Wyoming

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 08/15/2023 5.45.54 PM)

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 2024

End Year 2025

State SAPT Unique Entity Identification

Unique Entity ID JP1QRJYYJG73

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

Agency Name Wyoming Department of Health

Organizational Unit Behavioral Health Division

Mailing Address 122 W 25th Street Hershcler Building 2W, Suite B

City Cheyenne

Zip Code 82002

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

First Name Matthew

Last Name Petry

Agency Name Wyoming Department of Health

Mailing Address 122 W 25th Street Herschler Bldg 2W , Suite B

City Cheyenne

Zip Code 82002

Telephone 307-777-8763

Fax 307-777-5849

Email Address matt.petry1@wyo.gov

State CMHS Unique Entity Identification

Unique Entity ID JP1QRJYYJG73

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

Agency Name Wyoming Department of Health

Organizational Unit Behavioral Health Division

Mailing Address 122 W 25th Street Herschler Bldg 2W, Suite B

City Cheyenne

Zip Code 82002

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

First Name Matthew

Last Name Petry

Agency Name Wyoming Department of Health

Mailing Address 122 W 25th Street Herschler Bldg 2W , Suite B

City Cheyenne

Zip Code	82002
Telephone	(307) 777-8763
Fax	(307) 777-5849
Email Address	matt.petry1@wyo.gov

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	
Zip Code	
Telephone	
Fax	
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

First Name	Megan
Last Name	Norfolk
Telephone	3077777903
Fax	3077775849
Email Address	megan.norfolk1@wyo.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Prevention SUPTRS Contact:
First: Rachel
Last: Nuss
Address 1: 122 West 25th Street
Address 2: Herschler Building 3rd Floor West
City/State/Zip: Cheyenne, Wyoming 82002
Phone: 307-777-6463
Email: rachel.nuss3@wyo.gov

Data Specialist:
First: Andrew "Drew"
Last: Curtis
Address 1: 122 West 25th Street
Address 2: Herschler Building 2 West Suite B
City/State/Zip: Cheyenne WY 82002
Phone: 307-777-7292
Email: andrew.curtis1@wyo.gov

IV. State Expenditure Period (Most recent State expenditure period that is closed out):
SFY 2023: 07/01/2022 - 06/30/2023

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
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Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: Stefan Johansson

Signature of CEO or Designee[1]: _____

Title: Director, Wyoming Department of Health

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2024

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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
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8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Stefan Johannson

Signature of CEO or Designee[1]: _____

Title: Director, Wyoming Department of Health

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

1. Clearly describe the proposed/planned activities utilizing the funds for both fiscal years in two separate sections, including an estimated budget for each year. States will be required to report on what activities have been completed using this funding.

Fiscal Year 2024	**Period Performance Dates: 08/01/2023 – 10/16/2024**	
Activity Title	***Description***	***Amount***
Annual plans and MOU Updates	State contracted Community Mental Health Centers (providers) treating individuals with SMI and SED will be incentivized through contract to update and enhance their unique emergency preparedness and response plans along with any necessary Memorandums of Understanding (MOU). Evidence of completed deliverables prior to invoice approval.	$10,000.00
Needs and Gaps Assessment(s), Behavioral Health Crisis Response and/or Active Shooter Related Training	Needs and gap assessment to examine what needs to be addressed within communities. Funding to obtain appropriate behavioral health crisis response and/or active shooter related training for agencies, partners, providers, and stakeholders with relation to individuals with SMI and SED, to include identifiable training necessary to respond to the aftermath of mass shootings and other traumatic events in the communities, which may include but not limit to, behavioral health response training, culturally and linguistically appropriate supports and tailored messaging, and evidenced-based services training with intention to improve the public mental health systems.	$68,116.00
First Episode Psychosis (FEP) / Early Serious Mental Illness (ESMI) Set Aside Requirement	FEP/ESMI providers may utilize the funding to develop and/or enhance emergency preparedness and response plans, evidence-based services, and collaboration efforts to coordinate with multiple agencies and organizations to lead the representation for the FEP and ESMI populations. Training may be offered by the FEP/ESMI providers to other agencies, providers, partners, and stakeholders on evidence-based practices and emergency preparedness and response plans.	$8,680.00
Total		$86,796.00
No activities complete at this time. Total Costs of Activities to-date:		$0.00

Fiscal Year 2025	Period Performance Dates: 09/30/2023 – 09/30/2025	
Activity Title	***Description***	***Amount***
Annual plans and MOU Updates	State contracted Community Mental Health Centers (providers) treating individuals with SMI and SED will be incentivized through contract to update and enhance their unique emergency preparedness and response plans along with any necessary Memorandums of Understanding (MOU). Evidence of completed deliverables prior to invoice approval.	$5,000.00
Needs and Gaps Assessment(s), Behavioral Health Crisis Response and/or Active Shooter Related Training	Needs and gap assessment to examine what needs to be addressed within communities. Funding to obtain appropriate behavioral health crisis response and/or active shooter related training for agencies, partners, providers, and stakeholders with relation to individuals with SMI and SED to include identifiable training necessary to respond to the aftermath of mass shootings and other traumatic events in the communities, which may include but not limit to, behavioral health response training, culturally and linguistically appropriate supports and tailored messaging, and evidenced-based services training with intention to improve the public mental health systems.	$66,123.00
First Episode Psychosis (FEP) / Early Serious Mental Illness (ESMI) Set Aside Requirement	FEP/ESMI providers may utilize the funding to develop and/or enhance emergency preparedness and response plans, evidence-based services, and collaboration efforts to coordinate with multiple agencies and organizations to lead the representation for the FEP and ESMI populations. Training may be offered by the FEP/ESMI providers to other agencies, providers, partners, and stakeholders on evidence-based practices and emergency preparedness and response plans.	$7,903.00
Total		$79,026.00

1. Describe any plans to utilize the BSCA supplemental funds to develop/enhance components of your state's mental health emergency preparedness and response plan that addresses behavioral health. Please include in your discussion how you plan to coordinate with other state and federal agencies to leverage crisis/mental health

emergency-related resources.

The Wyoming Department of Health proposes to utilize BSCA supplemental funds to further develop and enhance components of the state's mental health emergency preparedness and response plan that addresses behavioral health by working with community mental health centers for individuals with SMI and SED to ensure local center plans align with the goals, objectives, and deliverables of the state plan.

The Wyoming Department of Health (Agency), Behavioral Health Division (Division) participates in the meetings hosted by the Agency's Public Health Division (PHD). The PHD meetings are a collaboration between multiple state agencies, county emergency managers, and key stakeholders. Meetings typically include a specific topic or an agenda, and participants are asked to provide an update or contribution. The PHD gathers Agency related information, including information from the Division, for the Continuity of Operations (COOP).

The Wyoming Office of Homeland Security (WOHS) training section is responsible for the coordination of courses from the National Training and Education Division of the Federal Emergency Management Agency (FEMA). Most pieces of training are provided through grants at little to no cost for registered FEMA students to attend; and in order to qualify for most training, the individual must have a local, county, or state agency affiliation or belong to a first response, receiver organization or volunteer organization. A full list of training and exercise opportunities offered through the WOHS training unit can be located on the Wyoming Information Sharing Platform (WISP).

At this time, the Division will continue to participate in the PHD meetings as requested and continue collaboration with those involved. The Division will forward appropriate WOHS training opportunities to the providers identified in the statewide plan. By incentivizing payment through contract deliverables, the Division will require plans to be updated for individuals with SMI and SED. The Division will release an opportunity to receive funding through a Request for Application (RFA) process. The RFA process is the state-approved bidding process for awarding grant dollars.

1. Describe any plans to utilize the BSCA supplemental funds to develop/enhance a state behavioral health team that coordinates, provides guidance, and gives direction in collaboration with state emergency management planners during a crisis.

Community Mental Health providers identified in the statewide plan:

- Big Horn Basin Counseling Services, Inc
- Central Wyoming Counseling Center
- Cloud Peak Counseling Center
- West Park Hospital District dba Cody Regional Health
- Fremont Counseling Service
- High Country Behavioral Health
- Mental Health & Recovery Services of Jackson Hole
- Southwest Counseling Service
- Yellowstone Behavioral Health Center
- Volunteers of America Northern Rockies

The Division will offer providers identified in the statewide plan to develop and enhance emergency preparedness and response plans along with collaborative efforts to create or enhance their multiple Memorandums of Understanding (MOU) annually through incentivized payment via Agency contracts in relation to individuals with SMI and SED. Proof of completed contract deliverables must be provided in order to receive payment.

The Division will open an RFA where responses may address needs and gaps to develop, enhance, and identify unique emergency preparedness and response abilities and necessary training to respond to a crisis, or perhaps an analysis of gaps and improvements necessary to meet evidence-based practices in regard to emergency preparedness and response plans in relation to individuals with SMI and SED. The total amount of funding for this project is to be determined. Overall, it will be available to improve the public mental health system's ability to respond to the need for mental health services in relation to individuals with SMI and SED, in the aftermath of mass shootings and other traumatic events in the communities.

2. Describe any plans to utilize the BSCA supplemental funds to develop/enhance a multidisciplinary mobile crisis team that can be deployed 24/7, anywhere in the state rapidly to address any crisis.

The Division has not identified the utilization of the BSCA supplemental funds to develop/enhance a multidisciplinary mobile crisis team that can be deployed 24/7, anywhere in the state, to rapidly address any crisis. At this time, mobile crisis teams are not ready to launch in Wyoming based on a comprehensive needs assessment from the National Council of Mental Wellbeing, MTM Services. If possible to implement mobile crisis teams, training will be encouraged and fall under the "Needs and Gaps Assessment(s), Behavioral Health Crisis Response and/or Active Shooter Related Training" in the criteria 1 box.

3. Describe any plans to utilize the BSCA supplemental funds to develop/enhance crisis/mental health emergency services specifically for young adults, youth and children, or their families. This includes those with justice involvement and having SED/serious mental illness.

The Division has not identified the utilization of the BSCA supplemental funding to develop/enhance crisis/mental health emergency services specifically for young adults, youth and children, or their families, including those with justice involvement and having serious emotional disturbance/severe mental illness (SED/SMI). If able to identify the need, training will be encouraged and fall under the "Needs and Gaps Assessment(s), Behavioral Health Crisis Response and/or Active Shooter Related Training" in the criteria 1 box.

The Division will continue collaboration efforts with individuals at the Wyoming Department of Education's AWARE project, individuals within the Governor's Behavioral Health Advisory Council, and other appropriate stakeholders.

The Division requires through contracts with providers "[t]he Contractor shall have policies and procedures, including action plans and training documents, in regards to emergency management directly impacting individuals with SMI and SED".

4. Describe any plans to utilize the BSCA supplemental funds to develop/enhance services provided to communities that are affected by trauma and mass shootings/school violence.

The Division requests BSCA supplemental funding to obtain appropriate behavioral health crisis response and/or active shooter-related training for agencies, providers, and stakeholders with relation to individuals with SMI and SED.

BSCA supplemental funding to develop/enhance services provided to communities that are affected by trauma and mass shootings/school violence may be associated with the community mental health providers' RFAs with regard to training opportunities with relation to individuals with SMI and SED. Having robust emergency preparedness and response plans allows providers to appropriately respond to communities experiencing and recovering from mass shootings, school violence, and other traumatic events.

5. Describe any plans to utilize the BSCA supplemental funds to develop/enhance culturally and linguistically tailored messaging to provide information about behavioral health in a crisis/mental health emergency and/or to identify culturally/linguistically appropriate supports for diverse populations.

The Agency complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, sex, age, or disability in its programs and services. The Agency provides appropriate communication aids and services when necessary for individuals with disabilities to be able to communicate effectively and to ensure meaningful access to programs and services. These aids and services include qualified sign language interpreters and written information in other forms, such as large print, audio, or accessible electronic formats. The Agency Non-Discrimination Notice can be found at health.wyo.gov/admin/privacy/non-discrimination-notice/.

The Agency has a listing of culturally/linguistically appropriate services, as needed, and may disseminate Agency service information to members of the public or other stakeholders.

Community mental health providers identified in the statewide plan and with relation to individuals with SMI or SED, will have the opportunity to request BSCA dollars through RFA to develop or enhance their appropriate FEP/ESMI programs related to emergency preparedness and response services, culturally and linguistically tailored messaging to provide information about behavioral health in a crisis or mental health emergency and to identify culturally/linguistically appropriate supports for diverse populations.

