Wyoming

UNIFORM APPLICATION
FY 2022/2023 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
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Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2022

End Year 2023

State SAPT DUNS Number

Number 809915796

Expiration Date 1/29/2022

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Wyoming Department of Health

Organizational Unit Behavioral Health Division

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City Cheyenne

Zip Code 82002

II. Contact Person for the SAPT Grantee of the Block Grant

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Agency Name Wyoming Department of Health

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State CMHS DUNS Number

Number 809915796

Expiration Date 1/29/2022

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Wyoming Department of Health

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III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
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Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	
Revision Date	

VI. Contact Person Responsible for Application Submission

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OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

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State of Wyoming Overview

Wyoming is a rural and frontier state, where approximately 576,851[1] people reside in the 97,093.14 square miles, and continues to be the least populated state in the nation. The state experienced an approximate one percent decline in residents from 2019 US Census of 578,759 and a 0.33 percent decrease since previous application submission. The population remains at approximately 49 percent female and 51 percent male. The ethnicity is predominately non-Hispanic White, which accounts for 83.7 percent of the total population. Latino or Hispanic with 10.1 percent, followed by American Indian at 2.7 percent, Black or African American at 1.3 percent, Asian at 1.1 percent, while Native Hawaiian and other Pacific Islanders are at 0.1 percent, and two or more races are 2.2 percent of the population (U.S. Census Bureau, 2019).

The two most populous towns are Cheyenne with 64,235 residents, and Casper with 57,931 residents, which collectively account for about 21.1 percent of the state's population. The remaining residents live in small towns, rural communities, and frontier settings throughout the state. Wyoming has 5.8 persons per square mile, compared to the national average of 87.4 persons per square mile (U.S. Census Bureau, 2019).

The Behavioral Health Division (Division), one of five divisions within the Wyoming Department of Health (WDH), is the Single State Authority (SSA) for the delivery of mental health and substance use treatment and recovery services. The Division is comprised of the Mental Health and Substance Abuse Services (MHSAS) section, the Early Intervention and Education Program (EIEP), the Wyoming Life Resource Center (WLRC), and the Wyoming State Hospital (WSH).

The units within the MHSAS section have been reorganized. This does not mean all the job duties have been changed. The four units are the Grants and Programs Unit, the Quality and Evaluations Unit, the Community Treatment Services Unit, and the Knowledge-Management, Analysis, and Technology (KMAT) Unit.

The Grants and Programs Unit applies, monitors, and implements grant requirements based on funding received and for related programs. This Unit will be the direct contact for the block grants for requests, revisions, and information.

The Quality and Evaluations Unit collaborates with the KMAT Unit to monitor data and information gathered from contractors and subrecipients. The Quality and Evaluation Unit also manages quality assurance and improvement activities.

The KMAT Unit provides a multitude of services to assist in collecting, obtaining, and verifying data. KMAT is a large partner in providing data for Treatment Episode Data Set (TEDS), grant reporting, and any other data requests. The Unit also oversees the Mental Health Statistics

[1] Wyoming Quick Facts for Demographics and Geographical information

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Improvement Program surveys to contracted providers, which collects direct evaluations from the individuals served, followed by a summarized report conducted by KMAT.

The Community Treatment Services Unit develops contracts with Community Mental Health Centers (CMHC) and Substance Abuse Centers (SAC), which outline the specific services to be provided to individuals with mental health and substance use disorders. These centers provide evidence-based mental health and substance use services within outpatient and residential settings and are funded largely by the State. Within the Community Treatment Services Unit resides the Court Supervised Treatment (CST) program. The CST program includes adult, juvenile, tribal, and Driving Under the Influence (DUI) categories within 14 counties in Wyoming and 19 state-funded courts. CST programs provide sentencing alternatives for the judicial system in cases stemming from substance abuse.

EIEP provides developmental screenings and services to help children get on track to a successful future through 14 child development centers across Wyoming. EIEP administers the Part C and Part B/619 programs of the Individuals with Disabilities Education Act (IDEA). Part C consists of early intervention services for infants and toddlers with disabilities, ages birth through two years, and their families. Part B/619 is intended to help states ensure all preschool-aged children (three-five years of age) with disabilities receive special education and related services.

The Division oversees two healthcare facilities. The WSH provides acute psychiatric and forensic care for adults. The WLRC is a residential community with therapeutic and medical support services for adults with intellectual disabilities, exceptionally difficult behaviors, and individuals who are hard to place, all requiring intermediate care.

The Division's mission is to support the Behavioral Health Community by providing an outcomes-driven continuum of care, which promotes individualized services, wellness, and accessibility through collaboration, advocacy, and stewardship. The MHSAS section mission is to further promote a healthier Wyoming by working with partners to provide access to affordable, high-quality mental health and substance use treatment services, promote evidence-based treatment, quality improvement, and person-centered services and supports through state contracts, grants, and collaboration with community providers.

As the SSA, the Division contracts with 15 providers for the delivery of outpatient and residential services for mental health and substance use disorders. Of those providers, 10 provide both mental health and substance use services, two provide substance use services only, and two provide mental health services only. A number providers have merged businesses and practices, reducing the number of providers contracted through the State, but does not decrease the services offered.

Through set contracts, the CMHC and SAC are obligated to provide services and supports as indicated by individual treatment plans to all population groups, even after state funding has been exhausted. Providers received higher reimbursement rates for the services provided to priority populations. Priority populations for mental health services include persons with Serious Mental

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Illness (SMI) and children with Serious Emotional Disturbances (SED). Prioritized substance use service populations include pregnant women, intravenous drug users (IVDU), women with dependent children, and veterans.

The WDH consists of five divisions which include Administration and Support, Health Care Financing (Medicaid), Aging, Behavioral Health, and Public Health. The Public Health Division (PHD) includes programs relevant to behavioral health such as Substance Abuse Prevention, the Wyoming Injury & Violence Prevention, Communicable Disease Prevention, and Tobacco Prevention and Control. The Division works closely with the PHD as it relates to the block grant services. The Healthcare Financing Division oversees public healthcare programs such as Medicaid and Kid Care CHIP. The Aging Division provides care, ensures safety, and promotes independent choices for Wyoming's older adults.

WDH collaborates with the Department of Family Services (DFS) and the Department of Corrections (DOC). During the time of the previous application, DFS was administered by the WDH. Since then, DFS has transitioned out of WDH due to new leadership. DFS assists in the delivery of services and the welfare needs of individuals with mental health and substance use disorders. DOC oversees the criminal justice and legal involvement of those in the criminal justice system who may also have mental health and substance use disorders. The Wyoming Department of Education (WDE) and local school districts are responsible for implementing PL 101-476 and its amendments. This law is the Education of the Handicapped Act Amendments of 1990, also known as, the Individuals with Disabilities Education Act (IDEA). This federal law amended and expanded The Education for All Handicapped Children Act of 1975. The act uses “people-first” language, replacing “handicapped children” with “individuals with disabilities” and the definition expanded of individuals with disabilities. The law mandates special education services for children ages three to 21 and extends services for infants from birth to age two.

Independent Peer Reviews occur annually with both mental health and substance use providers. The Division selects providers to participate in the peer review. Selections are based on provider performance, data, and relevant initiatives within the state. Providers visit (in-person or virtual) other agencies and review program areas such as clinical documentation, client satisfaction, and treatment. Providers are required to submit a report with their discoveries to the Division before the 1st of September of each year.

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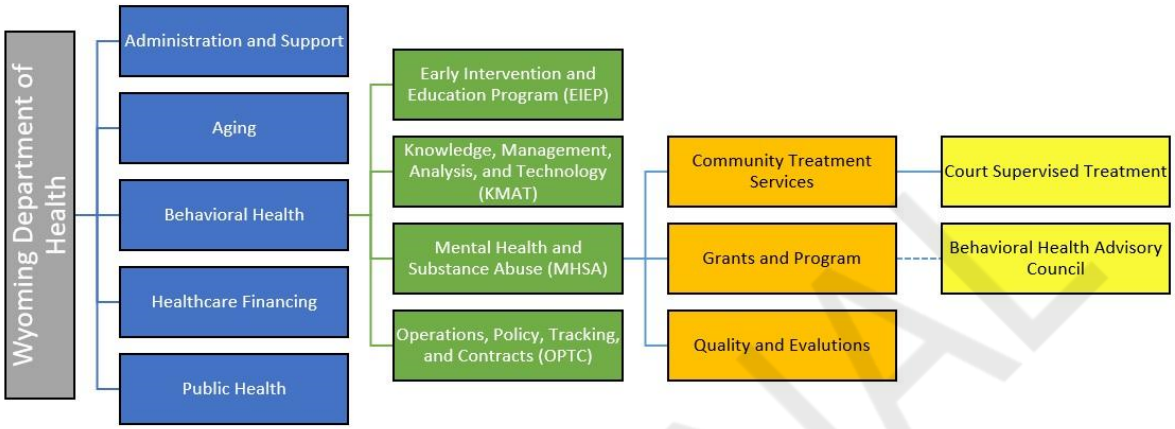
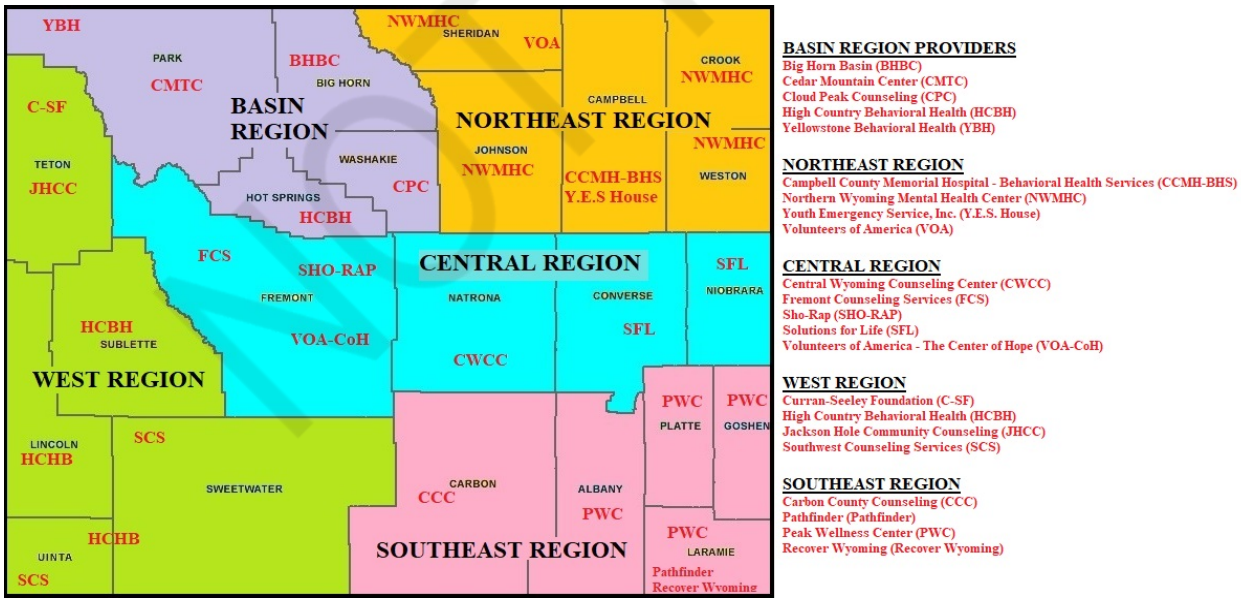
Wyoming Department of Health Organizational Chart



It should be noted Wyoming is not currently a Medicaid expansion state.

Wyoming Behavioral Health System Organization Comprehensive Care Regions

The following map portrays the comprehensive care regions in the state.



Treatment - Mental Health Description of Service System

As previously stated, Wyoming is a rural and frontier state. This provides a challenge with limited access to specialized services for priority populations. The population density in Wyoming has approximately 5.8 persons per square mile. Travel in the winter months is often restricted due to

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weather-related conditions. Along with challenges in traveling, internet services are frequently unavailable, limited, or hard to access. This is based on out-of-service and limited service areas, and due to COVID-related shutdowns, inability or extreme difficulty to access free internet at local businesses or public spaces (i.e. public library, schools, etc.). These unique or COVID-related limitations make service provision to individuals in need challenging and require state staff, providers, and communities to close gaps, create bridges, and increase services and care.

Historical funding has targeted adults with SMI and children with SED. Wyoming maintains the original focus of community mental health and substance abuse treatment by providing a range of services to broad populations throughout the state, with access priority given to persons with SMI, SED, and specified substance abuse populations.

The CMHC and SAC are private non-profit organizations with local volunteer governing boards. The citizen-board concept facilitates a natural attachment to the communities served. Citizen boards allow CMHC and SAC, at a local level, to be accountable, responsive to needs, and provide advocacy. Local control is enhanced by the politically active Wyoming Association of Mental Health and Substance Abuse Centers (WAMHSAC), which includes mental health and substance abuse center executive directors and board members.

The WSH, overseen by the Division, works to coordinate continuity of care for individuals with SMI and provides inpatient care for the state's most severe mentally ill clients. WSH is located in the southwest corner of the state on 160 acres. For the last two years the campus has been undergoing major changes with the construction of new patient care halls. As of mid-December 2020, all patients have been moved from the old campus and other parts of the existing building into the newly constructed areas. This is the first time since the early 1900's that all patients have resided under the same roof. In addition to providing updated treatment facilities and enhanced safety features, the new halls also allow for all patients to have private rooms. Construction will move into Phase 3 with a renovation of the old patient care halls and treatment areas into administrative and support service areas that will culminate in the majority of hospital services moving out of the old campus and be located in one location. Though not initially meant to house the state's overflow of individuals experiencing a mental health crisis, this acceptance generally pushes WSH at the maximum capacity and generates a waitlist[2].

