, history and goals of the organization and explained that they were considering hiring someone in a part-time advocacy role. They assured me that they did not have a legislative agenda that year and simply wanted a presence at the Wyoming legislature.

I agreed to accept the position and shortly after, when the legislature had been in session for all of two weeks, the directors and the boards decided that an increase in operational funding from the legislature was critical. I quickly went from a part-time presence at the legislature to a full-time lobbyist working to get an amendment on the budget bill.

I found WAMHSAC to be an engaging, energetic and seriously devoted group of advocates for their clients and for the system. At that point in time, there was little recognition of mental health and substance abuse as physical illnesses. The issues about how to deal with people with mental illness were increasingly complex and eventually the focus changed to treating the illness rather than locking people up in the State Hospital or other institutions. The centers were determined to provide active treatment for mentally ill individuals and facilitate their ability to live within the community.

I found that members of the Wyoming Legislature were generally supportive of WAMHSAC's efforts. There were not really opponents to mental health treatment; there were just some who

were more fiscally conservative and others who were more inclined to support community treatment programs. One of the things WAMHSAC did very well was to find very passionate and dedicated community members to serve on their local boards. Board members were nearly always people who believed in the cause, were articulate and willing to talk to legislators. WAMHSAC had one of the strongest grassroots advocacy efforts because its board members lived in their local communities and had established relationships with legislators.

WAMHSAC paved the road for mental health services in the state. In 1969, the legislature made a deliberate policy decision to support community governed boards to deliver mental health services in local communities. This decision led Wyoming down a different path at the time than other states. WAMHSAC members stepped forward and provided a strong leadership role in figuring out what kind of services were needed in the community to support persons with mental health and substance abuse problems.

WAMHSAC providers really did the work that helped form the system of care, the resources and the providers that exist in the state today. They came together to work to develop statewide services to support a system of care for all citizens and not just to benefit individual communities. Sure, there is still work to be done and issues, particularly around funding, to be resolved, but at the end of the day they deserve credit for building the system we have in Wyoming.



The original plaintiffs in the Chris S. lawsuit lived in Wyoming communities. “These were very much real people, real Wyoming citizens who had real problems and needed help.” Thobro said several individuals came forward as plaintiffs to represent a class of people who were either at the State Hospital, who were at risk of being placed at the State Hospital or who upon discharge from the State Hospital might be at risk because of lack of community placement of support. Thobro said the names were withheld for privacy concerns. However, the Chris S. family and Chris S. agreed to use the first name and the initials, Thobro said.

By a stipulation dated Aug. 31, 1995, the Chris S. lawsuit litigants, together with Protection and Advocacy and the Wyoming Alliance for the Mentally Ill agreed to create the Partnership for Resolution of Mental Health Issues in Wyoming. Set to expire in 2000, the partnership had the authority through the court system to resolve the contentions of the parties without formal judicial determination.

Despite the state’s reluctance, Protection and Advocacy insisted that WAMHSAC representatives be at the table for any settlement discussions “or we were not willing to enter into settlement discussions and enter into litigation and let the judge direct much of it,” Thobro said.<sup>33</sup> WAMHSAC was then allowed to attend.

WAMHSAC had a body of knowledge, had mental health experts on the community side and had a history

of experience, she said. “They had the history and the experience that was a wealth of help.” Thobro explained that WAMHSAC was not considered a party to the lawsuit as neither a defendant or a plaintiff. However, she said, “I assure you we heard them loudly and we took very seriously their comments.”<sup>33</sup>

Representing WAMHSAC, Mike Huston and David Birney were allowed to listen but not actually allowed to sit at the negotiations table. “We sat behind the table and were not able to talk during actual negotiations, though we were able to give advice on breaks,” Huston said.