6. What other mental health emergency/crisis behavioral health practices or activities does the state plan to develop or enhance using the BSCA supplemental funds?

The Division requests funding to obtain appropriate behavioral health crisis response and/or active shooter-related training for agencies, providers, and stakeholders with relation to individuals with SMI and SED.

As required per the Clarification to Bipartisan Safer Communities Act (P.L.117-159) MHBG Guidance (10/17/2022), states must spend BSCA funds in accordance with allowable MHBG expenses, including the set aside ten percent (10%) of the total allocation for first-episode psychosis or early SMI programs.

First Episode Psychosis (FEP) / Early Serious Mental Illness (ESMI) providers will have the opportunity to expend the allocated ten percent (10%) set aside funds in their RFA. Provider ESMI / FEP programs will be required to develop or enhance the programs' emergency preparedness and response plans, evidence-based services, and collaboration efforts to coordinate with multiple agencies and organizations.

FEP/ESMI providers will have the opportunity to offer training to other community mental health centers and stakeholders with relation to individuals with SMI and SED, on evidence-based practices and emergency preparedness and response plans related to the FEP/ESMI program. In addition, this will allow FEP/ESMI providers to update or establish MOUs to develop and enhance emergency response and recovery services for the FEP/ESMI program during a crisis.

The five percent (5%) set aside for Crisis Services is not required with BSCA funds. The Division has not identified the utilization for BSCA funding for Crisis Services at this time, but training for this category may fall under the "Needs and Gaps Assessment(s), Behavioral Health Crisis Response and/or Active Shooter Related Training" in the criteria 1 box.

The Division will not be requesting BSCA supplemental dollars in regard to the five percent (5%) maximum dollar amount for administrative costs at this time.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name

Stefan Johansson

Title

Director

Organization

Wyoming Department of Health

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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 (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system 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. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

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Footnotes:

Behavioral Health Division
Mental Health and Substance Abuse Services Section
Phone (307) 777-6494
Fax: (307) 777-5849

State of Wyoming Overview

Wyoming is a rural and frontier state, where approximately 581,381[1] (population estimates of July 1, 2022 (V2022)) residents reside in the 97,088.76 square miles, at approximately 5.9 persons per square mile.

Approximately 68.98% of the population is considered rural. The two largest towns in Wyoming are Cheyenne (approximate population 65,132) and Casper (approximate population 59,038); followed by a third town Gillette[2] (approximate population 33,403), the population change is significant at approximately 25,635 less people than Casper and 31,729 less people than Cheyenne[3]. The least populated County in Wyoming is Niobrara, containing four towns – Lusk, Lance Creek, Manville, and Van Tassell. Combined, Niobrara County has a population of approximately 2,380[4].

Wyoming is the least populated state in the United States of America. Wyoming's demographics are approximately 92.3% White; African American/ Black 1.2%; Hispanic 10.8%; Asian alone 1.1%; American Indian and Alaska Native alone 2.8%; Native Hawaiian and Other Pacific Islander along 0.1%; Two or More Races 2.4%, Hispanic or Latino 10.8%, and White alone, not Hispanic or Latino 83.1%[5].

The Wyoming Department of Health (Agency), Behavioral Health Division (Division) is one of five divisions and is the Single State Authority (SSA) for the delivery of community mental health and substance use treatment and recovery services. The Division is comprised of the Mental Health and Substance Use Services (MHSA) section, the Operations, Policy, Tracking and Contracts (OPTC) Unit, the Early Intervention and Education Program (EIEP), the Wyoming Life Resource Center (WLRC), and the Wyoming State Hospital (WSH).

[1] Wyoming Quick Facts for Demographics and Geographical information: https://www.census.gov/quickfacts/fact/table/rockspringscitywyoming,laramiecitywyoming,gillettecitywyoming,cheyennecitywyoming,caspercitywyoming,WY/PST045219

[2] Historical Decennial Census Population for Wyoming Counties, Cities, and Towns.: http://eadiv.state.wy.us/demog_data/cntycity_hist.htm

[3] Wyoming, Top Three Town Populations – Based off Census, April 1, 2020: https://www.census.gov/quickfacts/fact/table/gillettecitywyoming,caspercitywyoming,cheyennecitywyoming,WY/PST040221

[4] Niobrara County Census – Based off Census, April 1, 2020: https://www.census.gov/quickfacts/fact/table/niobraracountywyoming,WY/PST040222?

[5] Wyoming QuickFacts for Race and Hispanic Origin: https://www.census.gov/quickfacts/fact/table/WY/PST045222#qf-headnote-a

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The MHSA section contains four units: 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 regarding requests, revisions, and information.

The Quality and Evaluation 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 the Uniform Reporting System (URS) Tables, Treatment Episode Data Set (TEDS), grant reporting, and any other data requests.

The Community Treatment Services Unit develops and monitors contracts with Community Mental Health Centers and Substance Use Centers (providers), outlining the specific services to be provided to individuals with mental health and substance use disorders. These providers offer evidence-based mental health and substance use services within outpatient and residential settings and are funded largely by the Division.

Within the Community Treatment Services Unit resides the Court Supervised Treatment (CST) program. The CST program includes adult, juvenile, family, and Driving Under the Influence (DUI) categories within 12 counties in Wyoming and 16 state-funded courts. CST programs provide sentencing alternatives for the judicial system in cases stemming from substance use. 2023 Senate Enrolled Act No. 3 (SF0023; SEA No. 0003) requires the CST program to transfer responsibility of oversight from the Agency to the Wyoming Supreme Court. This program will no longer be in the Agency nor will it be a part of the Maintenance of Effort (MOE) as of July 1, 2024, as it previously has been. A significant reduction of approximately three million, three hundred sixty three thousand, and two hundred and twenty three dollars ($3,363,223.00) annually in the MOE will be anticipated.

Also within the Division, the OPTC Unit provides assistance and guidance over policies and contracts, along with providing operational services and tracking services efforts. OPTC is the liaison between the contract manager and all individuals involved with the RFP/RFA and contract process. The Unit also is responsible for ensuring one voice through publicly available documents and official Division correspondence.

The EIEP provides developmental screenings and services 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

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to help states ensure preschool-aged children (three to 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 or skilled nursing level of 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 MHSA section'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 support through state contracts, grants, and collaboration with community providers.

As the SSA, the Division contracts with ten providers for the delivery of outpatient and residential services for mental health and substance use disorders. Over the last several years, a number of providers have merged businesses and practices, reducing the number of total providers contracted through the State. Additional provider mergers are anticipated within the next few years. The mergers do not decrease the services offered, all counties have a representation of treatment services available.

Through set contracts, the providers are obligated to provide services and support as indicated by individual treatment plans to all population groups, even after state funding has been exhausted. Priority populations for mental health services include persons with Serious Mental Illness (SMI) and children with Serious Emotional Disturbances (SED). Prioritized substance use service populations include pregnant women, persons who inject drugs (PWID), women with dependent children, and veterans.

The Agency consists of five divisions which include (1) Administration and Support, (2) Healthcare Financing (Medicaid), (3) Aging, (4) Behavioral Health, and (5) Public Health. The Public Health Division (PHD) includes programs relevant to behavioral health such as Substance Use 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 Division of Healthcare Financing oversees public healthcare programs such as Medicaid and Kid Care CHIP. The Aging Division provides care, ensures safety, promotes independent choices for Wyoming's older adults and conducts licensing and surveying of healthcare facilities. The Administration and Supports assist the Director and provide reports such as HealthStat and the Olmstead report.

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The Agency collaborates with the Department of Family Services (DFS) and the Department of Corrections (DOC). DFS assists in the delivery of services and the welfare needs of individuals with mental health and substance use disorders.

The 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 Division and DOC collaborate in regards to House Enrolled Act No. 62 (HEA 62)[6] of the 2020 Budget Session to reduce criminal offender recidivism by improving mental health and substance use creating new programs and units. Requirements from HEA 62 include creating programs to improve outcomes for justice involved individuals; adopting EBPs for treatment; increased communication between agencies, providers, and the justice involved individual; use of standardized tools and assessments for diagnosis and treatment; and includes expanding services for justice involved individuals, quality improvement and access to services, and training for providers and stakeholders. The overall goals are to decrease recidivism rates; improve mental health and substance use disorders; and improving quality and use of assessments. The local community jail systems and State prisons have access to providers and the WSH to provide necessary services and evaluations.

The Wyoming Department of Education (WDE) and local school districts are responsible for implementing P.L. 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 years and extends services for infants from birth to age two.

During the 2021 General Session of the Wyoming Legislature, House Enrolled Act No. 56 was passed and signed by the Governor. This legislation specifies and prioritizes persons to receive state-funded mental health and substance use disorder treatment services. The legislation directs the Wyoming Department of Health (Agency) to prioritize the contracted Community Mental Health and Substance Use Disorder Treatment Centers (providers) for state-funded services. Redesign efforts started in summer 2021 and the work will continue until the prescribed implementation date of July 1, 2024.

Independent Peer Reviews occur annually with providers. The Division selects providers to participate in the peer review. Selections are based on provider previous year(s) completed, 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 and for those who are selected, the selected providers are obligated through annual contracts.

[6] House Enrolled Act No. 62

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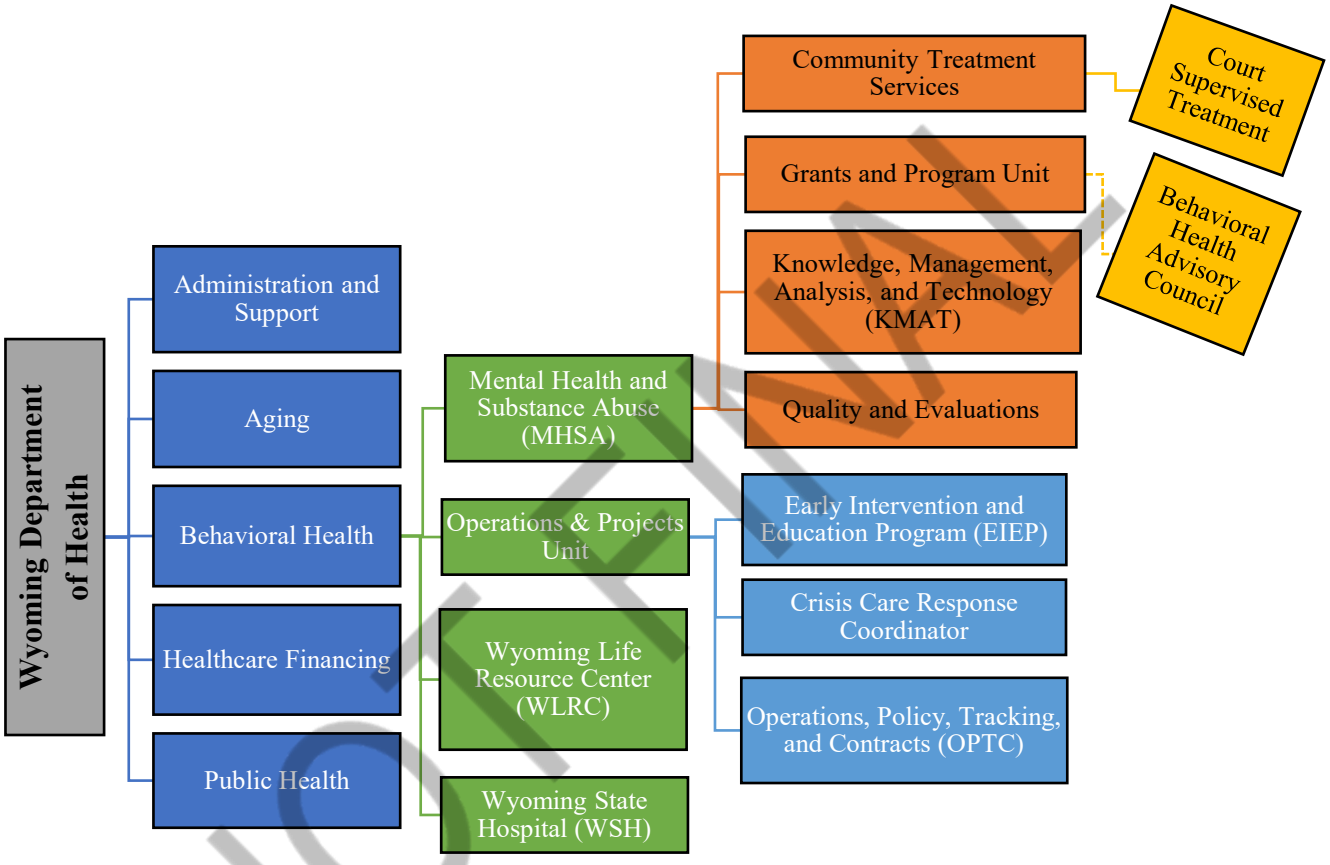
Wyoming Department of Health Organizational Chart



Wyoming is not a Medicaid expansion state.