Adults with SMI are primary clients served through the involuntary commitment process, known in Wyoming as the Title 25 system (Wyo. Stat. § 25-10-101 – 129). MHSAS section assists the mental health system by focusing on clients with high needs through contracting strategies and conducting projects, such as analyzing utilization and reducing the length of stay in mental health community housing options. Reducing the length of stay will assist in providing an increased number of available beds for individuals discharged from Title 25.

[2] Wyoming State Hospital

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The MHSAS of the Division has targeted several initiatives for individuals at the status of involuntary hospitalization or at risk of hospitalization, to increase access to the least restrictive environment. Wyoming's involuntary hospitalization statute (Wyo. Stat. Ann. § 25-10-101 – 129 aka Title 25) intervenes and detains individuals against their will if they are deemed to be a danger to themselves or others, or have the inability to care for oneself because of mental illness. Engagement and cooperation between state staff, providers, and other agencies strengthens partnerships by creating teams that work closely together to implement initiatives and projects.

Gatekeeper services came about as a result of changes to the Title 25 statue language in an effort to divert clients from going straight to WSH. The gatekeeper role includes duties, such as providing guidance to courts, healthcare providers, and other stakeholders on the detention and hospitalization process. Furthermore, gatekeepers are intended to monitor and facilitate effective client treatment before, during, and after any emergency detention or involuntary hospitalization. Gatekeepers also provide intensive case management to clients. Previously, a separate memorandum of understanding (MOU) was created with CMHC for purposes outlining each center's role in the Title 25 process relevant to each county, and to formally "designate" the entity as the gatekeeper for the service area, this is still in practice as it is part of the statue language. MHSAS has discontinued individual contracts with the CMHCs and has made the funds available to all of the centers within the treatment services contracts. Additional funding has also been made available to CMHCs for the development of diversionary services, such as gatekeeping and crisis stabilization. Through the gatekeeper designations, providers can play a vital role in diverting individuals from the Title 25 system, including providing services under directed outpatient commitment. Directed outpatient commitment allows individuals to stay in the community under a required treatment plan as providers work together with other agencies to assist the individual in obtaining needed supports and services.

The Mental Health Block Grant (MHBG) will be utilized to directly fund mental health providers for outpatient treatment services. MHBG funds will continue to be utilized in contract with the mental health Ombudsman program through Wyoming Guardianship Corporation, an advocate on behalf of individuals with mental health or substance use issues. First Episode Psychosis (FEP) services are also a priority and funded through the block grant to Southwest Counseling Services and Yellowstone Behavioral Health Center. Through American Rescue Plan Act (ARPA) funding, the Division is planning to build the ability for an additional provider to provide services in Wyoming, making three providers.

Through the ARPA funding, the Division determined not less than 10 percent of the total allocation of funds to be used to enhance the capacity of another subrecipient to provide ESMI/FEP services in an additional geographic catchment region. Since this will entail adding a service line for the provider, startup costs including training and policy engagement will be included as well as the provision of treatment and recovery services. Allowing a total of three providers in Wyoming to provide First Episode Psychosis services.

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There are MHBG funds supporting activities conducted by Subrecipients of the Project for Assistance in Transition from Homelessness (PATH) Grant related to SMI and SED services. There are currently four providers, three serve the adult population and one serves strictly youth. PATH providers are encouraged to work with contracted CMHCs and SACs. To reduce duplicated payment, PATH providers are only allowed to bill for non-mainstream services by working with other mental health and substance abuse centers within the individual's area.

Treatment - Substance Use Description of Service System

The MHSAS section has recognized an increase in demand for opioid and methamphetamine treatment services. The Division was awarded the State Opioid Response (SOR) Grant and it is being utilized throughout the state with nine treatment providers. Wyoming aims to prevent the opioid epidemic experienced in other states, focusing on providing access to Medication-Assisted Treatment (MAT), expanding the opportunities to reach more people through integrated behavioral health and partnerships with criminal justice, and reducing opioid overdose-related deaths through provisions of treatment and recovery activities for Opioid Use Disorder (OUD).

As a priority population, SACs are required by contract to provide treatment according to the priority population hierarchy outlined in the provider contracts, i.e., prioritized substance use service populations including pregnant women, intravenous drug users (IVDU), women with dependent children, minority populations, and veterans.

The Division promotes the use of standardized screening and assessment tools, along with placement criteria to improve patient retention and treatment outcomes. The State of Wyoming Substance Abuse Rules and Regulations state that certified providers shall utilize an evidence-based assessment tool which includes the comprehensive information regarding the client's biopsychosocial and spiritual needs. Addiction Severity Index (ASI).

According to Wyoming contract requirements, substance abuse services are to be prioritized to those persons who meet the special populations identified by Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SAPT) requirements for admission preference. The SAPT will be utilized to directly fund community SACs for outpatient and residential treatment services. The 10 percent set-aside of the Grant is utilized for women's outpatient services.

The Division continues to ensure compliance with the Wyoming State Treatment Standards and Federal Block Grant Requirements for women's treatment and parenting women, such as primary medical care for women and dependent children, prenatal care, therapeutic child care, drug-free housing, and education and employment training programs. Wyoming currently has several specific programs meeting federal requirements for priority populations. Not only are all funded providers required to meet the priority population guidelines, several programs are specific to various populations. One main service area considered a strength for Wyoming is its Women's Treatment programs. The Division continues to provide technical assistance and federal funding

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for substance abuse residential treatment for women and day treatment programs for women to Central Wyoming Counseling Center, Volunteers of America Northern Rockies, and Southwest Counseling Center for women and children's treatment. The Division utilizes the Mountain Plains Addiction Technology Transfer Center (ATTC) training for all statewide provider trainings related to substance use, and informs and encourages providers to utilize free trainings (i.e. online by out-of-state companies) across the state.

Southwest Counseling Service's Women's Addiction Program was the first program in the state of Wyoming that allowed pregnant women and mothers with substance abuse addiction to receive intensive residential treatment while maintaining their responsibilities to their children. The children are in the program with their mothers, allowing the women the opportunity to enhance parenting and life skills.[3]

The PHD, Substance Abuse Prevention Program utilizes the 20 percent set aside of the Grant for community-level prevention efforts. Although low incidence of tuberculosis (TB) cases are found in Wyoming, the PHD, Communicable Disease Unit utilizes approximately 0.8 percent of allocated SAPT funds for treatment and testing services for TB. CMHC and SACs are able to refer clients to the local TB program, when necessary. Some centers can provide dual treatment. CMHC and SACs are also able to receive training from local Public Health Nurses or through the PHD TB program.

Recovery Support

Wyoming has one Recovery Community Organization (RCO), Recover Wyoming, located in Cheyenne. Recover Wyoming provides services primarily in the southeast region, and have the ability to utilize online meeting resources (i.e. Zoom). RCOs are independent, non-profit entities governed and run by people in recovery, working to bridge the gap between treatment and long-term recovery. Recover Wyoming is closely connected to the national RCO network, allowing Wyoming to learn from the experience of others, and gain access to tools and techniques proven effective in sustaining long-term recovery. Recover Wyoming is a community-based organization dedicated to advocacy advancement and involvement for individuals in recovery from substance and alcohol addiction. Recover Wyoming conducts training for persons in recovery aiming to "equip people in recovery, their families, and friends to change how health, public safety, workplace, and criminal justice systems deal with alcohol and drug problems." Recover Wyoming is also a contractor under the PATH Grant for those individuals who are literally homeless or at imminent risk of being homeless.

The Division supports recovery coaches and peer specialists through four mechanisms:

[3] Southwest Counseling

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- Peer Specialist Certification, for individuals with their own recovery history, who have completed a 40-hour Division approved peer specialist training course or recovery coach course.
- Funding from federal grants to support a Wyoming-developed annual 40-hour peer specialist training course taught by experienced Wyoming peer specialists and recovery coaches.
- Inclusion of optional peer support services in community mental health and substance use treatment contracts.
- Inclusion of peer support services in federally funded special grant contracts.

Wyoming recognizes recovery coaches as peer specialists. Both persons in mental health and substance use recovery may qualify as a peer specialist. Wyoming Medicaid includes peer support as a billable service.

Peer specialists are employed through the substance use treatment contractors under the DOC, at the WSH, the Veteran's hospitals, tribal and reservation providers, and private providers. The number of persons certified to provide peer support has increased over time:

Number of Certified Wyoming Peer Specialists								
2013	2014	2015	2016	2017	2018	2019	2020	2021
18	23	20	26	54	67	97	130	155

Individuals and family members are frequently presented with opportunities to proactively engage and participate in treatment planning, shared decision-making, and the behavioral health services delivery system. The Consumer Survey project is a way to collect the overall satisfaction of consumers as it pertains to services. Consumers may also participate on agency-level advisory boards. The Behavioral Health Advisory Council includes consumer representation.

The Division wishes to continue to support and broaden current recovery initiatives for individuals with and their family members, which provide care coordination and support of persons with SMI and SED, as well as those with substance use disorders. The Division is in the process of transitioning the certification process to Recover Wyoming by the end of the current fiscal year. Recover Wyoming worked with International Certification & Reciprocity Consortium (IC&RC) to incorporate their process for Wyoming Peer Specialists. This change will allow for reciprocity for peer specialists that move to other states or countries.

Recovery Support - Individuals with Co-occurring Disorders

A majority of Wyoming providers provide integrated mental health and substance abuse services. Integrated mental health and substance abuse services are delivered in both residential and

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outpatient programs. It is considered a standard of care to serve all of the needs of an individual, including those with co-occurring disorders.

Children/Adolescents

Children are served throughout the state of Wyoming by CMHC's with center-based and community-based services.

Children / Adolescents Substance Use Services. Intensive outpatient substance use treatment programs for adolescents have been developed in some of the more populated areas of the state. An example of a provider with SUD service is Southwest Counseling in Rock Springs. Substance use disorder residential services are available through Division funding. An example of a business with this service is Central Wyoming Counseling Center in Casper. Casper can be found in Natrona County and Central Region. All SACs provide outpatient services for adolescents.

Children / Adolescents Mental Health Services. The mental health system of care for children and adolescents in Wyoming is the shared responsibility of several systems and the local providers which are contracted. CMHCs provide a full range of mental health services for children/adolescents and their families. However, accessing these specialty services is more challenging in the more rural regions of the state.

The WDE oversees 48 school districts, which are administered with considerable local autonomy. School districts are responsible for providing or purchasing services to meet the needs of children with SED, including arranging for residential placement, if needed. To be eligible for these services, a child's SED must adversely affect their educational performance. In some school districts, this is a fairly subjective decision and appropriate services for these children are difficult to access without intense advocacy.

The Children's Mental Health Waiver (CMHW) is a Medicaid program and can be found within the Wyoming Department of Health, Healthcare Financing Division. CMHW is for children with SED. The goal of the program is to keep youth with SED in their home communities with their parents/families involved in all aspects of their treatment, and custody relinquishment prevention. The program works to strengthen families' skills to support the physical, emotional, social, and educational needs of the child. The CMHW provides non-clinical mental health support services, as a part of the overall children's mental health system of care. The program seeks to reduce or prevent children from needing placement in psychiatric hospitals.

The CMHW serves children/youth ages four through 20. Participants must meet the definition of SED, have a Diagnostic and Statistical Manual (DSM) Axis I or ICD diagnosis; meet at least one Medicaid criteria for inpatient psychiatric hospitalization; have a Child and Adolescent Service Intensity Instrument (CASII) composite score of 20-27 (ages 6-20) or Social/Emotional Assessment (ages 4-5); must be financially eligible for Medicaid based on their own resources; and must receive services provided by certified waiver providers (available in all counties in

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Wyoming). Through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) grant program and statewide implementation, Wyoming seeks to improve clinical, functional, and cost outcomes; access to home and community-based services; youth and family resiliency of Medicaid children and youth with serious behavioral health challenges; and historically high costs or at risk of high cost through implementation of a Care Management Entity (CME) pilot in Wyoming. The CME for the CMHW is Magellan.

In the past, the Division has invested extensive resources to train public and private community providers across the state in the implementation of the High Fidelity Wraparound model (HFWA). Through contract agreements, the Division has fostered the use of wraparound with children, youth, and their families, in addition to those families served through the CMHW program. Successful implementation of a wraparound individual service plan will increase a child's opportunities for successful outcomes, and enhance a family's potential for safely caring for their child, through natural supports and community-based services. The HCF piloted two programs in the state to demonstrate HFWA. The pilot programs were intended to advance the CMHW and CHIPRA efforts. Services provided through the CMHW include family care coordination, youth and family training and support, and respite care. The HCF has made a concerted effort towards HFWA but most of the projects were eliminated or reduced due to past and current (2020) budget reductions and restrictions.

Prevention

Since 2012, the Substance Abuse Prevention Program and the Tobacco Prevention and Control Program have fallen under Prevention and Health Promotion Unit, in the PHD, increasing collaboration with the Chronic Disease Prevention Program, as well as the Integrated Cancer Program. This has strengthened programs at the State and community level because of the shared populations and risk factors. The chart on the next page, depicts the current organization of primary prevention services in Wyoming.