Protection and Advocacy would often run ideas by WAMHSAC during the negotiations. For example, at first, the partnership considered implementing national accreditation standards regulated by JCAHO (Joint Commission on Accreditation of Healthcare Organizations). “I remember David Birney almost screaming at the top of his lungs that it was a medical model and that wasn’t going to work,” Thobro said.<sup>33</sup>

“WAMHSAC was pivotal in helping drive the settlement agreement by consulting and weighing in on thumbs up or thumbs down, and helping to advise on important kinds of services,” Thobro added.<sup>33</sup>

In the 1995 WAMHSAC report to legislators, David Nees, then president for the directors association and

*Continued on page 33.....*

**LEFT PHOTO: Pat Henry talks to board members; RIGHT PHOTO: Stephen Lottridge, director of Southwest Counseling, works on documents with a board member. Photos from WAMHSAC archives.**



# 1990s

**“WAMHSAC was pivotal in helping drive the settlement agreement by consulting and weighing in on thumbs up or thumbs down, and helping advise on important kinds of services.”**

***-Jeanne Thobro, chief executive office for Protection and Advocacy, talking about the settlement of the Chris. S. lawsuit<sup>33</sup>***

director of Pioneer Counseling Services in Evanston, raved in his message about how the Supported Independence Projects have developed into a highly efficient and cost effective service for seriously mentally ill patients who just a few years ago would have been institutionalized. “Many of these same former patients, with assistance, now live independently, generate their own income through productive labor, attend school and even college, and even give back to their own home communities by serving in volunteer positions.” Additionally, Nees pointed out that community-based programs worked with seriously emotionally disturbed children in their home, school and community to help them with specific behavior changes that would allow them to live healthy and productive lives in their own homes.<sup>27</sup>

When Dr. Pablo Hernandez came on board at the state department, he came with some innovative ideas in terms of ideas on how to get people out of the state hospital and for the community to take better care of those people, Huston said. Protection & Advocacy saw that as acceptable, he said. Hernandez went to the legislature for dollars to enhance and strengthen community programs with funding to provide liaison services where each mental health center had a designated contact person for the State Hospital.

By 1996, an increase in state funding resulted in expansion of services to seriously mentally ill clients. The Mental Health Division began targeting adults

with serious and persistent illnesses and children with very serious emotional disturbances and their families beginning in 1996.

Huston said, “It was not a huge amount of money but it was important money in terms of being able to deal with the targeted populations. the seriously persistently mentally ill or now seriously mentally ill and seriously emotionally disturbed children. At the time, there really were not any services really being provided in a meaningful way to children and to adolescents who had serious emotional problems.”<sup>9</sup>

In 1996, Ken Kamis, Administrator of Wyoming’s Medicaid agency, the Division of Health Care Financing, proposed that community-based mental health centers could reduce their share of the state Medicaid match from the full state match rate to 15 percent match by developing intensive community-based services for children and adolescents who would otherwise be in placement outside their communities. The centers quickly applied and qualified for the reduced match rate, making more services available to both Medicaid eligible and non-Medicaid eligible clients of all ages.<sup>35</sup>

In the late 1990s, data collection became more automated, moving away from the paper and pencil into a computerized data collection recording system. The Wyoming Client Information System was developed. Carol Day explained that a lot of data collection was driven by the legislature by accountability and standards.

In this decade, methamphetamine or “meth” soon began stealing headlines in the state, drawing attention to what substance abuse services existed in the state. In the late 1990s, there was a push to get more funding in community based treatment for alcohol and other drugs. By 1998, the legislature took an unprecedented step and appropriated \$3.2 million, as part of the Methamphetamine Initiative, in seed money to implement a comprehensive substance abuse plan and pilot projects around the state. The initiative was led by the Governor’s Statewide Drug Policy Board. A year later, the legislature appropriated another \$5.2 million to continue the Methamphetamine Initiative, as well as providing funds to improve clients’ quality of life.

## 2000

WAMHSAC developed a report, *Wyoming Treatment Works!*, offering recommendations for the role of community centers within the system of care for the treatment and prevention of substance use disorders.