Wyoming Behavioral Health System Organization Comprehensive Care Regions

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

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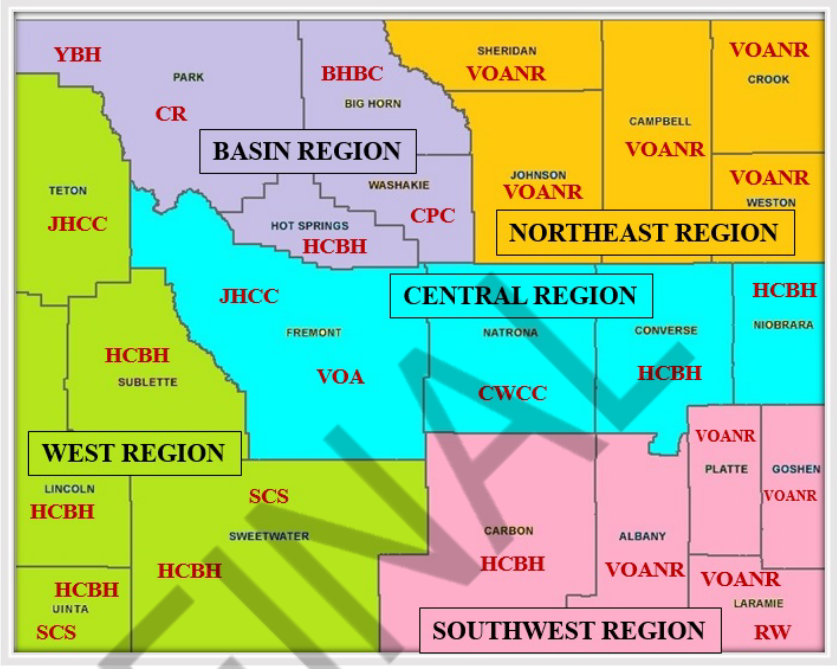
Wyoming Map of Providers

Contracted MH/SA Treatment Providers
Big Horn Basin (BHBC)
Cody Regional dba West Park Hospital District (CR)
Central Wyoming Counseling Center (CWCC)
Cloud Peak Counseling (CPC)
Fremont Counseling Services (FCS)
High Country Behavioral Health (HCBH)
Jackson Hole Community Counseling (JHCC)
Southwest Counseling Services (SCS)
Yellowstone Behavioral Health (YBH)
Volunteers of America of the Norther Rockies (VOANR)

Other Services:
Recover Wyoming (RW) – Services include: Certified Peer Specialist, Recovery Services, and PATH Provider



Treatment - Mental Health Description of Service System

Wyoming is a rural and frontier state, providing a challenge with limited access to specialized services for priority populations. The population density in Wyoming has approximately 5.9 persons per square mile. Travel in the winter months is often restricted due to 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. These unique 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 use 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 use populations.

The contracted providers 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 the providers, 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 use 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. In addition to providing updated treatment facilities and enhanced safety features, the new halls also allow for all patients to have private rooms. 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.

Adults with SMI are the primary clients served through the involuntary commitment process, known in Wyoming as the Title 25 system (Wyo. Stat. §§ 25-10-101 – 129). The Division 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.

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 the individual is 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.

The Community Mental Health Block Grant (MHBG) will be utilized to directly fund mental health providers for outpatient treatment services. MHBG funds were previously 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. Now the contract is fully funded through State General Funds (SGF). First Episode Psychosis (FEP) services are also a priority and funded through the block grant to Southwest Counseling Service (SCS) and Volunteers of America of the Northern Rockies (VOANR).

Utilizing the MHBG Supplemental COVID-19 funds, SCS anticipates exceeding the target to this population by early identification of initial onset of a DSM-5 diagnosable mental, behavioral or emotional disorder. Specific activities reported by SCS, include: identification of those who present in the ER for crisis situations, and provide coordination of care to enroll clients into behavioral health services; job coaching is provided for those at risk of decreased occupational functioning; the use of EBPs are utilized in the treatment of those identified as ESMI; and SCS will continue to provide education to primary care providers regarding the identification of early onset.

VOANR is new and in developmental and implementation stages of the FEP/ESMI program. After several mergers with local providers, VOANR has 14 locations and aims to streamline services and skilled staff training over the next several years. Though there are many new and exciting

happenings with VOANR, the FEP/ESMI program has a dedicated staff to enhance and provide necessary care to individuals in need.

Yellowstone Behavioral Health Center previously provided FEP/ESMI services, and has decided to no longer partake in the FEP/ESMI funding. Two FEP/ESMI service providers remain in Wyoming.

MHBG COVID-19 Funds

The MHBG Supplemental COVID-19 funds include no less than ten percent of allocated funds for the Early Serious Mental Illness requirement, where the Division plans to enhance early intervention services in Wyoming through the provision of additional resources for treatment to Subrecipient providers.

The five percent administrative funds will support functions necessary for implementation of the funding and activities including but not limited to data collection, contract administration, Subrecipient monitoring, grant management, and the Behavioral Health Advisory Council initiatives.

The five percent minimum and additional funds will be used for Crisis Services. The funding for Crisis Services will help to develop, implement, and enhance crisis services throughout Wyoming as determined by the crisis service evaluation study and congruent with national guidelines from the National Council of Mental Wellbeing through MTM Services.

At this time, the Division has funds allocated to assist and support information dissemination and infrastructure building needs in order to establish the 988 functions.

MHBG ARP Funds

Through the American Rescue Plan (ARP) Act 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. Using the ARP funding, VOANR has initiated development of ESMI/FEP services within their organization.

The Division declined the administrative funds from the MHBG Supplemental ARP funds.

Crisis services continue to maintain the five percent requirement and additional ARP funds to develop, implement, and enhance crisis services throughout Wyoming as determined by the crisis service evaluation study and congruent with national guidelines. Crisis services funding will assist in creating an estimated eight additional crisis beds.

MHBG Mitigation Funds

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The MHBG Supplemental ARP COVID-19 Mitigation funds were requested by SCS and VOANR. SCS will use the funds for disinfectant cleaning supplies and a full time janitorial position to maintain a healthy environment; and while VOANR utilized the funds for monthly rental of quarantine units, internet and telecommunications, and personal protective equipment (PPE).

Treatment - Substance Use Description of Service System

The Division has recognized an increase in demand for opioid and methamphetamine treatment services. The Division was awarded the State Opioid Response (SOR) Grant. 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, providers 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 and women with dependent children (PWWDC), persons who inject drugs (PWID), individuals with tuberculosis (TB) and/or human immunodeficiency virus (HIV), 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 requires certified providers utilize an evidence-based assessment tool which includes the comprehensive information regarding the client's biopsychosocial and spiritual needs. Meaning the biological, psychological, social, and spiritual needs of a client, which play a significant role in a behavioral health disorder and contribute to the client's functioning.

According to Wyoming contract requirements, substance use services are to be prioritized to those persons who meet the special populations identified by Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Use Prevention, Treatment and Recovery Services Block Grant (SUPTRS) requirements for admission preference.

The SUPTRS will be utilized to directly fund community providers for outpatient and residential treatment services. Twenty percent of the federal funding is provided to the PHD Prevention program. The minimum requirement for the women and children (family units) specialized funding is considered and wrapped in data collection and drawdown reporting. The five percent of recovery services will be contracted through an appropriate Request for Proposal process through the State of Wyoming's Administrative and Information (A&I) Procurement Department. The funding will go to Recover Wyoming and the contract is in draft. The five percent of administrative funds will be used for the independent peer reviews and the remaining amount will go towards personnel costs. No funds will be used for indirect costs per the previous Notice of Awards.

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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. All funded providers are required to meet the priority population guidelines, several programs are specific to various populations. The Division continues to provide technical assistance and federal funding for substance use residential treatment for women and day treatment programs for women to Central Wyoming Counseling Center, Volunteers of America Northern Rockies, and Southwest Counseling Service for women and children's treatment.

SCS's Women's Addiction Program was the first program in the state of Wyoming that allowed pregnant women and mothers with substance use 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.

The Division utilizes the Mountain Plains Addiction Technology Transfer Center (ATTC) training for all statewide provider training related to substance use, and informs and encourages providers to utilize free training (i.e. online by out-of-state companies) across the state.

The PHD, Substance Use and Tobacco Prevention Program (SUTPP) utilizes the twenty percent set aside of the Grant for community-level prevention efforts.

Previously, the PHD, Communicable Disease Unit utilized approximately 0.8 percent of allocated SUPTRS funds for treatment and testing services for TB. Due to recent notification of no longer required funding, this unit no longer is a part of the SUPTRS budget nor narrative, but will remain per the requirement in the priority areas. Providers are able to refer clients to the local TB program(s) within the Public Health Nursing offices nearby, when necessary. Some providers can provide dual treatment. Providers are also able to receive training from local Public Health Nurses or through the PHD TB program for related services and medications. The Division recently requested all contracted providers to provide the TB policies and procedures. All current contracted providers have TB policies and procedures in place.

SUPTRS COVID-19 Funds

The SUPTRS Supplemental COVID-19 funds support housing through Subrecipients of the Project for Assistance in Transition from Homelessness (PATH) Grant related to SMI and SED services. There will be three providers during the FY 2024 contract year, two serve the adult population and one serves strictly youth. PATH providers are encouraged to work with contracted block grant providers. To reduce duplicated payment, PATH providers are only allowed to bill for non-mainstream services by working with other mental health and substance use centers within the individual's area.

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SUPTRS Supplemental COVID-19 funds also include the twenty percent set aside for prevention services, five percent of administrative costs, and the requirement to meet the minimum standards for women services since 1994 per year. Beyond the requirements, the Division has created contracts for the Court Supervised Treatment Program to assist and support treatment for individuals after the FY22 budget cuts.

Another contract created was a collaboration with the Wyoming Attorney General's Office, Division of Victim Services, Safe2Tell program. Safe2Tell works with youth and adolescents, and has created social media platforms to encourage reaching out to a trusted adult about issues witnessed. This is not a counseling program or a suicide prevention line, though can be used to find resources for assistance. The contract is to assist and support the program for information, breaking stigma, and outreaching in regards to suicide and substance use.

Through the previous Technical Assistant grant, MTM Services was asked to provide a gap and needs assessment of crisis services and more. Using the SABG Supplemental COVID-19 funds, the Division will assist subrecipients to build services and support for adolescents, outpatient SUD services, recovery services, etc.

SUPTRS ARP Funds

SUPTRS Supplemental ARP funding supports the required percentage amounts for prevention, administrative, and women and children services. The Division is working with the PHD, Communicable Disease unit to fund a Tuberculosis position.

Funding will go towards assisting with expanding MAT Services for the CST program to develop and expand the use of FDA-approved medications and digital therapeutics as a part of addiction treatment that can provide interactive, EBPs behavioral health therapies for treatment of OUD, alcohol use disorders, and tobacco use disorders, along with the implementation of other EBPs treatments and practices.

Crisis Intervention Training (CIT) for law enforcement partners, providers, and specified stakeholders will be provided via contract with the Wyoming Association of Sheriffs and Chiefs of Police.

All contracted providers can receive funding for development and expansion of Recovery services through support of expansion of peer-based recovery support services and recovery orientation. The goal will be to build or enhance programs in assisting individuals in recovery, engaging families and significant others, bridging gaps between treatment and long-term recovery, and supporting people reentering the community from incarceration. Other recovery services and training are also in consideration.

The VOANR was awarded additional funds for an expansion of crisis and detox services in two locations within the State – Sheridan and Cheyenne. To clarify there are no construction efforts under the block grant funding as it is not allowable.