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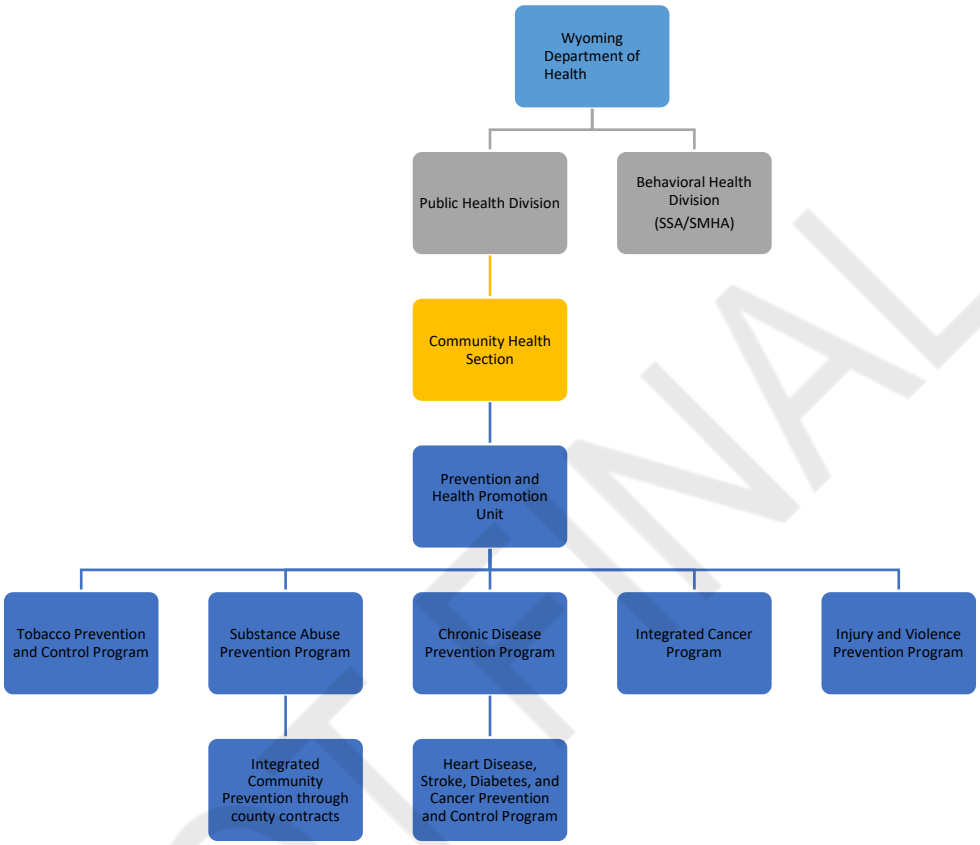
Wyoming Substance Abuse Prevention Program Organization



The Substance Abuse Prevention Program works closely with the Tobacco Prevention and Control Program as well as the injury and violence prevention program to provide prevention services throughout the State of Wyoming. The integrated community prevention model includes funding to all 23 counties in Wyoming through a grant agreement with each county government. Each county has a liaison with the State Department. The funding is a combination of the 20 percent set-aside from the SAPT, State General Funds, State Tobacco Settlement Funds, and other federal funds.

At both State and local levels, Wyoming employs a data-driven decision-making process. Part of the grant agreement with the counties is that they are required to create a work plan that is specific to their county's needs using evidence-based strategies and implementing the Strategic Prevention Framework (SPF) public health model in their prevention efforts. This obligates the community coalitions to engage in data-driven strategic planning. In the current grant agreement, each county will be required to update their strategic plans, identifying best-practice environmental strategies and evidence-based programs designed to appropriately meet their identified needs. This approach allows the prevention efforts to have greater reach across the lifespan of Wyoming residents.

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All funded communities are required to participate in evaluation of prevention efforts at the community level. Both the Substance Abuse Prevention and Tobacco Prevention and Control Program evaluations are currently administered by the Wyoming Survey and Analysis Center (WYSAC). Though the evaluations are contractually separate, WYSAC researchers collaborate on the development and maintenance of the Prevention Evaluation and Reporting for Communities (PERC) data collection system. WYSAC works closely with the communities to collect and analyze data while also utilizing user-friendly reporting for both state and local prevention stakeholders. The Substance Abuse Prevention evaluation data is also reported annually to the SAMHSA with regards to the National Outcome Measures.

The Substance Abuse Prevention Program currently contracts with the Wyoming Association of Sheriff's and Chiefs of Police to provide technical assistance and training for all funded communities. The technical assistance team provides ongoing expert and tailored technical assistance to communities including strategic planning and implementation support, and quality prevention workforce training and resources. Additionally, the State Prevention Programs work with the technical assistance contractor to identify strengths and weaknesses within the prevention infrastructure and is a key partner in prevention planning aimed at enhancing strengths and rectifying weaknesses.

The Substance Abuse Prevention Program strongly believes Wyoming communities must strive for population-level change in order to create healthier community outcomes. By endeavoring for community-level change, disparate populations will be afforded the same health opportunities and benefits as the rest of the population. Wyoming's environmental approach creates healthier environments for people in recovery who are reentering the larger community. This approach is also flexible enough to target our disparate populations when necessary.

Prevention - Behavioral Health Workforce

The Division has partnered with the University of Wyoming ECHO program, a learning community consisting of experts and various technologies. ECHO hosts live webinars to assist in obtaining resources for the behavioral health field. This partnership is utilized and has reduced the gap of behavioral health workforce.

Diverse Racial, Ethnic and Sexual Gender Minorities

Wyoming's demographic and cultural characteristics are not highly diverse and there are very few specialty programs addressing minorities. The Division is partnered with the Office of Multi-Cultural Health to address cultural health disparities. The Division has conversed with all provider agencies and reviewed their Commission on Accreditation for Rehabilitation Facilities (CARF) "Cultural Competency and Diversity Plan." The provider agencies address many areas of diversity including race, ethnicity, sexual orientation, gender, age, and socioeconomic backgrounds. Funded providers update and review cultural competency plans for relevancy on an annual basis and provide diversity training to staff, as required in CARF standards.

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Fremont County Counseling is a contracted outpatient mental health and substance abuse treatment provider serving clients in Fremont County, including Native Americans. Sho-Rap Lodge provides housing and employment services funded by the Division on the Wind River Indian Reservation.

Challenges and Limitations

Some of the challenges and limitations of the state include continued economic downfall and budget restrictions. As a result, Wyoming has reduced budgets for mental health and substance use services. In the past few years Wyoming has qualified for a waiver of the maintenance of effort (MOE) requirement due to the fact that the state met criteria for revenue reductions and unemployment increases. The following program areas were impacted due to budget reductions: children and adolescent services, recovery support services, residential treatment and housing, quality of life funds, and the outreach and advocacy program for veterans.

In addition, the state is experiencing prescriber and clinical staff shortages. The Division also works with the Behavioral Health Advisory Council on strategies to address these areas and limitations. Wyoming has applied for and received federal grants which augment efforts and enable the Division to focus on specific areas of need, such as opioids, and the implementation of directed outpatient commitment. In addition, Wyoming has worked collaboratively within each grant program to seek technical assistance when barriers arise.

COVID-19 Response and Relief Funds

Wyoming has submitted a funding plan proposal for the COVID-19 Response and Relief Funds for both the Community Mental Health and Substance Abuse Prevention and Treatment block grants. If providing the information in the FY2022 Application is not required but there is interest in requests, please see the FFY 2020-2021 Block Grant Application, the global revision request under the Chief Executive Officer's Funding Agreement – Certifications and Assurances / Letter Designating Signatory Authority [MH] and [SA] 2021.

American Rescue Plan Act Funds

Wyoming has submitted a funding plan proposal for the American Rescue Plan Act (ARPA) Funds for both the Community Mental Health and Substance Abuse Prevention and Treatment Block Grants. If providing the information in the FY2022 Application is not required but there is interest in requests, please see the FFY 2020-2021 Block Grant Application, the global revision request under the Chief Executive Officer's Funding Agreement – Certifications and Assurances / Letter Designating Signatory Authority [SA] 2021. For the MH funding plan proposal, the Division was asked to submit it to our State Project Officer and can provide a copy upon request.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

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Identify the unmet service needs and critical gaps within the current system. Prioritize state planning activities that will include MHBG and SABG. Develop goals, objectives, performance indicators, and strategies.

The Wyoming Department of Health (Agency), Behavioral Health Division (Division), is currently having a needs and gaps assessment conducted through a contract with the National Council of Mental Wellness dba National Council of Behavioral Health and their partner, MTM Services (referenced henceforth as MTM Services). MTM Services are requested to provide system assessment, evaluation and data analysis, and technical assistance to support and assist in coordinating state-level efforts to enhance delivery and reimbursement of mental health and substance abuse treatment services. The consultation would provide the Division and the contracted providers with the tools, data, and information in order to strengthen their business practices, clinical practices, and overall group practice management in an effort to prepare them for imminent system wide payment reform efforts and enable them to better withstand an uncertain economic outlook.

The following is an outline of the tasks requested of the consultants:

- Conduct assessments and consultation which provides information on the current status of the Agency funded public behavioral health system including the requirements for the federal Substance Abuse Prevention and Treatment Block Grant (SABG) and the Block Grants for Community Mental Health Services (MHBG).
    - Conduct a longitudinal costing analysis from Wyoming data, national data, and other comparison points.
    - Conduct an assessment of treatment system and the Agency funded community treatment providers' current operations against national best practice guidelines for access to care, clinical and business operations, and quality reporting measures.
    - Access to level of readiness of the Agency and provider organizations required for transformational change.
- Conduct an analysis of the crisis and emergency services structure, operations, management practices, and work environment within the Agency funded public behavioral health system to assess performance, effectiveness, and efficiency. Community environments and context shall be part of the analysis.
- Provide additional technical assistance and consultation to the Agency.

MTM Services' analysis and report(s) are anticipated to be completed fall 2021.

Wyoming's Governor Mark Gordon announced the Declaration of a State of Emergency and a Public Health Emergency on March 13th, 2020 in regards to the novel coronavirus disease (referenced henceforth as COVID-19).

Wyoming is a rural and frontier state that heavily relies on oil, coal, and natural gas. Production within these industries was and continues to be significantly impacted, therefore decreasing state

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generated revenue. Wyoming's hospitality and leisure businesses, tourism, and agriculture was also significantly impacted due to COVID-19. The Agency and other state agencies have begun the process of reducing state funded budgets, thereby reducing available funds for behavioral health services.

According to the Centers for Disease Control and Prevention (CDC), as of June 2020, 13% of Americans reported starting or increasing substance use as a way of coping with stress or emotions related to COVID-19.[1] Overdoses have also spiked since the onset of the pandemic. Reporting from Overdose Detection Mapping Application Program (ODMAP)[2] system shows an 18% increase nationwide in overdoses compared with those same summer months in 2019. All but one (1) of Wyoming's twenty-three counties participates in data submissions to ODMAP. Although Wyoming does not have comparable 2020 opioid overdose data, the University of Wyoming, Wyoming Survey & Analysis Center (WYSAC) conducted an internet survey on behaviors and attitudes toward COVID-19. WYSAC found that both the sale and consumption of alcohol increased from February to April, 2020.

The WYSAC research fact sheet of *Impacts of COVID-19 on Wyoming Women*[3] reports, that one in five women (20%) didn't know where to find help for mental health concerns or getting food if they needed it. The WYSAC fact sheet also identified that 20% of women with mental health concerns didn't know where to get help for mental health and that since COVID-19, Wyoming women reported an increase in: feeling tired or having little energy (42%); trouble falling or staying asleep or sleeping too much (37%); feeling down, depressed, or hopeless (38%); and trouble concentrating on things (23%)'.

The Division compiled information on the impact of COVID-19 on contracted Wyoming Behavioral Health and Substance Abuse Service Community Mental Health (CMHC) providers. Data collected is not a reflection of needs or gaps, but does identify the struggles and challenges of each CMHC and Substance Abuse Centers (SAC) across Wyoming during the early and current stages of COVID-19. In summary, challenges included transitioning to telehealth services, access to individuals in need of services, and group services. Telehealth services have improved and two facilities continue seeing individuals through this service only, the remaining CMHC and SACs are using CDC protocols to serve their individuals in-person.

Although more information is needed to make fully informed decisions for implementation, the mental health treatment and recovery system in Wyoming is currently designed to be responsive

[1] Czeisler MÉ , Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1

[2] Overdose detection mapping application program -. (n.d.). Retrieved March 30, 2021, from http://www.odmap.org/

[3] University of Wyoming, Wyoming Survey & Analysis Center, *The Impacts of COVID-19 on Wyoming Women*, https://wysac.uwyo.edu/wysac/reports/View/6705

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to the local and state-level environments and several needs/gaps have been previously identified. Geographically the 9th largest land mass state in the country, Wyoming is the least populous, with an estimated 576,851 population[4]. The state has a population density of 5.8 persons per square mile and is 69% rural[5] as defined by the USDA Economic Research Service, thus qualifying the majority of the state for frontier status. Public and federal funds support 15 community mental health providers across the state. Four providers also serve in strategic geographic areas as crisis centers providing acute psychiatric care and crisis stabilization. Access to care, especially crisis care, is often impeded by client proximity to services. The Rural Information Hub for 2021 lists the entire geographic area of twenty-two out of Wyoming's twenty-three counties as Mental Health Professional Shortage Area. The need for comprehensive telehealth and transportation are critical components of mental health services in a frontier state. The frontier environment also creates a lack of providers, especially psychiatrists and those specializing in working with children. Many providers report difficulties in maintaining their healthcare workforce and cannot easily compete with the wages and amenities offered to healthcare professionals by providers in more urban areas. Even communities that do have adequate staffing are often one practitioner away from a shortage.