The Behavioral Health Division was split into the Mental Health Division and the Substance Abuse Division.

## 2001

The Wyoming Department of Health developed a substance abuse control plan for the state of Wyoming titled “*Reclaiming Wyoming: A Comprehensive Blueprint for the Prevention, Early Intervention and Treatment of Substance Abuse.*”

## 2002

Substance funding took a jump with the passage of House Bill 59 Substance Abuse Planning and Accountability.

## 2005

The legislature sought to improve services in Wyoming by initiating an audit to review of House Bill 59 and its administration.

The legislature also created the Select Committee on Mental Health and Substance Abuse Services to find ways to improve mental health services in Wyoming.

The Mental Health Division presented the Select Committee with its 2005 System of Care Plan for Wyoming’s Public Mental Health System.

The settlement of the Chris S. lawsuit required improvements at the State Hospital, development of community-based mental health services and increased access to services.



*Photo provided by Mike Huston.*

## Increasing Access to Effective Treatment

**F**or many years, substance abuse took a back seat to mental health, but that changed in 2000 with an increase in funding for substance abuse and government reorganization. Soon, the legislature turned a more critical eye to the distribution of substance abuse funding, as well as meeting the settlement of the Chris S. lawsuit and improving mental health services in the state.

Feeling the importance of staying involved in the discussion over future substance abuse efforts in the state, WAMHSAC developed a report, *Wyoming Treatment Works!*, offering recommendations for the role of community centers within the system of care for the treatment and prevention of substance use disorders. The report highlighted that consumption of alcohol and drugs by both adults and youth exceeded national averages and that deaths from substance abuse related causes occurred at a rate which is one-third higher in Wyoming than the nation.<sup>36</sup> Describing the role WAMHSAC agencies should play, the report called for the development of a comprehensive statewide

*Continued on page 35.....*



# 2000s

substance abuse plan by 2001 that would adopt mutually agreed upon system of care goals and objectives.

In 2000, the Behavioral Health Division was split into the Mental Health Division and the Substance Abuse Division. According to the Department of Health's 2000 Annual Report, one of the missions of the Mental Health Division was to advocate for and participate in the development and maintenance of a comprehensive system of mental health services and supports throughout Wyoming that stresses independence, dignity, security and recovery. The Substance Abuse Division's mission was to be a leader in providing high quality substance abuse services that anticipate and respond to the changing needs of persons served.

Carol Day, who worked for the department at the time, explained, "One of the reasons substance abuse was split out was that stakeholders didn't think substance abuse got enough attention. There was also the growing realization of the impact of substance abuse on corrections and education." Under Diane Galloway, the new director for the substance abuse division, there was a lot of program building and prevention, Day said. "In mental health, we concentrated on building the system of care with some success."<sup>17</sup>

Support for continued substance abuse funding and the creation of a comprehensive community-based system of care plan for substance abuse disorders topped WAMHSAC's legislative agenda for the 2001 session. Some of WAMHSAC's efforts paid off. In 2001, stemming from a legislative mandate, the Wyoming Department of Health developed a substance abuse control plan for the state of Wyoming titled *"Reclaiming Wyoming: A Comprehensive Blueprint for the Prevention, Early Intervention and Treatment of Substance Abuse."*

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## 2007

Senate File 76 provided additional funding to expand the regionalization process further.

## 2008

Additions to the budget bill provided needed expansion of the crisis stabilization program, which was a part of the overall regionalization concept.



**Part of Cloud Peak Counseling Center, Bighorn Supported Apartments helps residential clients in Worland. Photo provided by WAMHSAC 2010 Legislative Report.**

**Part of Volunteers of America (WYSTAR), the Life House is a men's treatment facility in Sheridan. Photo provided by WAMHSAC 2010 Legislative Report.**





Serving on the Labor, Health and Social Services Committee since 1997 and the serving as chairman of the committee from 2003-2006, Rep. Doug Osborn was focused on the development of a substance abuse plan. "I felt that we did a good job getting the subject moving and sort of under control or at least good start on it."<sup>38</sup> He mentioned working closely with WAMHSAC people and having a good relationship with them in general.