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SUPTRS Mitigation Funds

The final SUPTRS Supplemental ARP COVID-19 Mitigation funds were awarded to three facilities. Central Wyoming Counseling Center will use the funds for COVID testing of clients entering the residential program. SCS received funds for partial salaries for two full-time employees, medical assessments, treatment, follow-up, and PPE. VOANR will receive funds for monthly rent for quarantine units, internet and telecommunications, and PPE.

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 subrecipient of 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:

- 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 Veterans hospitals, tribal and reservation providers, and private providers. The number of persons certified to provide peer support has increased over time:

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Number of Certified Wyoming Peer Specialists

2019	2020	2021	2022	2023**	* First IC&RC Certifications began with RW in April 2021. Top number is Division reported Certified Peer Specialist, second is RW reported Certified Peer Specialist. **Year-to-date information from July 25, 2023. ***Reported 134, however, fourteen (14) from the group has an expired certification and has not renewed.
97	130	155 87*	110	120***	

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. 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 SMI and SED 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 transitioned the certification process to Recover Wyoming. Recover Wyoming works with the 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 use services. Integrated mental health and substance use services are delivered in both residential and outpatient programs. It is considered a standard of care to serve all of the needs of an individual, including those with co-occurring disorders.

Contracts are in place with Recover Wyoming to provide training and support to individuals seeking and in recovery. Recover Wyoming will secure the coordination of peer specialist training and support services to advance recovery for Wyoming citizens and advance the peer specialist profession. Along with coordinating Wellness Recovery Action Plan (WRAP) training to current certified peer specialists, and will address substance use disorders and mental health through the implementation and further development of a telephone recovery support.

Community Mental Health and Substance Use Disorder Treatment Centers include 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. Providers assist individuals in connection to primary health care, educational resources, and other various community resources.

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Wyoming has one recovery community organization (RCO), Recover Wyoming.

Recover Wyoming is made up of volunteers, staff, a board, and includes individuals in long-term recovery and family members/allies of people affected by addiction. Services include recovery coaching, referrals to existing services, special events, and a safe place to be and to volunteer.

Recover Wyoming provides a small recovery community center allowing individuals a social acceptance atmosphere, which includes a meeting space, lounge area, small kitchen, kid zone, and computer/internet access. Recover Wyoming does not have group homes available, but does provide Projects for Assistance to Transition from Homelessness (PATH) services.

Recover Wyoming's mission is "to advocate for persons in recovery and mobilize resources to aid them, their families, & allies to increase the occurrence and quality of long-term recovery from addiction." Through recovery promotion and education, Recover Wyoming will work with communities and organizations to advocate that all people, seeking and in recovering, are treated with dignity and respect.

Further, Recover Wyoming is contracted to address SUD and MH through the implementation and further development of a telephone recovery support service which is funded through the SOR funds.

Children/Adolescents

Children are served throughout the state of Wyoming by providers 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 SCS 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 the Central Region. All providers 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. Providers 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

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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 Agency's Division of Healthcare Financing. 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 years. 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 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 support and community-based services. The Division of Healthcare Financing 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 Division of Healthcare Financing has made a concerted effort towards HFWA but most of the projects were eliminated or reduced due to past budget reductions and restrictions.

Prevention

The Community Prevention Unit is part of the Public Health Division and includes the Injury Prevention Program and the Substance Use and Tobacco Prevention Programs. This organization is meant to increase collaboration between substance use prevention with suicide prevention and unintentional poisoning prevention efforts. A significant amount of program potential synergy can be had at the State and community level because of the shared populations and risk factors.

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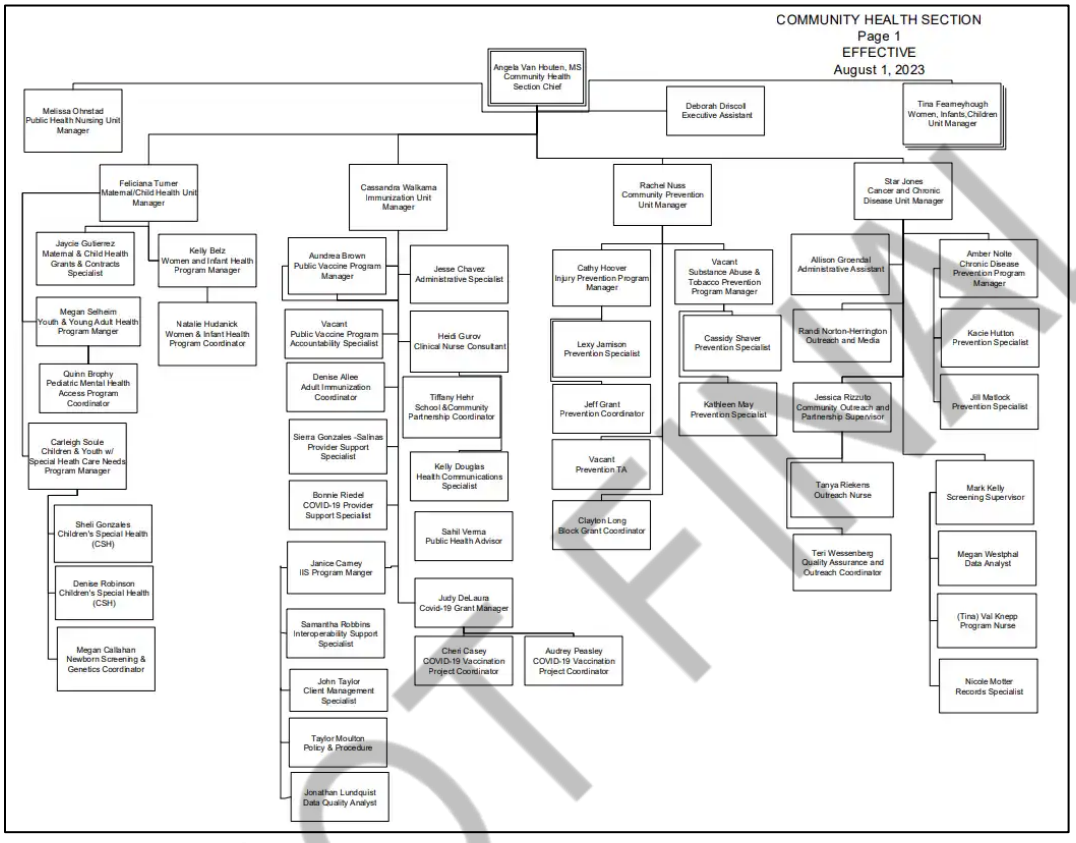
Wyoming Substance Abuse Prevention Program Organization



The Substance Use Tobacco Prevention Program works closely with Injury Prevention Program to provide prevention services throughout the State of Wyoming. The integrated community prevention model includes funding to populations in Wyoming through grant agreements. The model is primarily focused at the County level. Wyoming has 23 Counties and each county has a prevention specialist who liaisons with the State of Wyoming and local partners, to make the best fiduciary use of resources. The funding is a combination of the 20 percent set-aside from the SUPTRS, 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. Grant agreements required County specific work plans to identify and address needs using evidence-based strategies consistent with resource guidelines. Work plans are reviewed by State level designees for accuracy prior to approval.

Planning and implementation utilizes the Strategic Prevention Framework (SPF) public health model in their prevention efforts. This obligates the community coalitions to engage in data-driven strategic planning.

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Each county is required to have an updated strategic plan which identify best-practice environmental strategies and evidence-based programs designed to appropriately meet their communities' needs. The WDH Prevention Team reviews and supports this work with the use of subject matter experts or contractors. This approach allows the prevention efforts to have greater reach across the lifespan of Wyoming residents and reflect local needs.

All funded communities are required to participate in evaluation of prevention efforts at the community level. The state utilizes contractors to work with County and State personnel in performing the evaluations.

The State worked with independent contractor to build a more accessible, dynamic in-house, data collection system. The state will work closely with County Prevention Specialists to collect and analyze data in the new Prevention Reporting and Evaluation System. A key component of the upcoming evaluation contract is to provide County Level mentorship for data collection and reporting to improve consistency and reliability in the data. All recipients have availability to both in-person and web-based training opportunities. The State plans to utilize user-friendly reporting for both state and local prevention stakeholders. The data is also reported annually to the SAMHSA with regards to the National Outcome Measures.

Technical assistance is provided through contractual obligation with an independent contractor who regularly reports to the State and is contractually required to report, communicate, and support, at minimum, the Counties and State. This tailored technical assistance to communities includes strategic planning and implementation support, quality prevention workforce training, on the spot advice, resource recommendation, and one on one assistance where needed. Additionally, the State works with the technical assistance contractor to identify strengths and weaknesses within the prevention infrastructure.

The State 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.

Diverse Racial, Ethnic and Sexual Gender Minorities

Wyoming does not have a highly diverse demographic and cultural population or characteristics. There are very few active specialty programs addressing minorities. The Agency houses the Office of Training, Performance, and Equity to address cultural health disparities. The Division has conversed with all provider agencies and requested review of each 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 socio-economic backgrounds. Funded providers update and review cultural competency plans

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for relevancy on an annual basis and provide diversity training to staff, as required in CARF standards.

Several providers do not have specific goals or efforts in regards to addressing these populations, as quoted, “due to our small population this does not include specialty groups at this time. Groups would become available if we had sufficient demand”. Though services may not be in high demand, providers do have services available upon request or voluntary expression of gender identity, sexual orientation, and/or diverse racial and ethnic backgrounds. Provider’s goals are meeting the client where the individual is and addressing the client’s needs.

Further plans of several providers include “awareness of respect for, and attention to the diversity of the people with whom we serve, our personnel, our families, our community, and all our stakeholders”. Training and education is provided for staff to successfully address the needs of individuals identifying within the diverse, and disparity populations, including being aware of language, pronouns, etc. Providers also attempt to recruit staff representing the LGBTQI+ and other health disparity populations.

As previously stated, CARF standards are utilized. Thus, ensuring continuous quality improvement in this area of Cultural Competency and Diversity Plan. Beyond the CARF standards, treatment contracts require the inclusion of the following contract language:

> **Nondiscrimination.** The Subrecipient shall comply with the Civil Rights Act of 1964, the Wyoming Fair Employment Practices Act (Wyo. Stat. § 27-9-105, et seq.), the Americans with Disabilities Act (ADA), 42 U.S.C. § 12101, et seq., and the Age Discrimination Act of 1975 and any properly promulgated rules and regulations thereto and shall not discriminate against any individual on the grounds of age, sex, color, race, religion, national origin, or disability in connection with the performance under this Contract.

SCS reported one of their clinicians has completed a Transgender Care Certification Training and an Intimate Partner Violence Training. The clinician works to assist clients seeking hormonal treatment, and offers treatment and referrals from other clinicians to assist the LGBTQI+ populations encountering difficulties.

In relation to services for Native Americans in Wyoming, Fremont Counseling Service is a contracted outpatient mental health and substance use treatment provider serving clients in Fremont County. The Sho-Rap Lodge provides recovery housing and employment services funded by the Division on the Wind River Indian Reservation.

In regards to the Substance Abuse Prevention Program; Natrona County is a contracted substance use prevention provider. Natrona County contracts with Casper Pride to provide prevention services for the LGBTQI+ community throughout the region.

Challenges and Limitations

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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.

A $15 million reduction (funds for both MH & SUD) was recommended for the Division's 2023-2024 biennium budget, due to declining revenue. However, during the budget session, the Legislature allocated the $15 million in state general funds as one time funding to allow providers to operate at the same level while undergoing the Behavioral Health Redesign. The funding is temporary and is set to expire June 30, 2024. As such, it is anticipated that MOE will be significantly lower in the coming fiscal years due to the decreased funding as well as with the implementation of Behavioral Health Redesign. As stated above MOE will not include the CST program either, millions of dollars are anticipated to be reduced in the upcoming state general fund budgets.

In addition, the state is experiencing prescriber and clinical staff shortages. The Division 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.

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 systems, 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 behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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TREATMENT: 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) had a needs and gaps assessment conducted through a contract with the National Council of Mental Wellbeing and their partner, MTM Services (referenced henceforth as MTM Services). MTM Services were requested to consult and 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 use treatment services. The consultation provides 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:

- Provide additional technical assistance and consultation to the Agency.
- 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 Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS) 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 the treatment system and the Division 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 the 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.