A needs assessment conducted in October 2019 documented the need for adolescent specialists and psychiatrists throughout the state. The assessment examined services in five regions of the state: Basin, Central, Northeast, Southeast, and Western. Each region indicated adolescent services, specifically adolescents with serious emotional disturbance (SED), substance use disorders (SUD), or co-occurring SED/SUD, as underserved populations. According to the Behavioral Health Barometer, Wyoming, Volume Five, among youth aged 12-17 in Wyoming, the annual average percentage with a major depressive episode (MDE) in the past year increased between 2004-2008 and 2013-207 (10.1% to 13.3%). 13.5% MDE from 2013-2017 is similar to both the SAMHSA Region 8 average (12.8%) and the national average (12.1%). During this same period, under half (45.2%) of youth aged 12-17 in Wyoming with MDE in the past year received depression care. This is slightly better than the region at 40.96% and the national average at 40.3%.

Recovery support services are primarily provided through CMHCs. Only one independent organization in Wyoming is providing recovery services and although the single provider provides some state-level support, the majority of their services and focus are located in Laramie County, in the southeast region of the State. Therefore, recovery supports are available to the majority of individuals but are not comprehensive or consistent throughout the state.

Through an internal system analysis, the Division determined that Comprehensive Crisis Services is a considerable gap and plans to focus efforts in addition to the required 5% Crisis Services set aside to address the need. The MTM Services assessment and subsequent crisis services activities is currently analyzing the Wyoming crisis system using the National Guidelines for Behavioral

[4] U.S. Census Bureau, Wyoming Quick Facts: https://www.census.gov/quickfacts/fact/table/WY,US/POP010220#POP010220
[5] USDA Economic Research Service: State Fact Sheets (Updated: June 2, 2021): https://data.ers.usda.gov/reports.aspx?StateFIPS=56&StateName=Wyoming&ID=17854

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Health Crisis Care: Best Practice Toolkit. Further, this Toolkit will act as the guide to inform other developments including any adjustments to requirements within Subrecipient agreements, changes to service definitions, and allowances for service reimbursements. Funding for this assessment has been allocated from the Mental Health Block Grant Technical Assistance supplement.

Another known gap in the crisis system of care is that Wyoming does not have mobile crisis units that meet the national guidelines. Due to the frontier nature of the state, it is difficult to sustain 24/7 mobile crisis units that can be deployed centrally. Wyoming has been able to maintain some levels of mobile crisis in the more populated areas, but the lack of sufficient resources greatly decreases the capacity to meet the needs in these communities.

The State Epidemiological Outcomes Workgroup is not a part of the state planning process in regards to the combined MHBG and SABG.

All CMHC and SACs are reviewed on a bi-annual basis to view compliance with contracts. A list of attachments provide definitions, service time frames, deliverables, and reporting requirements that match both the federal reporting requirements of the MHBG and SABG. Upon shortfalls, the Division meets with the provider to develop a corrective action plan.

The Division's mission is to further promote a healthier Wyoming by working with partners to provide access to affordable, high-quality mental health and substance use treatment services, promote evidence-based treatment, quality improvement, and person-centered services and supports through state contracts, grants, and collaboration with community providers. The mandate of Wyoming's publicly funded mental health and substance abuse system is to provide services to those requesting assistance. While this policy has a positive effect on the greater population, it can have significant impacts on the higher need populations in Wyoming. There is a limited amount of funding and ability to provide services and must be spread among those with no pay source.

The Division goals, objectives, performance indicators, and strategies come from the services provided within the state. Each region and provider's ability does strongly influence what services are available to the residents of Wyoming. Services provided through unique contracts may include mental health outpatient services, early serious mental illness services and outreach, emergency diversion bundled services, mental health community housing services, crisis stabilization services, substance abuse disorder outpatient services, adult primary SUD residential treatment services, pregnant women and parenting women SUD residential treatment services, SUD transitional housing services, social detox services, quality of life support services, and administrative services which include providing a sliding fee scale and national accreditation.

Through the Wyoming Client Information System (WCIS), providers submit information for data reporting requirements. The performance indicators in Planning Tables, Table 1 Priority Areas and Annual Performance Indicators objectives and results are determined through the data collection in WCIS.

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Developed in 2011, the WDH performance management system involves the process of identifying challenges in program areas, by program managers of specific units, and the identification of metrics through which improvements can be measured. Strategies are then developed to address the challenges, data is routinely monitored, regular updates are provided to Division staff, and an annual report is provided to the Director's office. HealthStat efforts have bolstered the WDH's reputation as a responsive agency committed to improvement and accountability. In 2013, former Governor Matt Mead, adopted a similar system titled WyoStat, across all health and human service agencies in Wyoming. In the fall of 2014, Senior Leadership at the WDH met in a series of intensive workshops to analyze the overall performance of HealthStat, identifying several areas for improvement. It was determined the system had greatly enhanced reporting within the WDH, but lacked the follow-up needed for a true performance management system. In 2015, several changes happened under "HealthStat 2.0" to increase follow-up and accountability, allowing the WDH to pursue its mission to promote, protect, and enhance the health of all Wyoming citizens, to the fullest extent and with the highest level of excellence stakeholders have come to expect.

The HealthStat process ultimately helps the Division identify programmatic efficiencies and assistance to Wyoming citizens as well as deficit areas in need of improvement. The Division has utilized HealthStat along with contract requirements, and monitoring through the Division's quality management process to enhance accountability of the public behavioral health care system.

COVID-19 Response and Relief Funds

Wyoming has submitted a funding plan proposal for the COVID-19 Response and Relief Funds for both the Community Mental Health and Substance Abuse Prevention and Treatment block grants. If providing the information in the FY2022 Application is not required but there is interest in the requests, please see the FFY 2020-2021 Block Grant Application, the global revision request under the Chief Executive Officer's Funding Agreement – Certifications and Assurances / Letter Designating Signatory Authority [MH] and [SA] 2021.

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Improve access to behavioral health treatment services for individuals in the most need.

Priority Type: MHS

Population(s): SMI, SED, ESMI

Goal of the priority area:

Decrease average length of stay in mental health housing.

Strategies to attain the goal:

Maintain inventory of mental health housing beds for each facility and center to identify how each type is utilized, and determine consistency with state definitions. Determine the appropriate length of stay for mental health housing programs including criteria for length of stay. Execute provider contract requirements for each mental health housing program to reduce length of stay.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Decrease average length of stay in mental health housing.

Baseline Measurement: 525 days

First-year target/outcome measurement: 465 days

Second-year target/outcome measurement: 456 days

Data Source:

Providers input length of stays in Wyoming Client Information System (WCIS). Through contract, all providers are required to provide data including treatment completion. On review of semi-annual review and annual review of treatment contracts, the Division notes shortfalls. Upon a call or meeting with the provider, the Division works to review other types of discharge statuses to determine if individuals are dropping out of treatment or transferring to other programs.

Description of Data:

Providers report numbers of days individual occupies a bed in their facility to WCIS. Currently F19's target was 465 days, FY20's results were 420.75 days. FY22's goal is 445 days, in an anticipation of COVID-19 and mental health redesign impact.

Data issues/caveats that affect outcome measures:

COVID-19 impacts in the mental health system possible; along with a redesign to the mental health system in Wyoming, increase may be possible with changes, updates, and improvement efforts.

Priority #: 2

Priority Area: Work closely with providers to initiate individualized outcomes for individuals with methamphetamine use disorder.

Priority Type: SAT

Population(s): PWWDC, PWID

Goal of the priority area:

Increase treatment completion rate for outpatient clients with a primary, secondary, or tertiary methamphetamine use disorder.

Strategies to attain the goal:

Develop distinct provider contract targets focusing on the individuals with methamphetamine use disorder.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase treatment completion rate for individuals with a primary, secondary, or tertiary methamphetamine use disorder.

Baseline Measurement: FY16: 58%

First-year target/outcome measurement: FY19: 68%

Second-year target/outcome measurement: FY22: 65%

Data Source:

Treatment completion rate data is collected from all Division funded MH and SA providers and reported in WCIS. Through contract, all providers are required to provide data including treatment completion. On review of semi-annual review and annual review of treatment contracts, the Division notes shortfalls. Upon a call or meeting with the provider, the Division works to review other types of discharge statuses to determine if individuals are dropping out of treatment or transferring to other programs.

Description of Data:

Individual's treatment completion status is noted in discharge information through WCIS.

Data issues/caveats that affect outcome measures:

COVID-19 impacts possible.

Priority #: 3

Priority Area: Work closely with provider agencies to initiate individualized outcomes for individuals with opioid use disorder.

Priority Type: SAT

Population(s): PWWDC, PWID

Goal of the priority area:

Increase treatment completion rate for outpatient client with an opioid use disorder.

Strategies to attain the goal:

Expand MAT services by implementing programs throughout the state, utilizing a combination of SOR grant funds or state funds. Develop distinct provider contract targets focusing on individuals with an OUD. Provide technical assistance and training on evidence-based practices for opioids. Facilitate provider discussions to highlight shared success stories and lessons learned from providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase treatment completion rate for outpatient clients with primary, secondary, or tertiary opioid use disorder.

Baseline Measurement: FY16: 55%

First-year target/outcome measurement: FY20: 67%

Second-year target/outcome measurement: FY22: 69%

Data Source:

Treatment completion rate data is collected from all Division funded MH and SA providers and reported in WCIS. Through contract, all providers are required to provide data including treatment completion. On review of semi-annual review and annual review of treatment contracts, the Division notes shortfalls. Upon a call or meeting with the provider, the Division works to review other types of discharge statuses to determine if individuals are dropping out of treatment or transferring to other programs.

Description of Data:

Review semi-annual review of treatment contracts, noting shortfalls. Upon a call or meeting with the provider, the Division works to review other types of discharge statuses to determine if individuals are dropping out of treatment or transferring to other programs.

Data issues/caveats that affect outcome measures:

COVID-19 impacts possible.

Priority #: 4

Priority Area: Number of SUD residential individuals received treatment, education, and / or information about tuberculosis within a contracted community substance abuse centers (SAC).

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Improve access to tuberculosis treatments throughout the State of Wyoming.

Strategies to attain the goal:

To gather baseline data for FY22, request SACs to provide current tuberculosis policies and materials given. Request residential facilities for unique information for individuals in treatment who are tuberculosis positive, and method of information, education, and/or treatment within or referred.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase individuals abilities to obtain information and education, along with treatment options, resources, or referrals through Substance Abuse Centers (SAC(s)) in Wyoming.

Baseline Measurement: In progress

First-year target/outcome measurement: Goal is to have 100% of SACs with current, updated, or improved policy on tuberculosis (process, referral, treatment, etc), along with information and educational materials available and provided.

Second-year target/outcome measurement: TBD

Data Source:

To gather baseline data for FY22, request SACs to provide current tuberculosis policies and materials given. Request residential facilities for unique information for individuals in treatment who are tuberculosis positive, and method of information, education, and/or treatment within or referred.

Description of Data:

Increase individuals abilities to obtain information and education, along with treatment options, resources, or referrals through substance abuse centers in Wyoming. On review of providers policies and materials, Division will offer technical assistance as needed and requested. Goal is to have 100% of SACs with current, updated, or improved policy on tuberculosis (process, referral, treatment, etc), along with information and educational materials available and provided.

Data issues/caveats that affect outcome measures:

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Footnotes:

Wyoming is not a designated HIV state.

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$6,229,134.52		$0.00	$0.00	$49,959,547.00	$0.00	$0.00		$2,919,328.51	$2,521,239.00
a. Pregnant Women and Women with Dependent Children[c]	$1,120,330.00		$0.00	$0.00	$2,978,430.00	$0.00	$0.00		$321,161.00	$642,320.00
b. All Other	$5,108,804.52		$0.00	$0.00	$46,981,117.00	$0.00	$0.00		$2,598,167.51	$1,878,919.00
2. Primary Prevention[d]	$1,679,012.00		$0.00	$0.00	$0.00	$0.00	$0.00		$786,881.00	$679,580.00
a. Substance Abuse Primary Prevention	$1,679,012.00		$0.00			$0.00	$0.00		$786,881.00	$679,580.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services	$67,160.48		$0.00	$0.00	$0.00	$0.00	$0.00		$31,475.24	$27,183.00
5. Early Intervention Services for HIV	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$419,753.00		$0.00		$1,370,971.94	$0.00	$0.00		$196,720.25	$169,894.00
10. Crisis Services (5 percent set-aside)										
11. Total	**$8,395,060.00**	**$0.00**	**$0.00**	**$0.00**	**$51,330,518.94**	**$0.00**	**$0.00**	**$0.00**	**$3,934,405.00**	**$3,397,896.00**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

[d] The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Footnotes:
Use of COVID-19 and ARP Funds - full amount - at this time we are unable to break out ARP into years. Will provide updates to the State Project Officer as needed.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023.
Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2022

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)	J. ARP Funds (MHBG)[b]
1. Substance Abuse Prevention and Treatment										
a. Pregnant Women and Women with Dependent Children										
b. All Other										
2. Primary Prevention										
a. Substance Abuse Primary Prevention										
b. Mental Health Primary Prevention[e]		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[d]		$91,246.00	$0.00	$0.00	$0.00	$0.00	$0.00	$104,864.00		$181,128.00
4. Tuberculosis Services										
5. Early Intervention Services for HIV										
6. State Hospital			$0.00	$0.00	$80,549,230.00	$0.00	$3,364,266.00	$0.00		$0.00
7. Other 24-Hour Care		$661,470.00	$0.00	$0.00	$4,366,171.17	$0.00	$0.00	$0.00		$0.00
8. Ambulatory/Community Non-24 Hour Care		$68,498.00	$0.00	$2,055,546.67	$13,263,766.58	$0.00	$0.00	$100,000.00		$0.00
9. Administration (excluding program/provider level)[f] MHBG and SABG must be reported separately		$45,623.00	$0.00	$2,201.48	$733.82	$0.00	$0.00	$52,432.00		$0.00
10. Crisis Services (5 percent set-aside)[g]		$45,623.00	$0.00	$0.00	$2,166,997.44	$0.00	$0.00	$791,341.00		$1,630,155.00
11. Total	**$0.00**	**$912,460.00**	**$0.00**	**$2,057,748.15**	**$100,346,899.01**	**$0.00**	**$3,364,266.00**	**$1,048,637.00**	**$0.00**	**$1,811,283.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 – June 30, 2023, for most states.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025,** which is different from expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A-G are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states

[d] Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

[e] While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

[f] Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

[g] Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	379	67
2. Women with Dependent Children	4,663	1,094
3. Individuals with a co-occurring M/SUD	7,499	1,316
4. Persons who inject drugs	5,264	925
5. Persons experiencing homelessness	612	274

Please provide an explanation for any data cells for which the state does not have a data source.