"Rep. Doug Osborn worked tirelessly with the Division of Substance Abuse and WAMHSAC in the development of a comprehensive substance abuse care plan for Wyoming and was responsible for the passage of legislation which raised funding levels for substance abuse treatment programs in Wyoming," McMahan said.<sup>3</sup>

In terms of mental health, the 2005 settlement of the Chris S. lawsuit required improvements at the State Hospital, development of community-based mental health services and increased access to services. Protection and Advocacy Systems, INC. CEO Jeanne Thobro described the improvements stemming from the 1994 lawsuit during an interview in early 2012. "The population at the Wyoming State Hospital is smaller, more people are getting services, and more people are getting appropriate services. There is less recidivism of people going in and out of the State Hospital because we have more stable supports and opportunities to maintain them in the community which prevents admittance to the Wyoming State Hospital."<sup>33</sup> She added that fewer people with mental illness who have not committed a crime are being jailed inappropriately because of supports through community mental health centers.

Thobro said, "I give WAMHSAC a lot of credit for the outcome of the Chris S. litigation. They were great to work with. While we brought the litigation and carried a lot of it, they can lay claim to a lot of the good things that have come out of it too."<sup>33</sup>

In terms of improvements at the State Hospital, Thobro said recruiting and maintaining psychiatric staff continues to be a challenge, requiring continual dialogue and effort. Yet, Thobro conceded in an interview in early 2012, "Today the Wyoming State Hospital is better than it was when the lawsuit was brought. It waxes and wanes in terms of problem areas."<sup>33</sup>

Also important, the settlement drove an increase in quality of life funding, "making a huge difference

**"The services here have been focused on my daughter's needs. When things get too difficult, her needs are considered on how to proceed. I have seen a great deal of improvement."**

**"I deal better with my drug cravings and I'm learning to have a better relationship with my husband."**

**- Client quotes from 2009 Legislative WAMHSAC Report<sup>37</sup>**

in what the centers were able to do," Rardin said.<sup>7</sup> He explained the quality of life funding made it easier to help the seriously mentally ill move out of the State Hospital. The funding was used to support clients with emergency subsistence, medicine, health supports, housing supports, transportation, socialization services and respite care.

As part of the Chris S. lawsuit, the state required that the centers had to be CARF (Commission on Accreditation for Rehabilitative Facilities) accredited. McMahan called it an expensive undertaking to jump through the hoops and paperwork to demonstrate data integrity. While CARF pushed us to look at client involvement and standards, Allan Braaten, executive

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**Mountain View Apartments in Torrington serves residential clients as part of Peak Wellness Center. Photo provided by WAMHSAC 2010 Legislative Report.**



## Dr. Pablo Hernandez

Dr. Pablo Hernandez came to the state as the superintendent of the Wyoming State Hospital in Evanston. He became the first in charge of state oversight of both the State Hospital and the mental health program.

“Pablo played a helpful role in that happening,” said Dr. Don Rardin, former director of the Fremont Counseling Service.<sup>7</sup> Prior to that, the State Hospital was under the Board of Charities and Reforms and the mental health centers were separate under the Department of Health.

“He also helped play a role in increasing the richness of our services to the seriously mentally ill. Basically he took the stance that we need to do whatever we need to do to be effective with this population.”



**Dr. Pablo Hernandez. Photo provided by the Wyoming Department of Health.**

director at Hot Springs County Counseling Services, said it also cost the centers a lot of money and even more paperwork. Additionally, CARF only handled the mental health side, and centers had to follow different standards for substance abuse, as well as state reviews.