MTM Services' analysis and reports were completed at the end of 2021. The results overall recommended actions to increase productivity to reduce costs (including decrease costs, rate reviews, focus rates, and conversions to Certified Community Behavioral Health Centers (CCBHC)); review collection percentages and denial rates (confirming by claim denial, co-pay/bad debt collections, software issues, and other); and training (recommending collaborative documentation, standardized documentation / documentation reduction efforts, same day access, Just In Time Prescriber scheduling, centralized scheduling, no show/engagement management, utilization review/utilization management, cost finding, E&M coding reviews, documentation

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compliance risk audits and risk attenuation planning, and integrated care implementation). Each provider received individual reports.

Wyoming's next plans were to use supplemental block grant funding to build and enhance the Community Mental Health and Substance Use Centers (providers) programs and services based off of MTM Services' findings.

Wyoming's Governor Mark Gordon announced the Declaration of a State of Emergency and a Public Health Emergency on March 13, 2020 in regards to the novel coronavirus disease (referenced henceforth as COVID-19). On March 14, 2022, Governor Gordon signed an Executive Order rescinding the COVID-19 Public Health Emergency.

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 generated revenue. During FY22, Wyoming's hospitality and leisure businesses, tourism, and agriculture were impacted due to COVID-19. The Agency and other state agencies reduced State General Fund (SGF) budgets. As a result this reduced available funds for behavioral health services.

A $15 million reduction (funds for both MH & SUD) was recommended for the Division's 2023-2024 biennium budget, due to declining revenue. However, during the budget session, the Legislature allocated the $15 million in state general funds as one time funding to allow providers to operate at the same level while undergoing the Behavioral Health Redesign. The funding is temporary and is set to expire June 30, 2024. As such, it is anticipated that MOE will be significantly lower in the coming fiscal years due to the decreased funding as well as with the implementation of Behavioral Health Redesign. As stated above MOE will not include the CST program either, millions of dollars are anticipated to be reduced in the upcoming state general fund budgets.

The Division compiled information on the impact of COVID-19 on contracted Wyoming providers. Data collected is not a reflection of needs or gaps, but does identify the struggles and challenges of each provider 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 the providers continue to follow CDC protocols to serve 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 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 581,381 population. The state has a population density of 5.9 persons per square mile and is approximately 69% rural as defined by the USDA Economic Research Service, thus qualifying the majority of the state for frontier status. Public and federal funds support 10 providers

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across the state. Four providers also serve in strategic geographic areas as crisis centers providing 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 2013-2017 (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 delivered through providers. 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 individuals but are not comprehensive or consistent throughout the state.

Through an internal system analysis, the Division determined that Comprehensive Crisis Services are 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 were to review the Wyoming crisis system using the National Guidelines for Behavioral 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. Additional efforts are in progress to have manuals for the block grant and recovery services created for use at the Agency and provider level.

Another known gap in the crisis system of care in Wyoming, is the lack of a mobile crisis unit that meets the national guidelines. Due to the frontier nature of the state, it is difficult to sustain 24/7

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mobile crisis units to 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 SUPTRS.

All providers are reviewed on a frequent basis to view compliance with contracts. A list of attachments provide definitions, service time frames, deliverables, and reporting requirements matching both the federal reporting requirements of the MHBG and SUPTRS. 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 support through state contracts, grants, and collaboration with community providers. The mandate of Wyoming's publicly funded mental health and substance use 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 use 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.

The providers submit data reporting requirements in the Behavioral Health Management System (BHMS). The performance indicators in Planning Tables, Table 1 Priority Areas and Annual Performance Indicators objectives and results are determined through the data collection in BHMS and align with the HealthStat report.

Developed in 2011, the Agency performance management system, HealthStat 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 Agency Director's office. HealthStat efforts have bolstered the Agency's reputation as a responsive agency committed to improvement and accountability.

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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 Agency 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 Agency, 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 Agency 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.

The Mental Health Outpatient Treatment program's purpose is to provide access to effective outpatient treatment services to improve the levels of functioning for individuals with mental illness, including SMI, SED, and ESMI/FEP. Outcomes measure the access to care is the primary focus by the average days from time of first contact to first treatment services. The target for providers is seven days or less.

Due to the budget reductions in SFY2022, Mental Health Outpatient Treatment services were reduced by approximately $4.8 million dollars. The number of clients fluctuated between steady and fewer clients, but the number of hours increased and the increase resulted in lower average cost per client and lower average cost per service hour. Partial credit to the reduction of clients is due to staff retention and recruiting, and another partial credit is due to the reduction of funding through multiple funding streams.

On the positive side, telehealth services have increased. Providers found some clients prefer the option for service delivery and the use of telehealth allowed providers to offer services in more rural areas without the need for travel by the clinician or client.

The Substance Use Outpatient Treatment program's purpose is to provide access to outpatient substance use treatment services, decrease alcohol and drug use, and increase levels of personal functioning. The target for SFY 2023 percentage of completing treatment is set at fifty (50%) percent. The review of individualized provider performance determined the lower completion rate. Access to care is also measured through the BHMS with the average number of days from the time of first contact to the first treatment service.

In SFY 2022, there was a twelve (12%) percent reduction in the number of service hours delivered and another eight (8%) percent reduction in the number of clients served. The same echoes in substance use treatment as it does mental health, budget reductions and staffing. Additionally with the changes to exclude methamphetamines treatment from the State Opioid Response (SOR)

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Grant, there is an anticipation of increase in clients to be served for SFY 2023 through the block grant funding and programs.

Other impacts to the Wyoming behavioral health system include:

Emergency Care Coordination and Gatekeeping Services (ECCGS) and Crisis Clinical Response Services (CCRS) were added to the services for both Substance Use Disorder Outpatient Treatment and Mental Health Outpatient Treatment in SFY 2021. Due to the previous service definitions not being discrete enough for individual provider organizations, changes were divided into ECCGS and CCRS. Definitions were developed in collaboration with the provider's executive leadership and clinical directors in an attempt to better capture how local services are delivered. In the same collaboration efforts, it was determined that ECCGS and CCRS services could be delivered to those in Substance Use Disorder Outpatient Treatment as the crisis situations are not limited to those who experience mental illness.

In a recently completed pilot project, selected providers provided a number of beds for sub-acute residential services, with a goal to maintain fifty (50%) percent of those beds for sub-acute services. This was determined as a need for crisis services. Data was collected in the BHMS.

Contracts are in place with Recover Wyoming to provide training and support to individuals seeking and in recovery. Recover Wyoming will secure the coordination of peer specialist training and support services to advance recovery for Wyoming citizens and advance the peer specialist profession. Along with coordinating Wellness Recovery Action Plan (WRAP) training to current certified peer specialists, and will address substance use disorders and mental health through the implementation and further development of a telephone recovery support. Outcomes will be based on the contract and statement of work completion at a satisfactory rate as determined by the Division.

The Global Assessment of Functioning (GAF) in conjunction with Daily Living Activities-20 (DLA-20) was discontinued in SFY 2023. The metric will change to the improved functioning as measured by the DLA-20 functional assessment.

Providers started merging in SFY 2019 where there were 18 providers. Since then, there has been one closure and six mergers, two occurring in the beginning of SFY 2023. In SFY 2024 there is anticipated to be at least one more merge. Currently, there are ten contracted providers for SFY 2024. One previous provider was not funded due to a competitive application by a provider who has contracts in multiple other locations.

Retention and recruiting qualified staff is difficult. Wyoming does not offer large cities or many shopping options (grocery, retail, bulk retail, etc.) and some Wyomingites, frontier and rural, have to travel to larger cities for essentials. The distances between towns are long and can make for dangerous travel. For out-of-state individuals, the way of life is difficult to adjust to. Once winter rolls in and the major interstates are shut down for days, along with the highways, towns and cities, and general inability to drive on clear roads, makes for a difficult selling point to stay. There are

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reasons Wyoming has less than 600,000 individuals living in such a vast open area in a world of heavy population.

Wyoming is not a designated HIV state and has low numbers of individuals with tuberculosis and a substance use disorder. As instructed by the previous State Project Officer for the SUPTRS, funding will not go towards either programs, though the Division will ensure that access to the treatment services for tuberculosis and HIV will be required through contract. Providers will submit their tuberculosis policies and procedures annually through the Request for Application (RFA) process.
During the 2021 General Session of the Wyoming Legislature, House Enrolled Act No. 56 was passed and signed by the Governor. This legislation prioritized certain persons to receive state-funded mental health and substance use disorder treatment services. The legislation directs the Wyoming Department of Health (Agency) to prioritize the contracted Community Mental Health and Substance Use Disorder Treatment Centers (providers) for state-funded services. Redesign efforts started in summer 2021 and the work will continue until the prescribed implementation date of July 1, 2024 and beyond. This initiative and efforts involved are a factor in the state's inability to implement or seek additional major changes to the Wyoming behavioral health system.

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

Wyoming continually collects data to address unmet service needs and critical gaps within the current prevention system in order to reach individuals in need of primary substance abuse prevention. Data sources used to identify primary prevention needs include the National Survey on Drug Use and Health, the Behavioral Risk Factor Surveillance System, the Wyoming Prevention Needs Assessment, American Communities Survey, Adult Criminal Investigation, Fatal Accident Reporting System, Hospital Discharge Database, Pregnancy Risk Assessment Monitoring System, Synar, Uniform Crime Reports, United States Census, Compliance Checks, Web-based Injury Statistics Query and Reporting System, Wyoming Vital Statistics, and Wyoming Department of Transportation Crash Reports.

The Statewide Epidemiological Outcomes Workgroup (SEOW) continues to be one of the most valuable aspects of the prevention system. The SEOW has a wide range of membership including representation from the WDH, the Wyoming Survey Analysis Center, the University of Wyoming, Omni Institute, the Wyoming Pharmacy Board, Department of Corrections, Department of Education, Department of Family Services, Department of Transportation, and Wyoming community members. The SEOW reviews consequences, consumption, and risk/protective factor data and contributes to prevention planning by providing state and community profiles on alcohol, tobacco, other drugs, and mental health for state and community use. The SEOW provides guidance to numerous data collection efforts around the state.

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The SEOW focuses on six areas including alcohol, tobacco, illicit drug use, prescription drug abuse, mental health, and general related factors, with subcommittees focusing on a particular area when necessary. The SEOW guides many efforts to address data gaps.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Access to effective outpatient treatment services to improve levels of function for persons with mental illness.

Priority Type: MHS, ESMI

Population(s): SMI, SED, ESMI

Goal of the priority area:

Access to care: improve average days from time of first contact to first treatment services.

Strategies to attain the goal:

Utilize telehealth services and improve access to care through EBPs, crisis coordination, and local provider collaboration with local partners (i.e. law enforcement, hospitals, etc).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Access to care: average days from time of first contact to first treatment service.

Baseline Measurement: SFY2023: 3 days

First-year target/outcome measurement: SFY2024: 2.9 days

Second-year target/outcome measurement: SFY2025: 2.8 days

Data Source:

Previously known as the Wyoming Client Information System and currently called the Behavioral Health Management System (BHMS).

Description of Data:

Contracted providers are required to report data in the BHMS and how many days it takes from first contact to first treatment services. Providers track treatment completion; percentage of clients with SMI who left treatment against medical advice (AMA) or were "no shows" for appointments and were discharged; and percent of clients with diagnosis of SMI, SED, or ESMI/FEP, with an improvement of functioning of five points or more as measured by the Daily Living Activities-20 functional assessment.

Data issues/caveats that affect outcome measures:

A historical note on data before SFY 2023: The Global Assessment of Function (GAF) has been used in conjunction with the DLA-20 in previous fiscal years. However, the GAF is an outdated tool and has been discontinued for SFY2023. In SFY2022 and older, the improvement of function of five points or more as measured by the Daily Living Activities-20 functional assessment was translated into GAF scores. SFY2023 and forward, the metric will change to the percent of clients with improved functioning as measured by the Daily Living Activities-20 (DLA-20) functional assessment.
2021 HEA 56 requires a redesign of the public behavioral health system to serve specific priority populations through state funding. The framework for the system redesign was completed and agreed upon in SFY 2022. Workgroups will be convened in SFY2023 to begin working on details and implementations of pilot programs.
Recruiting and retaining qualified staff within the mental health facilities is a continued challenge. With the difficulties in retaining staff, particularly in the more frontier areas of the state, and with reduction in state general funds and other funding streams, Community Mental Health Centers previously were not able to meet SFY2022 targets, and the trend is anticipated to continue.