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Footnotes:

Data pulled from WCIS SQL report; Data is not finalized for SFY2021 until August 15, 2021; Client can be counted in more than one category.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$3,114,250.00	$2,919,329.00	$2,521,239.00
2 . Primary Substance Use Disorder Prevention	$839,421.00	$786,881.00	$679,580.00
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$33,577.00	$31,475.00	$27,183.00
5 . Administration (SSA Level Only)	$209,855.00	$196,720.00	$169,894.00
6. Total	**$4,197,103.00**	**$3,934,405.00**	**$3,397,896.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

A		B		
Strategy	IOM Target	FFY 2022		
		SA Block Grant Award	COVID-19[1]	ARP[2]
1. Information Dissemination	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
2. Education	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
3. Alternatives	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
4. Problem Identification and Referral	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			

	Selective			
5. Community-Based Process	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
6. Environmental	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
7. Section 1926 Tobacco	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
8. Other	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$0**	**$0**	**$0**
Total SABG Award[3]		**$4,197,103**	**$3,934,405**	**$3,397,896**
Planned Primary Prevention Percentage		**0.00 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
Universal Direct			
Universal Indirect			
Selective			
Indicated			
Column Total	**$0**	**$0**	**$0**
Total SABG Award[3]	**$4,197,103**	**$3,934,405**	**$3,397,896**
Planned Primary Prevention Percentage	**0.00 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☐	☐	☐
Tobacco	☐	☐	☐
Marijuana	☐	☐	☐
Prescription Drugs	☐	☐	☐
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☐	☐	☐
Bath salts, Spice, K2)	☐	☐	☐
Targeted Populations			
Students in College	☐	☐	☐
Military Families	☐	☐	☐
LGBTQ	☐	☐	☐
American Indians/Alaska Natives	☐	☐	☐
African American	☐	☐	☐
Hispanic	☐	☐	☐
Homeless	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☐	☐	☐

Underserved Racial and Ethnic Minorities	☐	☐	☐

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Footnotes:

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Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems					$558.00
2. Infrastructure Support				$271,720.25	
3. Partnerships, community outreach, and needs assessment				$25,000.00	
4. Planning Council Activities (MHBG required, SABG optional)					
5. Quality Assurance and Improvement	$5,000.00			$1,872,704.00	
6. Research and Evaluation		$80,000.00			
7. Training and Education					$409,894.00
8. Total	**$5,000.00**	**$80,000.00**	**$0.00**	**$2,169,424.25**	**$410,452.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2021 MHBG Planning Period End Date: 06/30/2022

Activity	FFY 2022 Block Grant	FFY 2022[1] COVID Funds	FFY 2022[2] ARP Funds	FFY 2023 Block Grant	FFY 2023[1] COVID Funds	FFY 2023[2] ARP Funds
1. Information Systems	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00	$905,642.00	$0.00	$0.00	$905,642.00
3. Partnerships, community outreach, and needs assessment	$0.00	$50,000.00	$0.00	$0.00	$50,000.00	$0.00
4. Planning Council Activities (MHBG required, SABG optional)	$5,000.00	$0.00	$0.00	$5,000.00	$0.00	$0.00
5. Quality Assurance and Improvement	$5,000.00	$26,216.00	$0.00	$5,000.00	$26,216.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
7. Training and Education	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
8. Total	**$10,000.00**	**$76,216.00**	**$905,642.00**	**$10,000.00**	**$76,216.00**	**$905,642.00**

[1] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15,2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds.
The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[37] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[38] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**;

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

a. The Division contracts with Community Mental Health Centers (CHMCs) and Substance Abuse Centers (SACs). Several CMHC and SACs have nursing and primary care services available on site. Each CMHC and SAC arranges for primary care and specialty services base on individual client need and encourage individuals to receive those services from Federally Qualified Health Centers.

Due largely to COVID-19, Wyoming has integrated telehealth into the mental health and substance abuse services systems to provide M/SUD prevention, treatment, and recovery to rural areas.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

Wyoming does not provide services and supports towards integrated systems of care at this time.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? ○ Yes ◉ No

b) and Medicaid? ○ Yes ◉ No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

The Behavioral Health Program Manager and the Program Integrity Unit of the Healthcare Financing Division are responsible for monitoring access to M/SUD services for client receiving Wyoming Medicaid.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ○ Yes ◉ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

ii) heart disease ◉ Yes ○ No

iii) hypertension ◉ Yes ○ No

iv) high cholesterol ◉ Yes ○ No

v) diabetes — (•) Yes ( ) No

c) Recovery supports — (•) Yes ( ) No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? — ( ) Yes (•) No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? — ( ) Yes (•) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

No issues or problems related to the implementation and enforcement of parity provisions reported.

10. Does the state have any activities related to this section that you would like to highlight?

Wyoming is not a Medicaid expansion state.

Please indicate areas of technical assistance needed related to this section

None at this time.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(•) Yes ( ) No
b) Ethnicity	(•) Yes ( ) No
c) Gender	(•) Yes ( ) No
d) Sexual orientation	(•) Yes ( ) No
e) Gender identity	(•) Yes ( ) No
f) Age	(•) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ( ) Yes (•) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ( ) Yes (•) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ( ) Yes (•) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ( ) Yes (•) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ( ) Yes (•) No

7. Does the state have any activities related to this section that you would like to highlight?

Wyoming did participate in the Disparities and Health Equity Inventory request by NASADAD. It was an overall collaboration.

The Wyoming Department of Health (SSA) is a "super-agency" that includes Aging Services, Behavioral Health Division, Healthcare Financing Division (WY Medicaid), and Public Health Division. In addition, the Agency oversees five (5) health care facilities, including the Wyoming State Hospital, Wyoming Life Resource Center, Wyoming Retirement Center, Wyoming Pioneer Home, and Veterans Home of Wyoming. At this time, the Agency as a whole does not have a robust or comprehensive health equity infrastructure and framework. The majority of health equity efforts are currently housed within the PHD where the focus is primarily building internal and staff competencies and capacity to advance equity. Overall, the Agency follows non-discrimination rules and regulations. Each division and program has different needs assessments, and data collection processes. Some programs may be more advanced based on action of needs assessments or program requirements.

Please indicate areas of technical assistance needed related to this section

None at this time.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☑ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☑ Provider involvement in planning value-based purchasing.
- **e)** ☑ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☑ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

https://wyoleg.gov/Legislation/2021/HB0038

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (●) Yes ( ) No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? (●) Yes ( ) No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

The State has two providers implementing First Episode Psychosis (FEP) treatment programs. The challenges of being a rural and frontier state complicate set models, and facilities are exploring how to best implement EBPs. Due to the geographical challenges and limited community resources, FEP models are difficult to implement. Family involvement and education are critical in the clients' treatment process, in order to develop a resilience to psychotic triggers and symptoms. When families cannot participate, the alternative is natural supports. Though, limited communities and social resources, can hinder adequate treatment.
Southwest Counseling Service (SCS) utilizes many EBP's for the treatment of individuals with ESMI/FEP. These include:
• Cognitive Behavioral Therapy
• Motivational Interviewing
• Dialectical Behavioral Therapy
• Eye Movement Desensitization and Reprocessing (EDMR)
• Complementary and alternative medicine (CAMS)

In addition, SCS utilizes Peer Specialist Supports, employment supports, integrated primary health care, medication management services and family education support.

Yellowstone Behavioral Health (YBHC) provides a coordinated specialty care program to address the needs of those individuals experiencing early symptoms of a serious mental illness. Borrowing from Navigate, an FEP treatment model, YBHC's ESMI program emphasizes Individual Resiliency Training and helps clients to identify their strengths and resiliency factors and then utilize these to manage their illness and to facilitate and maintain recovery. Within this framework of individual resiliency training, a variety of evidenced based practices are incorporated as needed, including CBT, targeted case management, family systems treatment, supported employment and education, housing supports, and illness management and recovery.

With funds from the COVID-19 Response and Relief Funds and American Rescue Plan Funds, an increase of one provider is anticipated for a total of three providers in Wyoming.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

The State requires contracted treatment providers to utilize EBPs, but does not specify which EBPs should be used. The state encourages providers to engage with other state's FEP programs to explore different EBP's and learn successes. For example, SCS utilizes the EBPs as a part of the individualized treatment for individuals experiencing the first onset of psychosis. Additionally, SCS employs an APRN, which provides clients with direct access to primary health care. Due to the rural and frontier nature of Wyoming, EBPs need to be adjusted to fit the population served and resources available.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? ○ Yes ◉ No

5. Does the state collect data specifically related to ESMI? ◉ Yes ○ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ◉ Yes ○ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

The State requires contracted treatment providers to utilize EBPs, but does not specify which EBPs should be used. The state encourages providers to engage with other state's FEP programs to explore different EBP's and learn successes. Due to the rural and frontier nature of Wyoming, EBPs need to be adjusted to fit the population served and resources available.

8. Please describe the planned activities for FFY 2022 and FFY 2023 for your state's ESMI programs including psychosis?

The State will continue to work with providers based on requests for technical assistance. Along with the review of systems to come from the needs and gap assessment currently being conducted by the National Council of Behavioral Health.

From the ARPA Funding, no less than ten percent (10%) of the total allocation will be used to support services for ESMI. Currently, two (2) sub-recipient providers receive MHBG funds to implement comprehensive and coordinated care for ESMI and FEP. Funding shall be used to enhance the capacity of another sub-recipient to provide ESMI/FEP services in an additional geographic catchment region. Since this will entail adding a service line for the provider, startup costs including training and policy engagement will be included, as well as the provision of treatment and recovery services. Focusing on enhancing crisis and ESMI/FEP services puts Wyoming closer to reaching the goal of having communities with no-wrong-door access to mental health and substance use care. Through additional capacity to provide these vital services, Wyoming will have more resources to address all residents in need of crisis support including SMI and SED. Further, the Wyoming crisis system leveraging MHBG ARPA resources to increase capacity will allow the state mental health system to be better equipped to support and reduce the need for first responders including law enforcement, fire, and emergency medical to provide crisis services.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

At this time the Division utilizes the Wyoming Client Information System (WCIS) to collect data by age, gender, race, diagnostic category, and agency code. Therefore, the Division collects data to demonstrate the impact of the set aside for First Episode Psychosis. Further evaluation of data is needed and has been described in the future activities section above. Both FEP agencies are currently reporting into the WCIS. Providers have submitted quarterly reports to the Division. These reports list critical details such as the number of outreach activities conducted over the quarter.

10. Please list the diagnostic categories identified for your state's ESMI programs.

The diagnostic categories in the programs are:

a. Schizophrenia

b. Bi-polar Disorder

c. Schizoaffective Disorder

d. Borderline Personality Disorder

e. Major Depressive Disorder, Severe with Psychotic Features

f. Schizoaffective Disorder Bipolar Type, and other Unspecified Stimulant Use Disorder, Cannabis Use Disorder, and Alcohol Use Disorder

g. Other Specified Schizophrenia Spectrum and Other Psychotic Disorder, Generalized Anxiety Disorder, and Nightmare Disorder

h. Major Depressive Disorder with Mood Congruent Psychotic Features

i. Bipolar Disorder with Psychotic Features, and Gender Identity Dysphoria, ADHD combined type

j. Major Depressive Disorder with Anxious Distress and Mood Congruent Psychotic features.

Please indicate areas of technical assistance needed related to this section.

Training specific to psychosis has been requested by the FEP providers and team members. The clinicians on the teams are licensed family and child therapists and have significant training and experience in engaging families and providing systemic family treatment. However, they would benefit from training and education specific to the pathology of psychosis, as well as, any unique impact of psychosis on family systems.

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? (•) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

N/A

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

The Division contracts with providers responsible for engaging consumers through consumer satisfactory surveys, driven boards, along with care coordination including primary care. The State provides ongoing technical assistance as requested. One provider, Recover Wyoming, provides free Shared Decision-Making (SDM) training throughout the State for both participants and providers. SDM is an emerging best practice in behavioral and physical health ensuring all clients are well-informed and involved in decisions about their health. The training provides an overview of the various ways counselors, treatment centers, and providers can apply SDM, while participants increase understanding of the process through interactive exercises, and by developing an Action Plan for future use.

4. Describe the person-centered planning process in your state.

The Division contracts with nationally accredited providers with the ability to involve clients in the planning of care and services. By national accreditation, providers are required to provide person centered services. Wyoming Rules and Regulations require clients to have an individualized treatment plan (or action plan) based on initial and on-going assessment information in which identify the client's needs, strategies to provide services meeting those needs, measurable treatment goals and objectives, and criteria for discharge. Initial treatment plans are developed with the client, which can involve other entities working with the client. Commonly, the provider's clinical team assists in integration between assessment and treatment plan, involving family and any necessary medical liaisons.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

Agency provides annual grant management training as a reminder for State and Federal rules and requirements, which include grant monitoring.