Substance abuse funding took a jump in 2002 with the passage of House Bill 59 Substance Abuse Planning and Accountability, which called for the development of a comprehensive substance abuse plan and for a \$25 million appropriation. The bill outlined several interventions to expand, including: substance abuse treatment services, including a Substance Abuse Control Plan, an Addicted Offenders Accountability Act, drug courts, expanded revenue streams, and designated tobacco settlement funds.<sup>39</sup>

By 2005, the legislature sought to improve services in Wyoming by initiating an audit review of House Bill 59 and its administration. According to the audit, released in 2006, substance abuse treatment efforts in the state continued to be fragmented, despite the continued appropriations. “At the state level, standards have been established but a single comprehensive plan has not been identified; compartmentalization of state agency budgets, personnel, and efforts continues, and little inter-agency sharing of data occurs. At the regional level, the provider network remains much the same as it was in 2002 and a coordinated continuum of care remains elusive.”<sup>39</sup>

“Senator John Schiffer has provided outstanding leadership in the legislature on behalf of mental health and substance abuse treatment services in Wyoming,” McMahan commented, noting that Schiffer served on the board of the Northern Wyoming Mental Health Center in the early 1980s.<sup>3</sup>

In the 2005 session, the legislature created the Select Committee on Mental Health and Substance Abuse Services to find ways to improve mental health services in Wyoming. Sen. John Schiffer served as co-chair with Rep. Colin Simpson. Rep. Keith Gingery explained that it became apparent that we were falling further behind, so Colin Simpson and John Schiffer set up the original committee, which I was one of the original members.”<sup>40</sup>

Rep. Osborn also served on the Select Committee as well as chaired the Labor, Health and Social Services Committee. The Labor Committee was set up to handle mental health and substance abuse issues, but the issues received more attention by creating a select committee, Osborn said. “It had enough people in legislative leadership on it that it got more attention than it would have gotten if you just relied upon the Labor Committee to do.”<sup>38</sup>

The bill that created the Select Committee arose from Rep. Simpson’s passion to see the state do a better job addressing mental health issues for the people in

*Continued on page 38.....*

**“We cochaired the committee for two years and really pushed through great changes in the system of care to allow for a broader net of care for people and greater opportunities for care in their home communities.”**

***-Rep. Colin Simpson, cochair of the Select Committee on Mental Health and Substance Abuse Services<sup>41</sup>***

Wyoming especially in those areas without big population centers or hospitals. Rep. Simpson put in the bill, asking Sen. Schiffer to cosponsor it and agree to co-chair the committee. The bill passed.

“We co-chaired the committee for two years and really pushed through great changes in the system of care to allow for a broader net of care for people and greater opportunities for care in their home communities,” Rep. Simpson said.<sup>41</sup> The Select Committee looked at many things from examining models of care around the state, available resources and data reporting. He recalled that members of WAMHSAC testified often and helped the committee find resources.

Simpson said, “WAMHSAC provides a valuable service to the citizens of Wyoming. They work very hard, at least in my experience with the directors. The people who we worked with and came and testified before the Select Committee did their best to be forthright, to provide us with information and to work towards the best interest of their clients. I respected their ability to do that.”<sup>41</sup>

Another aspect that arose from the Select Committee’s efforts was the need for quality reporting. Rep. Simpson explained that the entire data reporting system needed improvements “so you could actually tell whether the services a person gets actually does something and not just that they get some counseling. The whole data system needed significant work.”<sup>41</sup>

**Left to Right: Legislators who served on the Select Committee on Mental Health and Substance Abuse Services included: Sen. Patricia Aullman, Sen. Doug Osborn, Sen. John Schiffer, Rep. Keith Gingery, Rep. Jerry Iekel and Rep. Colin Simpson. Photos provided by State of Wyoming Archives and the Legislative Services Office.**



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# 2000s

The Select Committee faced obstacles typical of changing a system, from turf battles to egos and people not wanting to change. However, Rep. Simpson pointed out that the committee was successful in getting most of WAMHSAC unified and had great support from the legislature.