Priority #: 2

Priority Area: Facility-based sub-acute residential services provided as part of a pilot project.

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

Selected contracted providers under this pilot project must maintain fifty percent (50%) of the contracted number of beds for sub-acute residential services.

Strategies to attain the goal:

Payments will be made at $325.00 per day per occupied bed, and must be reported to the RaHS module in BHMS.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Maintain, on average, at least 50% of contracted beds to be used for sub-acute residential services.

Baseline Measurement: SFY23: 17.46

First-year target/outcome measurement: SFY24: 18.5

Second-year target/outcome measurement: SFY25: 18.5

Data Source:

Data through the Behavioral Health Management System (BMHS), as required by contracted providers agreements with the Wyoming Department of Health, Behavioral Health Division.

Description of Data:

Contracted providers must upload the requested data in the RaHS, or the residential and housing services module within the BHMS. The RaHS is used for tracking real-time usage and waiting lists for SUD residential beds, Social Detox, MH community housing, and sub-acute crisis residential services.

Data issues/caveats that affect outcome measures:

This is a pilot project and is anticipated to have some needs and gaps identified through the first three (3) years of the pilot project, which may include multiple or large changes between programs, contracted providers, and bed capacity, availability, and need.

Priority #: 3

Priority Area: Access to effective outpatient substance use treatment services to increase levels of personal functioning.

Priority Type: SUT

Population(s): PWWDC, PWID

Goal of the priority area:

The Substance Use Outpatient Treatment program provides access to effective outpatient substance use treatment services, decreases alcohol and drug use among those individuals engaging in substance use outpatient treatment services, and increase levels of personal functioning.

Strategies to attain the goal:

A monthly report for monitoring compliance deliverables was deployed in SFY 2022. It was designed to give contracted providers a monthly single point of reference for contract compliance and would allow for easy identification of areas that may need attention. The report has been refined and automated to become part of the standard monthly report packets shared with providers beginning in SFY2023.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase outpatient substance use treatment completion rates.

Baseline Measurement: SFY23: 69.03%

First-year target/outcome measurement: SFY24: 71%

Second-year target/outcome measurement: SFY25: 72%

Data Source:

Formally known as the Wyoming Client Information System and currently known as Behavioral Health Management System (BHMS).

Description of Data:

Contracted providers are required through contract to provide information to the BHMS, such as providing information in the ESR or Event Service Record. This is the data set submitted to BHMS that contains the service performance and the unit(s) of time the client spent receiving the service(s).

Data issues/caveats that affect outcome measures:

2021 HEA 56 requires a redesign of the public behavioral health system to serve specific priority populations through state funding. The framework for the system redesign was completed and agreed upon in SFY 2022. Workgroups will be convened in SFY2023 to begin working on details and implementations of pilot programs.
Recruiting and retaining qualified staff within the mental health facilities is a continued challenge. With the difficulties in retaining staff, particularly in the more frontier areas of the state, and with reduction in state general funds and other funding streams, Substance Use Treatment Centers previously had a 12% reduction in the number of service hours delivered and an 8% reduction in the number of clients served, and the trend is anticipated to continue.

Priority #: 4

Priority Area: Tuberculosis treatment, education, and/or generalized information.

Priority Type: SUT

Population(s): TB

Goal of the priority area:

Ensure all contracted providers have a tuberculosis (TB) policy in regards to substance use treatment and residential services. Policies may be unique, and should contain information about method of TB information sharing, education, and if treatment services are within the center or if there is a referral system.

Strategies to attain the goal:

During the Request for Application (RFA) process, the providers will submit current, or an action plans to create with date of available, TB policies. All providers are encourage to collaborate with local Public Health Nurses and Offices in their local areas for education, treatment, and referrals.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Contracted substance use treatment providers have current TB policies.

Baseline Measurement: SFY23: 100%

First-year target/outcome measurement: SFY24: 100%

Second-year target/outcome measurement: SFY25: 100%

Data Source:

RFA submissions.

Description of Data:

Contracted substance use treatment providers submit the TB policies to the Wyoming Department of Health, Behavioral Health Division, where the document is kept in a digital file with the application.

Data issues/caveats that affect outcome measures:

Possible caveats would be (1) new providers or (2) changes to TB requirements, which would require updates and completions before the end of the SFY.

Priority #: 5

Priority Area: Recovery services for substance use disorder individuals

Priority Type: SUR

Population(s): PWWDC, PWID, Other

Goal of the priority area:

Provide access to recovery services to individuals in need.

Strategies to attain the goal:

Recover Wyoming is the single recovery community organization (RCO) in Wyoming. Recover Wyoming is contracted to implement, enhance, and provide telephone recovery support; and provide Wellness Recovery Action Plan (WRAP) facilitator training to certified peer specialist as a tool to assist someone newly in recovery as well as those in long-term recovery.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Develop, enhance, and increase recovery service access.

Baseline Measurement: SFY23: TBD

First-year target/outcome measurement: SFY24: Contract and statement of work is complete at a satisfactory rate.

Second-year target/outcome measurement: SFY25: Contract and statement of work is complete at a satisfactory rate.

Data Source:

Monthly invoice submissions as required through the Recover Wyoming contract(s).

Description of Data:

Data will be provided in a format approved by the Wyoming Department of Health, Behavioral Health Division.

Data issues/caveats that affect outcome measures:

This is contract based, meaning the data is produced by the contractor on a monthly basis and the information provided is not based on client completion rates, but the contract and statement of work completion. If the contract is not fully drawn down, it is possible the end cost was lower than quoted, and does not reflect the completion of enhancements or accessibility to recovery services.

Priority #: 6

Priority Area: Primary Prevention: Adult Alcohol Use

Priority Type: SUP

Population(s): PP, Other

Goal of the priority area:

Reduce adult overconsumption rates in Wyoming

Strategies to attain the goal:

Continue to support community prevention planning and implementation activities, which utilize the Strategic Prevention Framework (SPF) model, under which each community is required to implement evidence-based/best-practice strategies to address tobacco use; underage drinking and adult binge drinking; and prescription, over-the-counter and illicit drug misuse/abuse (when there is a demonstrated need).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Binge Drinking

Baseline Measurement: 15.9

First-year target/outcome measurement: 15

Second-year target/outcome measurement: 14.5

Data Source:

Behavioral Risk Factor Surveillance System.

Description of Data:

(The "Behavioral Risk Factor Surveillance System" BRFSS) is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984." (CDC, 2013b).

Data issues/caveats that affect outcome measures:

BRFSS: Reporting lag may occur due to the timeliness of when the data is published.

Indicator #: 2

Indicator: Heavy Drinking

Baseline Measurement: 6.7% (2021 BRFSS)

First-year target/outcome measurement: 6.5%

Second-year target/outcome measurement: 6.5%

Data Source:

Behavioral Risk Factor Surveillance System.

Description of Data:

(The "Behavioral Risk Factor Surveillance System" BRFSS) is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984." (CDC, 2013b)

Data issues/caveats that affect outcome measures:

BRFSS: Reporting lag may occur due to the timeliness of when the data is published. For example, in reporting for State Fiscal Year 2018, the most current data available to use was 2016, even though the survey is conducted on an annual basis.

Priority #: 7

Priority Area: Primary Prevention: Alcohol Use Among Youth

Priority Type:

Population(s): PP, Other

Goal of the priority area:

To reduce harmful consequences of alcohol misuse in youth.

Strategies to attain the goal:

Continue to support community prevention planning and implementation activities, which utilize the Strategic Prevention Framework (SPF) model, under which each community is required to implement evidence-based/best-practice strategies to address tobacco use; underage drinking and adult binge drinking; and prescription, over-the-counter and illicit drug misuse/abuse (when there is a demonstrated need).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Youth 30-Day Alcohol Use Rates

Baseline Measurement: Middle School: 6.83%; High School: 25.33% (PNA 2022)

First-year target/outcome measurement: Middle School: 6.5%; High School: 25%

Second-year target/outcome measurement: Middle School: 6%; High School: 24.5%

Data Source:

Prevention Needs Assessment (PNA).

Description of Data:

The PNA is a Wyoming Department of Health (WDH) funded student survey of 6th, 8th, 10th, and 12th grade students in participating school districts. The PNA measures students' self-reported substance use and participation in problem behaviors, attitudes, beliefs, and perceptions (risk and protective factors) that influence students' substance use and participation in problem behaviors.

Data issues/caveats that affect outcome measures:

The PNA is administered in even-numbered years, which causes a reporting lag. The Youth Risk Behavior Surveillance System (YRBSS) was previously used to collect data in odd years to supplement data. Wyoming no longer participates in the YRBSS, so we are expecting this will help increase the number of communities participating in the PNA. The March 2020 school closures for COVID-19 mitigation efforts interrupted data collection, resulting in lower response rates and less participation than typical survey years. The 2020 survey results are unweighted, which is why you won't see that data here.

Indicator #: 2

Indicator: Alcohol Compliance Rate - Statewide

Baseline Measurement: 85.6% (2021)

First-year target/outcome measurement: 89%

Second-year target/outcome measurement: 90%

Data Source:

Alcohol Sales Compliance Checks Report.

Description of Data:

The Wyoming Department of Health contracts with the Wyoming Association of Sheriffs and Chiefs of Police (WASCOP) to conduct alcohol retailer education and compliance checks statewide. Data from the inspections is gathered and reported to the Wyoming Liquor Division and developed into an annual report published by WASCOP and the University of Wyoming Statistical Analysis Center.

Data issues/caveats that affect outcome measures:

Not all counties participate in the compliance reports.

Priority #: 8

Priority Area: Primary Prevention: Other Drugs

Priority Type: SUP

Population(s): PP, Other

Goal of the priority area:

Reduce harmful consequences associated with Marijuana, meth, and prescription drugs.

Strategies to attain the goal:

Continue to support community prevention planning and implementation activities, which utilize the Strategic Prevention Framework (SPF) model, under which each community is required to implement evidence-based/best-practice strategies to address tobacco use; underage drinking and adult binge drinking; and prescription, over-the-counter and illicit drug misuse/abuse (when there is a demonstrated need).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Youth 30-day youth marijuana use

Baseline Measurement: 14.1 % among high school (2022 PNA)

First-year target/outcome measurement: 13.5%

Second-year target/outcome measurement: 13%

Data Source:

Prevention Needs Assessment (PNA).

Description of Data:

The PNA is a Wyoming Department of Health (WDH) funded student survey of 6th, 8th, 10th, and 12th grade students in participating school districts. The PNA measures students' self-reported substance use and participation in problem behaviors, attitudes, beliefs, and perceptions (risk and protective factors) that influence students' substance use and participation in problem behaviors.

Data issues/caveats that affect outcome measures:

The PNA is administered in even-numbered years, which causes a reporting lag. The Youth Risk Behavior Surveillance System (YRBSS) was previously used to collect data in odd years to supplement data. Wyoming no longer participates in the YRBSS, so we are expecting this will help increase the number of communities participating in the PNA. The March 2020 school closures for COVID-19 mitigation efforts interrupted data collection, resulting in lower response rates and less participation than typical survey years. The 2020 survey results are unweighted, which is why we have stuck with using 2018 data.

Indicator #: 2

Indicator: Youth 30-day prescription drugs (non-prescribed)

Baseline Measurement: 5.3% (PNA 2022 High School)

First-year target/outcome measurement: 5%

Second-year target/outcome measurement: 5%

Data Source:

Prevention Needs Assessment (PNA).

Description of Data:

The PNA is a Wyoming Department of Health (WDH) funded student survey of 6th, 8th, 10th, and 12th grade students in participating school districts. The PNA measures students' self-reported substance use and participation in problem behaviors, attitudes, beliefs, and perceptions (risk and protective factors) that influence students' substance use and participation in problem behaviors.