Please indicate areas of technical assistance needed related to this section

None at this time.

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

The Wyoming Department of Health (WDH) and various inner Divisions, including WDH Behavioral Health Division (BHD), WDH Public Health Division, WDH Healthcare Financing, WDH Aging Division, and Vital Statistics continue to meet quarterly with the Tribal Leadership Advisory Council. The purpose is to discuss updates in regards to health care. BHD has a contract with the Tribal provider Sho-Rap Lodge in regards to recovery housing and maintaining communication with their representatives. The Behavioral Health Advisory Council, which includes representation from tribal members, is given the opportunity to join in the quarterly meetings through a conference line, if unable to attend in person.

2. What specific concerns were raised during the consultation session(s) noted above?

Due to COVID-19, the concern mentioned were in relation to health care, particularly capacity of hospitals and hospital staff.

3. Does the state have any activities related to this section that you would like to highlight?

None at this time.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Community Mental Health Centers (CMHCs)
CMHC are able to provide community services to support patients functioning outside of inpatient or residential institutions. CMHC include mental health and co-occurring outpatient treatment services, individual, group and family therapy, case management, wrap around services, rehabilitation services, housing/residential, medication management, recovery support, peer support services, and are designed to ensure individuals are receiving the least restrictive services based on needs and continuity of care. CMHC assist individuals in connection to primary health care, educational resources, and other various community resources.

Medication Assisted Treatment
Use of medications in combination with counseling and behavioral therapies for treatment of substance use disorders. Several CMHCs offer this service in Wyoming.

Convalescent Leave
An individual who has shown marked improvement in the Wyoming State Hospital may be considered for convalescent leave. This leave is contingent on the individual having a plan of treatment on an outpatient, or non-hospital basis.

Discharge Planning
The Division hosts monthly calls with providers on discharge planning. The purpose of these meetings is to identify transition opportunities for individuals at the Wyoming State Hospital (WSH). The Division reviews regional bed availability in the crisis centers and attempts to identify WSH clients who are appropriate to step-down to those open beds.

Memorandum of Understanding (MOU)
Hospitals and community mental health centers are contractually obligated to have an MOU. This MOU lists expectations for coordination of care and communication regarding discharge plans of individuals receiving services.

Title 25 (Wyo. Stat. Ann. 25-10-101 - 129)
The Division coordinates many activities to address the high number of involuntary hospitalization in the state. The Quality Management Unit is the coordinator responsible for collecting and analyzing the data related to hospitalizations and individuals receiving care. Data can be evaluated to determine what changes are needed with regards to appropriate placement of individuals.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No

h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

By virtue of CMHCs and Public Health Nursing within the centers, physical health services can be provided. Through Quality of Life funding, medical and dental services can be provided. Services provided by local school systems under IDEA have the ability to provide community resources to those in need.
EIEP provides screenings and services to help children get on track to a successful future through fourteen (14) child development centers across Wyoming. EIEP administers the Part C and Part B/619 programs, of the Individuals with Disabilities Education Act (IDEA). Part C consists of early intervention services for infants and toddlers with disabilities, age's birth through age two (2) years, and their families. Part B/619 is intended to help states ensure all preschool-aged children (three-five years of age) with disabilities receive special education and related services.

3. Describe your state's case management services

All state funded CMHCs provide case management; services include advocacy, linkage, monitoring, and follow-up services. Case managers serve as primary links between basic needs, community resources, family, legal, primary care services, and recovery support.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Wyoming CMHC programs are designed to ensure individuals are receiving the least restrictive services based on needs. The Division has an executed contract with the National Council for Mental Wellbeing (previously known as: National Council for Behavioral Health) to evaluate the mental health crisis treatment system in Wyoming. Funding for this assessment has been allocated from the Mental Health Block Grant Technical Assistance supplement. Through this evaluation, the Division will have a heightened understanding of the current mental health treatment and recovery system, identifying areas of readiness for improvement, and identify gaps in the system. The evaluation should be completed by fall 2021 with technical assistance, planning, and implementation of quality improvement activities beginning shortly after. The Division is looking forward to the recommendations from the National Council for Mental Wellbeing. The Division will use information collected during this assessment process, technical assistance from the National Council for Mental Wellbeing, and the National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit to create a plan for quality and capacity enhancements to maximize access to timely services. Stakeholders to be included in the assessment are local emergency medical services, law enforcement, other local crisis stakeholders as determined by each community, and CMHC providers.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	11037	7903
2.Children with SED	3240	1891

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The Statewide incidence rate was determined using WCIS as providers are required to input information such as, "SMI Clients Served/Hours Provided" and "SED at Transaction Date". National data and evidence based practices for mental health treatment are taken into account when considering what providers will be awarded with State funding.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	( ) Yes (•) No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

Wyoming is a rural and frontier State, all services are individually based on availability and accessibility. Each county has a provider, which may be in different regions or stretch across multiple regions.

b. Describe your state's targeted services to the homeless population.

The State applies for the Projects for Assistance in Transition from Homelessness (PATH) Grant, a non-competitive grant each year. Allowing services to be provided through outreach and PATH case management services for adults at risk of homelessness in Wyoming. Only four providers provide services through the state, and the providers do work together in and outside of their counties. The MHBG is utilized to provide mental health services not supported by mainstream mental health programs to individuals with SMI or co-occurring disorders. MHBG funds are not allowed to be used for personnel, case management, staff travel, training, and associated fees, operational expenses, indirect costs, or housing direct actual costs within the PATH contracts.

The Division is currently utilizing PATH technical assistant dollars to support training and support for community providers (including PATH, CMHC, and SAC) to utilize the SOAR process for people who are literally homeless or at risk of homelessness to apply for SSI/SSDI.

CMHCs/SACs work to preempt unnecessary crisis/emergency detention of persons with SMI who are homeless. Further, CMHCs provide community based services in each county to adults and children.

c. Describe your state's targeted services to the older adult population.

Wyoming is a rural and frontier State, all services are individually based on availability and accessibility. Each county has a provider, which may be in different regions or stretch across multiple regions.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

Function is on the local communities; providers are required to submit emergency action plans, including training documents, resources, and plans. Providers can access MHTTC/ATTC for training opportunities or request specified technical assistance to the Division.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1.	Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?	(•) Yes ( ) No
2.	Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?	(•) Yes ( ) No
3.	Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?	(•) Yes ( ) No
4.	Does your state have an arrangement for ensuring the provision of required supportive services?	(•) Yes ( ) No
5	Has your state identified a need for any of the following:	
a)	Open assessment and intake scheduling	(•) Yes ( ) No
b)	Establishment of an electronic system to identify available treatment slots	(•) Yes ( ) No
c)	Expanded community network for supportive services and healthcare	(•) Yes ( ) No
d)	Inclusion of recovery support services	(•) Yes ( ) No
e)	Health navigators to assist clients with community linkages	( ) Yes (•) No
f)	Expanded capability for family services, relationship restoration, and custody issues?	( ) Yes (•) No
g)	Providing employment assistance	(•) Yes ( ) No
h)	Providing transportation to and from services	(•) Yes ( ) No
i)	Educational assistance	( ) Yes (•) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The PWWDC is monitored through the Division's contract monitoring process. Each state funded agency is required to comply with the PWWDC requirements set forth in the contract attachments. The Division then monitors the contract requirements through an on-site visit process. The State has the ability to pull individual client records and determine if the clients are receiving PWWDC services according to the requirements of the block grant. The Division has not had any compliance issues or corrective actions regarding PWWDC.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(•) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs, if applicable	( ) Yes (•) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	( ) Yes (•) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (•) No
c)	Use of peer recovery supports to maintain contact and support	(•) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	(•) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The PWID is monitored through the Division's contract monitoring process. Each state funded agency is required to comply with the PWID requirements set forth in the contract attachments. The Division then monitors the contract requirements through an on -site visit process. The state has ability to pull individual client records and determine if the clients are receiving PWID services according to the requirements of the block grant. The Division has not had any compliance issues or corrective actions regarding PWID.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (•) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	(•) Yes ( ) No
c)	Established co-located SUD professionals within FQHCs	( ) Yes (•) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Wyoming clients are eligible to receive financial assistance for TB medications through the Wyoming Department of Health (WDH), Public Health, Communicable Disease Unit, Tuberculosis (TB) program with respect and inner working relationships with the Public Health Nursing offices in each county. If the Division identifies a client who needs TB services, the client is referred to the closest Substance Abuse Center (SACS). SACS are required to have a policy in place for TB, where most provide referrals to local Public Health Nursing facilities for testing/treatment, or provide dual treatment, along with informational and educational materials in regards to TB.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? ( ) Yes (•) No

2. Has your state identified a need for any of the following:

a)	Establishment of EIS-HIV service hubs in rural areas	( ) Yes (•) No

b)	Establishment or expansion of tele-health and social media support services	○ Yes	◉ No
c)	Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS	○ Yes	◉ No

Syringe Service Programs

1.	Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)(F)?	○ Yes	◉ No
2.	Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?	○ Yes	◉ No
3.	Do any of the programs use SABG funds to support elements of a Syringe Services Program?	○ Yes	◉ No

If yes, plese provide a brief description of the elements and the arrangement

N/A

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ( ) Yes (●) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — ( ) Yes (●) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — ( ) Yes (●) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — ( ) Yes (●) No
- **c)** Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — ( ) Yes (●) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ( ) Yes (●) No

c) Updating written procedures which regulate and control access to records — ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — ( ) Yes (●) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

Four (4) of fourteen (14) or twenty-eight point five–seven percent (28.57%) of CMHC and SAC providers will be involved in peer reviews.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — (●) Yes ( ) No

If Yes, please identify the accreditation organization(s)

i) [x] Commission on the Accreditation of Rehabilitation Facilities

ii) [ ] The Joint Commission

iii) [x] Other (please specify)

The rules allow for other accreditation by other organizations; historically it was CARF.

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No

c) Performance-based accountability: ◉ Yes ○ No

d) Data collection and reporting requirements ◉ Yes ○ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ◉ Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ◉ Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) Mental Health TTC? ◉ Yes ○ No

c) Addiction TTC? ◉ Yes ○ No

d) State Targeted Response TTC? ◉ Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://health.wyo.gov/behavioralhealth/mhsa/rules-and-regulations/

Footnotes:

Wyoming is not a designated state for HIV. The Wyoming Department of Health does support the Syringe Services Program (SSP) in Wyoming. Due to challenges in Wyoming statutes, SSPs are currently not legal in Wyoming. There will be no funding towards the SSP using the block grant dollars based on this challenge.

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? ○ Yes ◉ No

Please indicate areas of technical assistance needed related to this section.

None at this time.

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12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1.	Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?	○ Yes ◉ No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	◉ Yes ○ No
3.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	○ Yes ◉ No
4.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	○ Yes ◉ No

5. Does the state have any activities related to this section that you would like to highlight.

None at this time.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

With respect to 2020 Wyoming House Enrolled Act 62, Wyoming Department of Health, Behavioral Health Division and the Wyoming Department of Corrections are currently working together to improve standards of care in mental health and substance abuse services for those within the justice involved population. The local community jail systems and those within the State Prison, have access to the Community Mental Health Centers and State Hospital to provide needed services and evaluations.

https://wyoleg.gov/Legislation/2020/HB0031

Please indicate areas of technical assistance needed related to this section.

None at this time.

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? ( ) Yes (●) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes (●) No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? ( ) Yes (●) No

5. Does the state have any activities related to this section that you would like to highlight?

None at this time.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☐ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☐ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☐ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☐ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☐ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Wyoming CMHC programs are designed to ensure individuals are receiving the least restrictive services based on needs. The Division has an executed contract with the National Council for Mental Wellbeing (previously known as: National Council for Behavioral Health) to evaluate the mental health crisis treatment system in Wyoming. Funding for this assessment has been allocated from the Mental Health Block Grant Technical Assistance supplement. Through this evaluation, the Division will have a heightened understanding of the current mental health treatment and recovery system, identifying areas of readiness for improvement, and identify gaps in the system. The evaluation should be completed by fall 2021 with technical assistance, planning, and implementation of quality improvement activities beginning shortly after. The Division is looking forward to the recommendations from the National Council for Mental Wellbeing. The Division will use information collected during this assessment process, technical assistance from the National Council for Mental Wellbeing, and the National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit to create a plan for quality and capacity enhancements to maximize access to timely services. Stakeholders to be included in the assessment are local emergency medical services, law enforcement, other local crisis stakeholders as determined by each community, and CMHC providers.

With COVID-19 Response and Relief funds, the Division anticipates developing, implementing, and enhancing crisis services throughout Wyoming as determined by the crisis service evaluation study and congruent with national guidelines.

With American Rescue Plan (ARPA) funds, the Division anticipates developing, implementing, and enhancing crisis services throughout Wyoming as determined by the crisis services evaluation study and congruent with national guidelines. The Division estimates a need for eight (8) additional beds at approximately two hundred and eighty dollars ($280.00) per bed per day. The Division also plans to use funding to help PATH providers develop and expand recovery services.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	(•) Yes ( ) No
b)	Required peer accreditation or certification?	(•) Yes ( ) No
c)	Block grant funding of recovery support services.	(•) Yes ( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(•) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes (•) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

State funded Community Mental Health Centers provide recovery services to these populations. Services include peer support through peer specialists, case management, life skills, housing, and group home services. Quality of Life funding is provided to community mental health centers for purposes of providing basic needs such as medication, transportation, and hygiene kits.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

State funded Community Mental Health Centers provide recovery services to these populations. Services include peer support through peer specialists, case management, life skills, housing, and group home services. Quality of Life funding is provided to community mental health centers for purposes of providing basic needs such as medication, transportation, and hygiene kits.