On the other hand, the Appropriations Committee leadership wasn't too thrilled with the efforts because there was significant funding attached, Rep. Simpson said. "The governor didn't like the amount of funding in it, but he did not overtly go after it."<sup>41</sup> The Select Committee thought the funding was appropriate to support the system of care it wanted, he said.

In October 2005, the Mental Health Division presented the Select Committee with its *2005 System of Care Plan for Wyoming's Public Mental Health System*. Developed with jointly with WAMHSAC, the plan divided the state into five comprehensive care regions in which the client is the "hub" or centerpiece of system services. Under the plan, clients would have equal access throughout the state to a continuum of services, some provided locally, some provided regionally and others provided on a statewide basis.<sup>42</sup> The Division updated the report in late 2006, providing the next steps in implementing the direction of regionalization and effectively utilizing the resources made available through the passage of House Bill 91 in 2006.

In Peak Wellness Center's 2006 Annual Report, Executive Director David Birney explained that "we are now in the middle of a significant transformation of our system of care in Wyoming, as individual centers are now grouped into regional service systems to ensure that comparable services are available to everyone in need."<sup>43</sup>

"Along with the structural changes came additional funding for salary adjustments, service expansion, funding for emergency services, funding for psychiatric services, and pilot projects for local crisis stabilization and inpatient care. Reconfiguring the state is a challenging and complex enterprise and we have only just begun. While each center struggles to work cooperatively with others, we are also working through numerous unexpected issues as they arise. One powerful and essential initiative is implementation of recovery principles throughout our services in order to empower clients to be full partners in their care."<sup>43</sup>

Problems popped up with implementation of some of the Select Committee's efforts, Rep. Simpson said. For instance, funding existed for crisis beds in the Big Horn Basin, but the Wyoming Department of Administration and Information said that none of the money could go to brick and mortar that it had to go to programming, Rep. Simpson said. "I didn't agree with that and went back and changed language in the budget amendment. And it still didn't happen for other reasons."<sup>41</sup>

"I was still hopeful that we could have greater improvements in Park County and the Big Horn Basin. We have had some improvements but I expected there to be more," Rep. Simpson said.<sup>41</sup>

Implementation was impeded further from the administration side, but Rep. Simpson was not sure whether it was the view held by Division directors or that the Divisions were "directed by the governor to slow it down and inhibit it in an effort to reduce funding." Simpson thought the opposition stemmed from the amount of funding tied to the efforts. "I think that was pretty detrimental to the effort in what was really kind of a back door way to avoid the effect of the legislation."<sup>41</sup>

After two years and two fairly sizable appropriations in a budget year and supplemental one, Sen. Schiffer and Rep. Simpson were removed as chairmen and replaced by Rep. Gingery and Sen. Pat Aullman in 2007. "Leadership was a little tired of the success of the committee," Rep. Simpson said.<sup>41</sup>

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## Total Outpatient Service Hours Provided in FY2009

Total Number of Individuals Served - 28,218  
(Includes both enrolled and unenrolled clients)





The Select Committee continued its work. In addition to House Bill 91, additional legislative efforts helped obtain support and funding for the regionalization efforts over the next several years. In 2007, Senate File 76 provided additional funding to expand the regionalization process further. In 2008, additions to the budget bill provided the needed expansion of the crisis stabilization program, which was a part of the overall regionalization concept.

In its Aug. 1, 2008 letter to the Joint Appropriations Interim Committee, the committee also reported that, "Implementation of regionalization is proceeding well. Both the Division and the WAMHSAC providers have done a good job of implementing the process. There have been some transition challenges, but overall the process is going well."<sup>44</sup> Reviewing regionalization efforts, the Select Committee on Mental Health and Substance Abuse advocated for a significant and needed appropriations request in a bill during the 2009 legislative session to bring regionalization closer to completion. Yet by 2009, the Select Committee disbanded.