Data issues/caveats that affect outcome measures:

The PNA is administered in even-numbered years, which causes a reporting lag. The Youth Risk Behavior Surveillance System (YRBSS) was previously used to collect data in odd years to supplement data. Wyoming no longer participates in the YRBSS, so we are expecting this will help increase the number of communities participating in the PNA. The March 2020 school closures for COVID-19 mitigation efforts interrupted data collection, resulting in lower response rates and less participation than typical survey years. The 2020 survey results are unweighted, which is why we have stuck with using 2018 data.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	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 (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$7,865,245.60		$0.00	$0.00	$24,310,125.38	$0.00	$0.00		$746,367.92	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$321,160.00		$0.00	$0.00	$321,160.00	$0.00	$0.00		$0.00	
b. Recovery Support Services	$1,008,032.80		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
c. All Other	$6,536,052.80		$0.00	$0.00	$23,988,965.38	$0.00	$0.00		$746,367.92	
2. Primary Prevention[d]	$2,110,066.00		$0.00	$0.00	$0.00	$0.00	$0.00		$300,407.10	$0.00
a. Substance Use Primary Prevention	$2,110,066.00								$300,407.10	
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
6. Early Intervention Services for HIV	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$525,016.40		$0.00	$0.00	$2,553,667.72	$0.00	$0.00		$0.24	
12. Total	**$10,500,328.00**	**$0.00**	**$0.00**	**$0.00**	**$26,863,793.10**	**$0.00**	**$0.00**	**$0.00**	**$1,046,775.26**	**$2,782,819.49**

[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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[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" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

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

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Footnotes:
MOE is not anticipated to be met for FY2024 and FY2025 due to budget cuts and the CST program moving from the Agency.
FFY2024 SGF: $13,676,094.19
FFY2025 SGF: $10,312,871.19

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	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 (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]		$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)[e]		$253,882.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
4. Other Psychiatric Inpatient Care			$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital			$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
8. Other 24-Hour Care		$0.00	$0.00	$0.00	$8,117,172.16	$0.00	$0.00	$0.00		$0.00	
9. Ambulatory/Community Non-24 Hour Care		$2,031,048.00	$0.00	$0.00	$27,598,802.28	$0.00	$0.00	$0.00		$0.00	
10. Crisis Services (5 percent set-aside)[f]		$126,941.00	$0.00	$0.00	$1,116,813.32	$0.00	$0.00	$0.00		$1,254,757.58	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$126,941.00	$0.00	$0.00	$2,846,688.28	$0.00	$0.00	$0.00		$0.00	
12. Total	**$0.00**	**$2,538,812.00**	**$0.00**	**$0.00**	**$39,679,476.04**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$1,254,757.58**	**$165,822.00**

[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" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[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" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

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

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

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

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

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Footnotes:

Wyoming did not request a "no cost extension" for the MH COVID-19 Supplemental funds.
Anticipated MOE not to be met FY2024 and FY2025 due to budget cuts.
FY2024 SGF: $23,589,738.02
FY2025 SGF: $16,089,738.02

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	272	48
2. Women with Dependent Children	4,855	897
3. Individuals with a co-occurring M/SUD	6,977	1,221
4. Persons who inject drugs	3,724	983
5. Persons experiencing homelessness	648	294

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

Request to use the most recent edition of SAMHSA's NSDUH provides no assistance in the Table 3; please find the request to provide guidance on how to determine the "Aggregate Number Estimated in Need" or, preferably due to this being SAMHSA data, a request to auto populate the information.

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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$3,428,606.40	$790,271.91	$1,801,888.00
2 . Substance Use Primary Prevention	$1,055,033.00	$300,407.10	$595,383.55
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$22,201.80
5 . Recovery Support Services[5]	$504,016.40	$0.00	$366,387.83
6 . Administration (SSA Level Only)	$262,508.20	$0.24	$125,631.01
7. Total	**$5,250,164.00**	**$1,090,679.25**	**$2,911,492.19**

[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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[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 FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP 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 use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data 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 SUPTRS BG 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 SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG 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 SUPTRS BG 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 will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
2. Education	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
3. Alternatives	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
4. Problem Identification and Referral	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			

5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
6. Environmental	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
7. Section 1926 (Synar)-Tobacco	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$0**	**$0**	**$0**
Total SUPTRS BG Award[3]		**$5,250,164**	**$1,090,679**	**$2,911,492**
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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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

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Footnotes:

Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$550,033	$168,742	$319,358
Universal Indirect	$350,000	$127,003	$213,634
Selected	$110,000	$4,663	$62,392
Indicated	$40,000	$0	$0
Column Total	**$1,050,033**	**$300,408**	**$595,384**
Total SUPTRS BG Award[3]	**$5,250,164**	**$1,090,679**	**$2,911,492**
Planned Primary Prevention Percentage	**20.00 %**	**27.54 %**	**20.45 %**

[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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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

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Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☐	☐	☐
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☑	☑	☑
Fentanyl	☑	☐	☐
Prioritized Populations			
Students in College	☑	☐	☑
Military Families	☐	☐	☐
LGBTQI+	☐	☐	☐
American Indians/Alaska Natives	☐	☐	☐
African American	☐	☐	☐
Hispanic	☐	☐	☐
Persons Experiencing Homelessness	☐	☐	☐
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" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

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

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Planning Tables

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

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$0.00		$0.00	$0.24	$0.00
2. Infrastructure Support	$0.00		$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$257,508.20	$1,000,000.00	$0.00	$0.00	$95,743.01
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$0.00		$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$5,000.00		$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$55,033.00	$0.00	$0.00	$0.00
7. Training and Education	$0.00		$0.00	$0.00	$29,888.00
8. Total	**$262,508.20**	**$1,055,033.00**	**$0.00**	**$0.24**	**$125,631.01**

[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 expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[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" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Footnotes:

Treatment COVID-19: $0.25
Treatment ARP: $125,631.01

Planning Tables

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

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total	**$**	**$**	**$**	**$**

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

Please wait while data loads...

[2] The expenditure period for The American Rescue Plan A **September 1, 2021 - September 30, 2025**, which is different from the 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, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

The Wyoming Department of Health (Agency), Behavioral Health Division (Division) did not request a no cost extension for the COVID-19 MHBG Supplemental funds. The Agency's original submission for MHBG ARP Supplemental funds did not include a request for use of administrative funds. Both categories should be zero ($0.00) dollars.

Note: When this page prints it shows an error. For the purposes of completing the application accurately, please reference the screenshot PDF titled 'Table 6 Non-Direct-Services/System Development [MH]' in the attachments.

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

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

Print | Instructions | Footnotes | Mark Form as: In Progress | Save | Cancel

MHBG Planning Period Start Date: 10/01/2023 MHBG Planning Period End Date: 09/30/2025

Activity	FY 2024 Block Grant	FY 2024[1] COVID Funds	FY 2024[2] ARP Funds	FY 2024[3] BSCA Funds	FY 2025 Block Grant	FY 2025[1] COVID Funds	FY 2025[2] ARP Funds	FY 2025[3] BSCA Funds
1. Information Systems	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
2. Infrastructure Support	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
3. Partnerships, community outreach, and needs assessment	$ 58,470.30	$ 0.00	$ 0.00	$ 58,116.00	$ 58,470.30	$ 0.00	$ 0.00	$ 10,000.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
5. Quality Assurance and Improvement	$ 5,000.00	$ 0.00	$ 0.00	$ 10,000.00	$ 5,000.00	$ 0.00	$ 0.00	$ 5,000.00
6. Research and Evaluation	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
7. Training and Education	$ 0.00	$ 0.00	$ 0.00	$ 18,680.00	$ 0.00	$ 0.00	$ 0.00	$ 64,026.00
8. Total	**$63,470.30**	**$0.00**	**$0.00**	**$86,796.00**	**$63,470.30**	**$0.00**	**$0.00**	**$79,026.00**

[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" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states. Note: if your state has an approved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[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 captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

The Wyoming Department of Health (Agency), Behavioral Health Division (Division) did not request a no cost extension for the COVID-19 MHBG Supplemental funds. The Agency's original submission for MHBG ARP Supplemental funds did not include a request for use of administrative funds. Both categories should be zero ($0.00) dollars.

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

All priority populations listed above are integrated into unique contracts and through unique collaboration efforts across the state.

The Wyoming Department of Health (Agency), Behavioral Health Division (Division) contracts with local Community Mental Health and Substance Use Disorder Centers (providers) throughout Wyoming. The Division encourages the providers to advertise services to their communities; through medical care providers (i.e. primary physicians, dentists, etc); the Departments of Corrections, Education, and Family Services; Judicial branch; and to current clients and their families. The Division has contracted with professional media companies and organizations to produce and distribute information regarding access to care via the Division's website and other means (e.g. 988).

The Division oversees programs and grants for communities to provide outpatient and regional mental health and substance use treatment services and supports; including court-supervised treatment programs, that are accessible, affordable, and provide the least restrictive and most appropriate environment. Through the combined block grants, other federal grants, and state general funds, the Division strives to enhance services and accessibility of those services for clients, and encourage development and improvement opportunities for providers.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

At this time there are no funding streams merging with the Medicaid system, nor parity efforts. Providers are required to be registered with the Medicaid system to bill, and utilize the block grant funds as the last resort. However, the Division is in the beginning phases of its Behavioral Health Redesign, which will be known as 'redesign'.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

All providers are encouraged and expected to provide access and resources linking clients to primary care services. Several providers have nursing staff and primary care services available onsite. Each provider arranges primary care and specialty services based on the individual client’s need(s), are encouraged to become Federally Qualified Health Centers, and make efforts to enhance services and care to become Certified Community Behavioral Health Centers.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

Care coordination is a part of the case management services, which is a standard for the providers. Outreach and education is addressed by providers as a deliverable of their contract with the Agency and is reimbursed through the base payment. Care coordination is person-centered and tailored to each individual based on their needs.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

In reference to both youth and adult services, the state provides assistance as requested and encourages through contract the integration of services and supports for individuals with co-occurring mental health and substance use disorders. State contracted providers are required to work with and be a resource partner to the local schools, hospitals, and law enforcement. The contracted providers serve the whole client using person centered and trauma informed treatment that allows for individualized services, regardless of their age.

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

None requested at this time.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], 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 orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., 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 **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are 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[5]. 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[6]. 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, LGBTQI+ 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. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. 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.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

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

[6] **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?

The Wyoming Department of Health (Agency), Behavioral Health Division (Division) is in the process of including (d) sexual orientation and (e) gender identity within the reporting system. As of June 30, 2023 there is no data able to be reported. Starting July 1, 2023 these criteria will be added to the current data collection efforts.

Please indicate areas of technical assistance needed related to this section

None requested 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. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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 for the efficacy and value of various mental and substance use prevention, SUD 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/NASEM 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 (EBPRC) 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 EBPRC 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 used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build 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[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was 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."[6] SAMHSA and other HHS federal partners, including the 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 innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] 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)**[8] 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. Each 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, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] 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

[3] 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 use disorder and Mental Health Services Administration.

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

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

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

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

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, ACO, 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?

Wyoming is not a Medicaid expansion state. The Wyoming Department of Health, Division of Healthcare Financing is a partner in the Behavioral Health Redesign (redesign), and is not included in reporting for the block grants as the funds are not co-mingling.

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

None requested 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. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Cognitive Behavioral Thereapy	2
Motivational Interviewing	2
Dialectical Behavioral Therapy	2
Eye Movement Desensitization and Reprocessing (EDMR)	2

Complementary and Alternative Medicide (CAMS)	2
Accelerated Resolution Therapy	1

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
126941	126941

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

The process is standard by uploading codes into the Medicaid version of the Event Service Record (ESR). The ESR contains data on service (s) performed and the unit(s) of time the client spent receiving service(s). The block grant funds are used as a last resort.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

The Wyoming Department of Health (Agency), Behavioral Health Division (Division) contracts with two treatment providers who implement the Early Serious Mental Illness (ESMI) and First Episode Psychosis (FEP) programs. Each provides an initial assessment with abilities to identify needs relative to the RAISE initiative. Wyoming, being a rural and frontier state by nature, provides challenges. Full FEP modules are difficult to implement due to geographical challenges and limited community resources. Family involvement and education are critical in the clients' treatment process and assist to develop a resilience to psychotic triggers and symptoms. When families cannot participate, the alternative is natural support. A challenge with the natural supports is the limited communities and social resources, which can hinder adequate treatment (example: local public transportation systems do not exist).

Southwest Counseling Services (SCS) utilizes many evidence-based practices (EBPs) for ESMI/FEP individuals. SCS also utilizes peer specialist supports, employment services/supports, integrated primary health care, medication management services, and family education support.