5. Does the state have any activities that it would like to highlight?

Due to COVID-19 related state general fund budget cuts, Quality of Life funds have been significantly reduced for Wyoming providers.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	(•) Yes ( ) No
Home and community based services.	(•) Yes ( ) No
Peer support services.	( ) Yes (•) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

https://health.wyo.gov/wp-content/uploads/2017/09/Wyoming-Department-of-Health_Olmstead-Primer-and-Plan_FINAL_Q1-SFY2018.pdf

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? ○ Yes ◉ No

b) The recovery and resilience of children and youth with SUD? ○ Yes ◉ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ◉ Yes ○ No

b) Juvenile justice? ◉ Yes ○ No

c) Education? ◉ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ◉ Yes ○ No

b) Costs? ○ Yes ◉ No

c) Outcomes for children and youth services? ◉ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ◉ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ◉ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ○ Yes ◉ No

b) for youth in foster care? ○ Yes ◉ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Community Mental Health Centers receive funding from the Division to provide mental health and substance use services to children. The Division works collaboratively with other agencies throughout the state such as the Department of Family Services who is responsible for social and welfare services, and juvenile justice/law enforcement. Wyoming Department of Education is responsible for the education services. The Division is a resource and participates as a liaison for the AWARE Grant.

7. Does the state have any activities related to this section that you would like to highlight?

None at this time.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

Wyoming updated the state suicide prevention plan at the beginning of 2017 and is set to conclude 2021. The goals and objectives have been closely aligned with the 2012 National Strategy for Suicide Prevention, a report from the U.S. Surgeon General and the National Action Alliance for Suicide Prevention. Activities intended to reduce incidents of suicide in Wyoming include: developing broad-based support for suicide prevention by increasing support for suicide efforts; develop and implement community-based suicide prevention programs and activities through support and development of community-based coalitions for suicide prevention and increasing capacity for suicide prevention in school districts; promote awareness that suicide is a public health problem that is preventable by developing media campaigns to raise awareness about suicide prevention and coordinating with other suicide prevention organizations to enhance outreach; reduce stigma associated with mental health including education of media on appropriate reporting; reduce access to lethal means by working with stakeholders including local gun shop owners and prescription drug abuse stakeholder groups; implement suicide prevention training to increase recognition of at-risk behavior and delivery of effective treatment, to include implementation of Zero Suicide; increase key services for individuals at risk for suicide and suicide survivors by establishing a statewide network of suicide survivors and support group leaders and collaborating with primary care facilities to incorporate suicide prevention appropriate responses to individuals at risk for suicide; build capacity for Lifeline services in Wyoming to increase the number of lifeline calls answered within the state; and finally we are working to improve and expand surveillance systems to collect suicide-related data.

Preventing Suicide in Wyoming, 2017 – 2021 State Suicide Prevention Plan can be found at this link https://health.wyo.gov/publichealth/prevention/wivpp/suicide-prevention/.

The Wyoming Injury & Violence Prevention Program is providing multiple trainings in attempts to save lives, along with a large network group of suicide prevention trainers who are able to provide in-person trainings for groups or organizations. Training opportunities include QPR (Question, Persuade, and Refer), ASSIST (Applied Suicide Intervention Skills Training), Mental Health First Aid and Mental Health First Aid – Youth, SafeTALK, Connect Training, AMSR (Assessing and Managing Suicide Risk), and RRSR -PC (Recognizing & Responding to Suicide Risk: Essential Skills in Primary Care).

3. Have you incorporated any strategies supportive of Zero Suicide? ◉ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? ◉ Yes ○ No

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted? ◉ Yes ○ No

If so, please describe the population targeted.

WDH collaborates with and provides multiple resources (i.e., funding and technical assistance) to suicide prevention efforts across the state through community-based coalitions. Coalitions in Wyoming counties have a focus of suicide prevention. Each coalition works with local stakeholders and decision makers to impact identified disparate populations through the implementation of a community level strategic plan reflective of the 2017-2021 State Suicide Prevention Plan.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

The Division is in collaboration efforts with the Wyoming Department of Corrections (DOC) to address 2020 House Enrolled Act 62 (HEA62). HEA62 requires the Division and DOC to collaborate to reduce criminal offender recidivism by improving mental health and substance use programming and funding; creating new programs; creating a unit within the DOC; making an appropriation; requiring reports; and providing for an effective date. The Division will be to be using COVID-19 Response and Relief funds to assist in infrastructure building such as: (1) purchase of personal protective equipment for staff and persons receiving SUD services; (2) purchase of increased connectivity, Wi-Fi, and other related technologies and equipment to improve service delivery; (3) hiring of outreach workers for regular check-ins for people with SUD; and (4) provision of workforce support.
The Division will use COVID-19 Response and Relief funds to assist with support of the 'Safe2Tell' program through the Wyoming Attorney General's Office, Division of Victim Services, to assist with support of the program for suicide and substance abuse. Safe2Tell is a program that allows confidential reporting that concerns or threatens an individual or an individual's friend(s), family, or community.

The Division collaborates with the Wyoming Department of Education (WDE) through the Project AWARE (Advancing Wellness and Resiliency in Education) Grant. The Division serves as a contact, liaison, and resource for the WDE.

The Division will also collaborate with the Wyoming Department of Health, Public Health Division, Injury Prevention Program which oversees state and local-level suicide prevention efforts. The Division is actively participating in the Injury Prevention Program's 988 Planning and Implementation Coalition. This Coalition is serving as the advising and action council for implementation of the changes in the National Suicide Prevention Lifeline.

The Division coordinates with CMHCs to produce the best possible outcomes and to enable consumers to function outside of inpatient and residential programs. Service contracts outline deliverables and expectations of these centers in order to allow the Division to maximize efficiency, effectiveness, quality and cost-effectiveness of the services and programs.

a. Memorandum of Understanding between hospitals and community mental health centers.
b. Behavioral Health Advisory Council
c. Gatekeeping and Diversion grants
d. Early Intervention and Education Program- Ensures that services are provided to eligible children birth through five with Developmental Delays and disabilities in accordance with the IDEA and Wyoming state laws.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

A robust planning process is utilized each year which includes alignment with the Division's strategic plan and funding decisions. This process involves Division staff, provider staff, and other key stakeholders. Once group decisions are made regarding the specific service needs and funds available, the Division contracts with provider agencies to carry out the services. The state provides data to the Council to help prioritize the delivery of substance abuse services. The Wyoming Association of Mental Health and Substance Abuse Centers (WAMSAC) representatives on the Council provide input based upon the experiences/services of their member organizations for substance abuse and mental health. Many of those agencies provide services to both populations with an emphasis on co-occurring disorders.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Council is responsible for the following three areas:
• To review the block grant and make recommendations;
• To monitor, review, and evaluate the allocation and adequacy of behavioral health services; and
• To advocate for people with behavioral health needs
The Council currently meets approximately four (4) times a year; two times annually is the minimum with the flexibility to have a meeting every two months in a twelve consecutive month period. These meetings focus on addressing concerns identified by the membership. Our membership reflects the populations identified as critical for our work: LGBTQ, persons recovering from substance abuse, persons experiencing mental health issues, and family members affected by behavioral health concerns. Members and others are encouraged to share "what is happening in their community or with the group they represent" at the beginning of each meeting. These discussions then drive the agenda for future meetings. Other agencies are also asked to provide information on data collected to help the Council understand behavioral health issues in a broader perspective.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.[70]

[70]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
AMANDA BIALAS	State Employees	DIVISION OF VOC REHAB	551 Running W Dr. Ste 100 Gillette WY, 82718 PH: 307-682-2672	amanda.bialas1@wyo.gov
KATHRYN CAMPBELL	Parents of children with SED/SUD	MAGELLAN WYOMING	PH: 307-223-1186	kcampbell2@magellanhealth.com
CLAUDIA CHAVEZ	Others (Advocates who are not State employees or providers)	HOUSING AUTHORITY	145 N. Durbin St. Casper WY, 82601 PH: 307-262-6426	IChavez@chaoffice.org
JASPER JAMES (JJ) CHEN	Others (Advocates who are not State employees or providers)		Cheyenne WY, 82001 PH: 307-577-6482	jjchencheyenne@gmail.com
TAMMY COOLEY	Youth/adolescent representative (or member from an organization serving young people)		10531 Choke Cherry Rd Cheyenne WY, 82009 PH: 307-286-6367	mycooley@gmail.com
CASSANDRA CRUMPTON	Others (Advocates who are not State employees or providers)		PO Box 2176 Pinedale WY, 82941 PH: 307-367-5103	cassie.crumpton@sublettewyo.com
PAUL DEMPLE	Providers	NORTHERN WYOMING MENTAL HEALTH CENTER	1221 W 5th Street Sheridan WY, 82801 PH: 307-674-4405	pauldemple@nwymhc.org
SCOTT ERICKSON	Others (Advocates who are not State employees or providers)		405 Beech Ave Kemmerer WY, 83101 PH: 307-708-2967	scotthecounselor@gmail.com
SUNNY GOGGLES	Representatives from Federally Recognized Tribes	WHITE BUFFALO RECOVERY	PH: 307-851-3386	whitebuffalorecovery@gmail.com
WAYNE GRAVES	Others (Advocates who are not State employees or providers)		1277 N 15TH ST LARAMIE WY, 82072 PH: 307-742-6222	gravesw@laramiecounty.com
BEN KIFER	State Employees	Wyoming Department of Health	122 West 25th Street Hershcler Building 2W, Suite B Cheyenne WY, 82002 PH: 307-777-6494	ben.kifer@wyo.gov

			FX: 307-777-5849	
CHERI KREITZMANN	Youth/adolescent representative (or member from an organization serving young people)		1507 BECK AVE CASPER WY, 82414 PH: 307-250-1338	kreitzmannco@gmail.com
ANDREW LEMKE	Others (Advocates who are not State employees or providers)	WYOMING PROTECTION AND ADVOCACY	PH: 307-632-3496	lawpanda@wypanda.com
CAITLIN LYLE	State Employees	DEPT OF CORRECTIONS	1934 Wyott Drive Cheyenne WY, 82002 PH: 307-777-6301	caitlin.lyle1@wyo.gov
LANA MAHONEY	Persons in recovery from or providing treatment for or advocating for SUD services	Recover Wyoming	122 West Lincolnway Cheyenne WY, 82001 PH: 307-421-7261	lanamahoney@recoverwyoming.org
SHERRY MERCER	Family Members of Individuals in Recovery (to include family members of adults with SMI)		736 FLORENCE SHERIDAN WY, 82801 PH: 307-672-0885	shermercer@charter.net
CHRISTY MISPLAY	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1601 A CANYON ROAD KEMMERER WY, 83101 PH: 307-677-4888	cmisplay2015@yahoo.com
JO ANN NUMOTO	State Employees	WYOMING DEPT OF EDUCATION	122 West 25th Street, Hershcler Building Suite 200E Cheyenne WY, 82002 PH: 307-777-7222 FX: 307-777-6234	jo-ann.numoto@wyo.gov
SHARON PUCILLO	State Employees	Wyoming Department of Family Services	1510 E PERSHING BLVD CHEYENNE WY, 82002 PH: 307-777-5190	sharon.pucillo@wyo.gov
DONNA SEDEY	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1117 CEDER AVE KEMMERER WY, 83101 PH: 307-877-3389	dmsedey@hotmail.com
BRENDA STOUT	State Employees	DEPT OF HEALTH - HEALTHCARE FINANCING	122 West 25th Street Hershcler Building 4th Floor West Cheyenne WY, 82002 PH: 307-777-2896	brenda.stout1@wyo.gov
MICHELE THOMPSON	Youth/adolescent representative (or member from an organization serving young people)			
MICHAELA TSCHIRHART	Persons in recovery from or providing treatment for or advocating for SUD services	FREMONT COUNSELING	PH: 307-349-9517	mtschirhart@fremontcounseling.com
JEFF WASSERBURGER	State Employees	WYOMING SENATE	4300 Longhorn Avenue Gillette WY, 82718 PH: 307-680-2943	jeff.wasserburger@wyoleg.gov

KELLIE WEBB	Representatives from Federally Recognized Tribes	EASTERN SHOSHONE RECOVERY	PH: 307-335-1169	esr.director@gmail.com
JESSI WESTLING	Others (Advocates who are not State employees or providers)	WYOMING GUARDIANSHIP CORP (OMBUDSMAN)	PH: 307-632-5519	jessi@wyoguardianship.org
CHASSITY WIEDERSPAHN	Youth/adolescent representative (or member from an organization serving young people)	MAGELLAN WYOMING	PH: 307-721-4860	wiederspahnc@magellanhealth.com
SUE WILSON	State Employees	LEGISLATURE/HOUSE		

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**25**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	1	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED/SUD*	1	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	7	
Persons in recovery from or providing treatment for or advocating for SUD services	2	
Representatives from Federally Recognized Tribes	2	
Total Individuals in Recovery, Family Members & Others	**15**	**60.00%**
State Employees	8	
Providers	1	
Vacancies	1	
Total State Employees & Providers	**10**	**40.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**1**	
Youth/adolescent representative (or member from an organization serving young people)	4	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?
Behavioral Health Advisory Council members received an invite for a special Zoom meeting in regards to reviewing the block grant application where questions and answers can be addressed. Any additional edits and suggestions have been requested to be sent to the State Planner via email.