With energy prices once again tanking in 2009, Gov. Dave Freudenthal instituted a 10 percent budget cut as a safety measure, carving \$3.8 million out from money going toward community mental health and substance centers. Huston said the cuts hit centers differently. "With \$650,000 cut out of its budget, Central Wyoming was unable to increase staff at its residential treatment facility while other centers had to lay off staff."<sup>9</sup>

This economic situation set the stage for conversations in the coming years as the state tried to cut costs while the community mental health centers fought to maintain and improve the developed system of care.



**A 2009 BBQ held at John McMahan's home in Buffalo, WY. (Photos provided by WAMHSAC)**

**TOP PHOTO: Jerry Iekel, Mike Huston and John McMahan**

**BOTTOM PHOTO: Allan Braaten and Ivan Kuderling**



# Summary

Over the last 60 years, Mike Huston, former director of Central Wyoming Counseling Center, emphasized that work done by the local mental health centers, the Wyoming Legislature and the Wyoming Department of Health strengthened the community-based model and increased services available to Wyoming residents where they live. Wyoming stands out in these efforts. Since the Mental Health Act in 1963, Wyoming focused on helping all residents, but many other states used their funding to just help targeted populations, Huston said. “Wyoming is really one of the few states that have held on to the original true intent of the Mental Health Centers Act. Our services are available to anybody regardless of their income within their community.”<sup>9</sup>

## 60 Years

**The development of community-based mental health centers has made a tremendous difference in the lives of many Wyoming individuals and families.**

Prior to these services being available in communities, anyone struggling with psychiatric and psychological problems such as major depressive disorders, schizophrenia, bi-polar disorders and substance abuse problems, would be forced to seek help at the emergency room at the local hospital or with their family practice physician or a minister. In some cases where an individual had no support system, people were locked up in jail cells. Many seriously mentally ill were sent to the Wyoming State Hospital to live out their lives. In the 1960s, the State Hospital had around 500 patients where today that is more around 80.

Deinstitutionalization efforts, along with federal grants, in the 1960s sought to transform services. Yet, returning patients to small, rural communities created new challenges as most Wyoming cities and towns didn't have trained mental health providers. Outpatient

services were housed in side-street, store-front locations, medical clinics and even county court houses. Outreach to smaller communities was offered on an intermittent basis in school facilities or churches.

In 1969, the Wyoming Legislature made a deliberate policy decision to support community governed boards to deliver mental health services in local communities. This decision led Wyoming down a different path at the time than other states. Local centers and their board members stepped forward and provided a strong leadership role in figuring out what kind of services were needed in the community to support persons with mental health and substance abuse problems.

The 1970s were a growing period as mental health centers started sprouting up in the smaller communities and as the local boards for the centers organized to push for statewide change. These local boards evolved into passionate, powerful advocates for change with contacts that included governors' wives and important legislators. Their influence and grassroots efforts took on new importance as state government and the Wyoming Legislature took on more active roles in funding and ensuring standards of care. In the late 1970s, the Legislature passed a mechanism to distribute state and federal funding to the centers.

*Continued on page 42.....*

# Summary

During the 1980s, the association for the local boards started to gain momentum and develop a legislative agenda, which came in handy as state government tried to define standards of care. During this time, legislators started advocating for increased accountability for funding overall, and state government tried to tie standards of care to funding. The first efforts caused a great uproar among the centers but, working with the centers and the association, state staff obtained buy-in for the standards, more specific contracts and a data system.

The drop in oil prices led to a devastating bust in the 1980s. The bust impacted the centers in terms of funding cuts and an increased demand in services from a stressed out population. In 1988, the Wyoming Association of Mental Health Directors and Wyoming Mental Health Center Boards Association joined together to issue the Report on Mental Health Services in Wyoming FY87. The report highlighted that the majority of treatment had to be subsidized by state funds.