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Footnotes:
Start Year: 2022

End Year: 2023

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a)	Public meetings or hearings?	○ Yes ◉ No
b)	Posting of the plan on the web for public comment?	◉ Yes ○ No
	If yes, provide URL: https://health.wyo.gov/behavioralhealth/mhsa/grants/	
c)	Other (e.g. public service announcements, print media)	◉ Yes ○ No

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Footnotes:

Newspaper ads

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

The Wyoming Department of Health does support the Syringe Services Program (SSP) in Wyoming. Due to challenges in Wyoming statutes, SSPs are currently not legal in Wyoming. There will be no funding towards the SSP using the block grant dollars based on this challenge.

Request for Determination of Need

Requesting jurisdiction: Wyoming

Geographic area for which the determination is requested: State of Wyoming

Reporting Agency: Wyoming Department of Health

Jurisdiction Contact: Brittany Wardle, Communicable Disease Prevention Program Manager

Phone: 307-777-3562

Email: brittany.wardle@wyo.gov

The Wyoming Department of Health (WDH) is submitting the following information in order to demonstrate the need to utilize federal funding to support allowable components of a syringe services program (SSP). Currently, Wyoming Statute criminalizes the delivery and possession with intent to deliver of drug paraphernalia (Wyo. Stat. Ann. § 35-7-1056). Conversely, the Department of Health has all rights and powers "to investigate and control the causes of epidemic, endemic, communicable, occupational and other diseases and afflictions, and physical disabilities resulting therefrom, affecting the public health" (Wyo. Stat. Ann. § 35-1-240 (a)(ii)). The Department also has "the power to prescribe rules and regulations for the management and control of communicable diseases" (Wyo. Stat. Ann. § 35-4-101). The controlled substances act and the Department's authority to control communicable diseases present somewhat of a statutory ambiguity. Under the current framework, the Department would have to ask for specific statutory authority or adopt rules under authority of state statute that authorizes the management and control of communicable diseases (Wyo. Stat. Ann. § 35-4-101 and 35-7-1052). Despite some ambiguity in state statute, the Department does have lawful options to ensure the legality of a syringe services program.

The Wyoming Department of Health is beginning the process of assuring the legality and financial viability of a syringe services program. At this time, WDH does not have the legislative authority to implement SSPs. This request for determination of need will assist in ensuring the financial viability of a SSP in Wyoming. WDH and the Wyoming Substance Abuse and Suicide Prevention Program (SASPP) have compiled sufficient evidence in order to demonstrate that **Wyoming is at risk for significant increases in viral hepatitis and HIV infections due to injection drug use**.

Increase in newly diagnosed HIV infections reporting IDU

Data Source	Beginning Year Number and/or Rate	Ending Year Number and/or Rate	Increase during assessment period
WDH Surveillance	2012	2016	33%
	0 of 8 newly reported cases	6 of 20 newly reported cases	

In 2012, no one newly diagnosed with HIV reported injection drug use as a risk factor. In the next four years, through 2016, 32% of those newly diagnosed with HIV reported injection drug use as a risk factor. In Wyoming, disease intervention specialists (DIS) follow-up with every patient newly diagnosed with HIV to solicit risk factors. This increase in injection drug use contributing to HIV infection contradicts national trends—the CDC reported that in the U.S., HIV diagnoses among people who inject drugs declined from 2008 to 2014.[i]

Increase in HCV rates among younger adults

Data Source	Beginning Year Number and/or Rate	Ending Year Number and/or Rate	Increase during assessment period
WDH Surveillance	2015	2016	20%
	31.4 per 100,000 population	37.6 per 100,000 population	

From 2015 to 2016, the number of people newly diagnosed with HCV that were younger than 36 increased by 20%. Although not possible to determine the duration of infection, most younger persons with HCV infection likely acquired their infections within a few years of being diagnosed and most likely were injection drug users (see data below).

Increase in newly diagnosed HCV infections reporting IDU (≤36 years)

Data Source	Beginning Year Number and/or Rate	Ending Year Number and/or Rate	Increase during assessment period
WDH Surveillance	2015	2016	64%
	27 of 97 cases attributed to IDU	52 of 114 of cases attributed to IDU	

From 2015 to 2016 the number of people newly diagnosed with HCV with reported injection drug use increased by 64%. In Wyoming, disease intervention specialists (DIS) contact those newly diagnosed with HCV who are 36 years or younger to ascertain risk and to provide risk reduction counseling and treatment referrals. This increase is especially concerning because of the differences between younger and older injection drug users. Evidence has shown that "among adolescents and young adults who inject drugs, HCV positivity has been associated with duration and frequency of injection. Additionally, adolescents and young adults may be more likely to

share drug equipment because of the nature of their social networks, which are characterized by trust and sharing."[ii]

Increase in treatment center admissions for heroin and meth use

Data Source	Beginning Years Number and/or Rate	Ending Years Number and/or Rate	Increase during assessment period
TEDS/SAMHSA	2004-2008	2010-2014	255%
	126 heroin treatment admissions	447 heroin treatment admissions	
TEDS/SAMSHA	2007-2010	2011-2014	18%
	2519 meth/amphetamines treatment admissions	2997 meth/amphetamines treatment admissions	
WCIS	2010	2015	69%
	78 outpatient heroin related admissions	132 outpatient heroin related admissions	
	15 residential heroin related admissions	62 residential heroin related admissions	313%

Heroin treatment admission rates were higher in only 7 of 46 states in 2014 compared to 2004. Wyoming was one of these states—there were 19 heroin admissions in 2004 and 150 in 2014. Information from the Wyoming Client Information System (electronic reporting system for mental health and substance abuse providers) parallels the TEDS data. This data submitted directly from providers show that residential admissions for heroin have quadrupled and outpatient treatment admissions have also increased. Similar to other rural areas across the country, Wyoming meth users likely experience circumstances that increase the risk of HIV/HCV transmission, including a belief that HIV is not present in rural areas, choosing to inject meth and injecting in a chaotic environment, limited treatment options, and stigma and marginalization.[iii]

Increase in heroin and methamphetamine related arrests

Data Source	Beginning Year Number and/or Rate	Ending Year Number and/or Rate	Increase during assessment period
Uniform Crime Reporting/WY DCI	2011-2012	2014-2015	
	33 heroin related arrests (2.88/100,000)	66 heroin related arrests (5.64/100,000)	100%
	413 meth related arrests (36.08/100,000)	548 meth related arrests (46.82/100,000)	33%

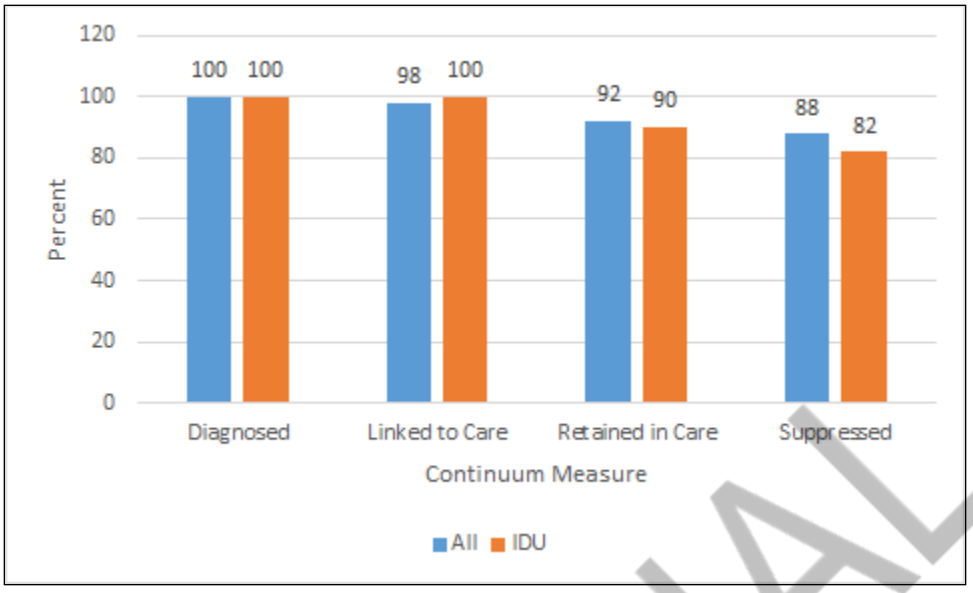
The Wyoming Department of Criminal Investigations compiles statewide crime data through the Uniform Crime Reporting system. Meth and heroin related arrests have increased significantly since 2011.

Increase in heroin related overdoses and deaths

Data Source	Beginning Year Number and/or Rate	Ending Year Number and/or Rate	Increase during assessment period
NVSS/WY Hospital Discharge Data	2011-2013	2014-2016	
	8 heroin related overdoses—inpatient admissions (.46/100,000)	17 heroin related overdoses—inpatient admissions (.96/100,000)	112%
	2011-2012	2013-2014	
	4 heroin related deaths (.35/100,000)	12 heroin related deaths (1.03/100,000)	200%

The National Vital Statistics System and Wyoming Hospital Discharge Data demonstrate a substantial increase in the number of heroin related overdoses and deaths in Wyoming.

Retention in care and viral suppression rates for HIV positive individuals



WDH HIV Surveillance data illustrates lower rates of retention in care and viral suppression for HIV positive individuals who reported injection drug use. Individuals who are not virally suppressed are more likely to transmit HIV to either sex or needle sharing partners. Strategies that reduce infectiousness, such as appropriate ART, have been shown to reduce acquisition of HIV.[iv] The benefit of a SSP for this population would include linkage to other "critical services and programs, such as HIV care, treatment, pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PEP), hepatitis C treatment, hepatitis A and B vaccines,"[v] and screening for other communicable diseases.

Summary of Evidence

In exploring the need to utilize federal funding to support a SSP in Wyoming, multiple variables have been assessed, including newly diagnosed HCV in younger adults, people newly diagnosed with HIV and HCV reporting injection drug use, treatment admissions for methamphetamine and heroin use, arrests, overdose and deaths. In combination, these measures demonstrate an increase in injection drug use and unsafe injection practices that will lead to significant increases in viral hepatitis and HIV infections.

Additionally, the State of Wyoming has policies and trends that encourage unsafe injection drug use—lack of treatment options and some of the least comprehensive prevention laws in the U.S.

- Opioid agonist medication-assisted treatment with methadone or buprenorphine is the most effective treatment for opioid use disorder. Historically, there has been limited access to methadone treatment programs and physicians who can prescribe methadone. In 2015, the American Journal of Public Health published a report about the availability of methadone treatment in every state. The opioid abuse or dependence rate in Wyoming (2012) was 6.2 per 1000 population; the

maximum potential for physician prescription of buprenorphine treatment in Wyoming was only 3.0 per 1000 population. Consequently, less than half of people in Wyoming with opioid abuse or dependence have access to methadone treatment programs—and that doesn't take into account some of the geographic barriers of living in a rural state.

Additionally, at the time of that report, there were no opioid treatment programs in the State of Wyoming. Since then, several facilities within the state have received funding to subsidize opioid treatment programs, but again, there are significant barriers to access in a large rural state. The shortage of this effective countermeasure may significantly impact the incidence of injection drug use and increase the risk of both HCV and HIV transmission.[vi]

- A study published in Morbidity and Mortality Weekly Report in May 2017 described the climate of HCV prevention and treatment services for people who inject drugs. Wyoming Medicaid treatment restrictions are among the most permissive in the U.S., but state laws pertinent to the prevention of HCV infection among people who inject drugs (PWID) are among the least comprehensive in the U.S. In other words, Wyoming state laws hamper the prevention of HCV transmission.[vii]

The occurrence of injection drug use associated HCV infection among young adults and the increases in drug injection is a disturbing trend in Wyoming. High risk populations in the state could greatly benefit from the availability of syringe services and a more comprehensive harm reduction paradigm. When the determination of need is approved, WDH will be better able to guarantee the fiscal availability of a syringe exchange and harm reduction program in the state.

[i] CDC. *HIV and Injection Drug Use*. https://www.cdc.gov/hiv/pdf/risk/cdc-hiv-idu-fact-sheet.pdf. Accessed May 9, 2017.
[ii] CDC. *Hepatitis C Virus Infection among Adolescents and Young Adults—Massachusetts, 2002-2009.* https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6017a2.htm. Accessed May 18, 2017.
[iii] Rural Center for AIDS/STD Prevention. *Rural Methamphetamine Use and HIV/STD Risk, Fact Sheet.* 2006. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0ahUKEwiF96H26LjUAhUM9mMKHS6zAYwQFggsMAE&url=http%3A%2F%2Fwww.indiana.edu%2F~aids%2Ffactsheets%2Ffactsheets18.pdf&usg=AFQjCNFkQEInUFxUdBneE5BXhT7H3nlLPg&cad=rja. Accessed June 12, 2017.
[iv] Shoptaw, S., Geffen, D. *HIV Prevention for People Who Use Substances: Evidence-based Strategies.* J Food Drug Anal. 21(4):S91-S94. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158848/. Access May 24, 2017.
[v] CDC. *Syringe Services Programs.* https://www.cdc.gov/hiv/risk/ssps.html. Accessed June 12, 2017.
[vi] Jones, C., Campopiano, M., Baldwin, G., McCance-Katz, E. *National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment.* Am J Public Health. Aug 2015; 105(8):e55-e63. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4504312/. Accessed May 23, 2017.
[vii] CDC. *State HCV Incidence and Policies Related to HCV Preventive and Treatment Services for Persons Who Inject Drugs—United States, 2015-2016.* https://www.cdc.gov/mmwr/volumes/66/wr/mm6618a2.htm. Accessed May 23, 2017.

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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