Efforts in the 1990s stressed expanding care to adults and children with serious and persistent illness, highlighting substance abuse problems in communities and adding quality of life funding. To do that, the directors and the local boards agreed to become one association to better communicate to the legislature and the public. The Wyoming Association of Mental Health and Substance Abuse (WAMHSAC) formed as an official association in 1991. Having a strong political base in the legislature also brought WAMHSAC forward. During the early 1990s, WAMHSAC hired Wendy Curran as its executive secretary to strengthen their legislative presence.

In 1994, the state's efforts to provide adequate services at the State Hospital were publicly questioned when Protection & Advocacy System, Inc. sued the State of Wyoming on behalf of patients, identified only as Chris S., et al., alleging inadequacy and unavailability of appropriate facilities and services for people with mental illness. One of the main goals was to get a ramped-up community system that would not have a person who did not need the Wyoming State Hospital go there.

The Chris S. Lawsuit was critical in increasing effectiveness of services. In terms of mental health, the 2002 settlement of the Chris S. lawsuit required improvements at the State Hospital, development of community-based mental health services and increased access to services.

For many years, substance abuse took a back seat to mental health, but that changed in 2000 with an increase in funding for substance abuse and government reorganization. Soon, the legislature turned a more critical eye to the distribution of substance abuse funding, as well as meeting the settlement of the Chris S. lawsuit and improving mental health services in the state.

In the 2005 session, the legislature created the Select Committee on Mental Health and Substance Abuse Services to find ways to improve mental health services in Wyoming. One of the outcomes of increased scrutiny, the Mental Health Division released a plan that divided the state into five comprehensive care regions in which the client is the "hub" or centerpiece of system services. Under the plan, clients had equal access throughout the state to a continuum of services, some provided locally, some provided regionally and others provided on a statewide basis.

The 2000s started a significant transformation of the system of care in Wyoming, as individual centers were grouped into regional service systems to ensure that comparable services are available to everyone in need. Reconfiguring the state remained a challenge for centers as they worked together while also ensuring adequate services for their own communities.

The creation of the mental health and substance abuse system of care in Wyoming has been a partnership among legislators, governors, Department of Health and Division staff, advocates, and professionals. We are extremely grateful for everyone who has participated. As we have during that past sixty years, WAMHSAC will continue this partnership to serve the behavioral health needs of the citizens of Wyoming.



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# WAMHSAC Directors July 2013



**TOP ROW:** Darwin Irvine, Big Horn; Peter Edis, Behavioral Health Services of Campbell County; Ed Wigg, Curran/Seeley; Cori Cosner-Burton, Mercer Family Resource Center; Mark Russler, Cloud Peak Counseling Center; David Birney, Peak Wellness Center; Peggy Hayes, Solutions for Life; and Jeff Holsinger, Volunteers of America Northern Rockies

**BOTTOM ROW:** Deidre Ashley, Jackson Hole Community Counseling Center; Kipp Dana, High Country Behavioral Health; Ralph Louis, Big Horn; Ivan Kuderling; Allan Braaten, Hot Springs County Counseling Center; Lynne Whittington, Northern Wyoming Mental Health Center; and David Monhollen, Central Wyoming Counseling Center

*(Photo provided by WAMHSAC)*



**TOP LEFT:** A WAMHSAC meeting. **TOP RIGHT:** Deidre Ashley talks to Kipp Dana with Dr. Alice Russler. *(Photos provided by WAMHSAC.)*





*(Photos provided by WAMHSAC)*

**TOP LEFT:** Peggy Hayes (left) and Lynne Whittington (right)

**TOP RIGHT:** Jackson Hole Community Counseling Center

**SECOND ROW:** Ed Wigg (left) and Cori Cosner-Burton (right)

**LEFT THIRD ROW:** Jeff Holsinger (left) and Mark Russler(right)

**RIGHT THIRD ROW:** Mercer Family Resource Center

**BOTTOM LEFT:** Peak Wellness Center

**BOTTOM RIGHT:** Linda Acker, Southwest Counseling Service