Volunteers of America - Northern Rockies (VOANR) is new to providing ESMI/FEP services in Wyoming. Currently, VOANR is working on developing, implementing, and enhancing ESMI/FEP services. VOANR has 14 locations throughout the state and is in the process of implementing more accessible services between all locations including job skills training and cross training for staff.

5. Does the state monitor fidelity of the chosen EBP(s)?

○ Yes ◉ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

◉ Yes ○ No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

SCS offers social connection through a community center where SCS provides lunch on Mondays and Wednesdays and sometimes provides other activities such as concerts, bowling/games, crafts, or other community events. SCS is also able to collaborate with local middle schools. VOANR has navigator positions, homeless outreach services, independent case managers, adolescence day centers, and is constructing another building (not using block grant funds) for social detox, SMI residential services, and crisis stabilization. Both providers work through their community engagements and communications, through practice and outreach to increase access to essential services and improve ESMI/FEP client outcomes. Examples include booths at local fairs, within primary care networks, and school inclusion and engagement activities. All the above can improve client outcomes by advertising services and accommodating needs.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

Continued support for the contracted providers.

9. Please list the diagnostic categories identified for your state's ESMI/FEP 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

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

Based on https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5811263/table/T1/, the 2010 US Census information related to the article attached, and general math, the estimated incidence of individuals with a first episode psychosis in Wyoming is 2,715 between the ages of 15 to 29; and 6,022 between the ages of 30 to 59.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

The Agency will continue to provide encouragement and support to providers to promote their programs and services. Each provider program has opportunities to provide outreach through their collaboration efforts within and around their community and local areas.

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

None requested at this time.

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Footnotes:

Duplicative of the #2 to Table 2.

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for 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.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

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 Wyoming Department of Health (Agency), Behavioral Health Division (Division) contracts with Community Mental Health and Substance Use Disorder Centers (providers). Providers are required via contract and are responsible for engaging consumers through consumer satisfaction surveys, boards, along with care coordination (i.e. primary care services). The Division provides technical assistance as requested and as opportunities are available.

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

The Division contracts with nationally accredited providers with the ability to involve clients within planning of care and services. Through national accreditation, providers are required to provide person-centered care treatment services. Wyoming rules and regulations require clients to have an individualized treatment plan (or action plan) based on initial and ongoing assessment information. The treatment plan may include a variety of components including the client's needs as identified, strategies to provide services to meet those needs, measurable treatment goals and objectives, and criteria for discharge. Initial treatment plans are developed with the client, including a care team made of individuals supporting the client's treatment and life goals. The care team will typically include members of the provider's clinical team who will provide integration between assessment and treatment plan(s), including involvement of family and medically necessary liaisons.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

The Division provides resources to providers in regards to resources, training opportunities, and directives. The Division meets with providers for a 'Monthly Provider Meeting' allowing another option to provide and share resources, in addition to allowing further discussion on current topics.

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

None requested at this time.

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG 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 SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary 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 SUPTRS BG. 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:

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?

   No highlights at this time.

   Please indicate areas of technical assistance needed related to this section

   None requested 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 State of Wyoming Legislature has a Select Committee on Tribal Relations. Members are made up of three members from the House and the Senate, totaling six members. 2023 interim topics include (1) collection of state sales tax for online purchases, (2) education, (3) public safety, (4) update from the State Indian Child Welfare Act (ICWA) Task Force, and (5) Review of Tribal Liaison Program.

The Attorney General's (AG's) Office in relation with the Tribes, have created unique Tribal templates for all Agencies to utilize in contracting processes. Examples of other templates provided to all state agencies from the AG's Office are amendment templates, general services for state or federal funds templates, interagency agreements templates, and Memorandum of Understanding (MOU) templates.

The Wyoming Department of Health (Agency) meets quarterly with the Tribal Leadership Advisory Council to discuss health care in Wyoming. Various individuals participate from different divisions including Behavioral Health Division, Public Health Division, Division of Healthcare Financing, Aging Division, and Vital Statistics.

The Behavioral Health Division (Division) has scheduled quarterly meetings set with the Agency Director's Office, Leadership, and Tribes, as mentioned above. The Division has a contract in place with Sho-Rap Lodge in regards to recovery housing and Division staff maintain communication with the representatives.

All members of the Governor's Behavioral Health Advisory Council are given the opportunity to join in the conference via Zoom, this includes the two tribal representatives, one (1) representing the Eastern Shoshone Tribe and the other representing the Northern Arapaho Tribe.

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

Specific concerns were related to COVID-19 and other health related illnesses, inquiries about testing and assessment tools were addressed.

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 requested.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** [ ] Children (under age 12)
- **b)** [x] Youth (ages 12-17)
- **c)** [x] Young adults/college age (ages 18-26)
- **d)** [x] Adults (ages 27-54)
- **e)** [x] Older adults (age 55 and above)
- **f)** [x] Cultural/ethnic minorities
- **g)** [ ] Sexual/gender minorities
- **h)** [ ] Rural communities
- **i)** [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- **a)** ☑ Archival indicators (Please list)

  Archival indicators include but are not limited to hospital discharge data and arrest data.
- **b)** ☑ National survey on Drug Use and Health (NSDUH)
- **c)** ☑ Behavioral Risk Factor Surveillance System (BRFSS)
- **d)** ☐ Youth Risk Behavioral Surveillance System (YRBS)
- **e)** ☑ Monitoring the Future
- **f)** ☑ Communities that Care
- **g)** ☑ State - developed survey instrument
- **h)** ☐ Others (please list)

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

- **a)** If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

  Allocation of resources and primary prevention strategies is based on annual community epidemiological profiles created by the SEOW and community-level comprehensive alcohol, tobacco, and other drug (ATOD) needs assessments. As Wyoming's population density is sparse with very few populous areas, funding all twenty three (23) counties for prevention services is a necessity. Funding levels are determined on a population-based funding model. Results from a coalition and community capacity assessment are also used as part of the decision-making process for resource allocation within individual communities. Communities are required to spend funds on evidence-based programs. The evidence-based workgroup compiles a list of eligible programs and reviews any additional programs that communities might suggest to ensure they meet the standards as set forth by the workgroup.
- **b)** If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? ○ Yes ◉ No

- **a)** If yes, please explain in the box below.

  Yes. CLAS standards are considered during the assessment step.
- **b)** If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? ○ Yes ◉ No

- **a)** If yes, please explain in the box below.

  Yes. All subrecipients were required to put together a sustainability strategic plan in recent years. Subrecipients are also required to use the SPF model in allocating funds.
- **b)** If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

Wyoming requires all funded prevention specialists to be trained in Substance Abuse Prevention Skills Training (SAPST) within six months of employment. Additionally, the substance abuse prevention unit established an International Certification and Reciprocity Consortium (IC&RC) Prevention Specialist credential in Wyoming in the beginning of 2017. This credential helps establish standardized expectations and qualifications for the prevention workforce and other interested individuals who oversee alcohol, tobacco, other drug (ATOD) within the state. We highly encourage all prevention professionals who are or will be funded by the Wyoming Department of Health to be certified. This allows the prevention certification to remain voluntary, but emphasizes the importance that Wyoming places on the need for highly qualified professionals providing the service.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe mechanism used.

WDH provides state and national level support through a full-time Prevention Technical Assistance Coordinator and consultation and resources to address organizational and community level technical assistance. Technical assistance through WDH is targeted and customized by professionals with subject matter expertise for the purpose of developing or strengthening process, knowledge application, or implementation of services. Strategies include development and dissemination of tools and resources to help identify and implement prevention programs and strategies using the best available evidence; identification and promotion of effective strategies in rural settings; provisions of proactive technical assistance to prevention staff to support coordination, implementation, dissemination, and evaluation of prevention efforts; and enhancement of capacity. Wyoming conducts a skills and interest inventory to guide where technical assistance efforts should be focused.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) If yes, please describe mechanism used.

Capacity assessments were conducted in Wyoming, establishing a 2016 baseline of existing capacity for all 23 counties in Wyoming. An assessment was conducted again in 2020. The capacity assessments identified key ingredients including prevention workforce, resources, effective community, community engagement, active leadership, readiness for change, and sustainability. A rubric was then created to describe these key ingredients and rank the capacity of the community

from 1 to 5. Ranking was based on interviews with the Community Prevention Specialists (CPSs), community focus groups, and results from a coalition member survey to determine readiness. Overall, Wyoming communities ranked some to most capacity in most areas.

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

CLAS Standards are integrated into the work that we do.

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

All subrecipients are required to consider sustainability. Subrecipients all have a sustainability plan in place and are required to use the SPF model when allocating resources locally.

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
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6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

WDH has a Substance Use and Tobacco Prevention Plan for 2023-2028.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [ ] Roles and responsibilities
- **d)** [ ] Process indicators
- **e)** [ ] Outcome indicators
- **f)** [ ] Cultural competence component (i.e., National CLAS Standards)
- **g)** [ ] Sustainability component
- **h)** [x] Other (please list):

  The plan focuses on how the program can strengthen the prevention system in Wyoming.
- **i)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ( ) Yes (●) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

Wyoming's substance abuse treatment and prevention rules require the use of evidence-based substance use prevention practices and programs. The Evidence-Based Workgroup is a subcommittee of the SEOW. The group ensures that funded

communities are utilizing Evidence Based Practices (EBPs) in their prevention work. This group includes WDH program managers, epidemiologists, stakeholders, and researchers from our current outside evaluators for prevention efforts administered by WDH. This group meets on an as-needed basis to discuss ongoing progress and challenges in the design and implementation of EBPs in Wyoming communities.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ○ Yes ◉ No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

Wyoming's substance abuse treatment and prevention rules require the use of evidence-based substance use prevention practices and programs. The Evidence-Based Workgroup is a subcommittee of the SEOW. The group ensures that funded communities are utilizing Evidence Based Practices (EBPs) in their prevention work. This group includes WDH program managers, epidemiologists, stakeholders, and researchers from our current outside evaluators for prevention efforts administered by WDH. This group meets on an as-needed basis to discuss ongoing progress and challenges in the design and implementation of EBPs in Wyoming communities.

8. Does your state integrate the National CLAS Standards into the planning step? ◉ Yes ○ No

a) If yes, please explain in the box below.

National CLAS Standards are considered in the planning step.

b) If no, please explain in the box below.

N/A

9. Does your state integrate sustainability into the planning step? ◉ Yes ○ No

a) If yes, please explain in the box below.

The intent of the strategic plan is to strengthen the prevention system which means creating sustainability.

b) If no, please explain in the box below.

N/A

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☐ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

plans and determine evidence-based practices (EBPs) that will have the greatest impact on preventing substance abuse in their community. Expected Information dissemination strategies include:
-Social media campaigns that target underage drinking by targeting youth or parents
-Radio Announcements
-Speaking Engagements
-Partnership with Wyoming High School Activities Association (WHSAA) to target youth and their guardians. WHSAA is the organization that runs and regulates all high school activities in Wyoming. They have direct access to both youth and their guardians through those activities and we are able to share information and promote prevention efforts at high school activities throughout the state in addition to having access to publishing in their newsletter.

b) Education:

Our counties have representation from a Community Prevention Specialist (CPS) who works with local coalitions to

develop strategic plans and determine evidence-based practices (EBPs) that will have the greatest impact on preventing substance abuse in their community. Expected Education strategies include:
-Responsible Beverage Service Training through TIPS (Training for Intervention Procedures)
-Law Enforcement training through ARIDE (Advanced Roadside Impaired Driving Enforcement), a program that provides officers with general knowledge related to drug impairment and by promoting the use of Drug Evaluation and Classification programs in the state
-Educating parents about the health and safety risks of providing alcohol to you through programs such as Parents who Host Lose the Most
-Educating youth on use of texting tip lines, such as Safe2Tell

c) Alternatives:

Our counties have representation from a Community Prevention Specialist (CPS) who works with local coalitions to develop strategic plans and determine evidence-based practices (EBPs) that will have the greatest impact on preventing substance abuse in their community. Expected Alternatives strategies include:
- Substance use free drop-in activities targeted at college students
- Substance use Free activities such as after-prom targeted at high school students

d) Problem Identification and Referral:

Our counties have representation from a Community Prevention Specialist (CPS) who works with local coalitions to develop strategic plans and determine evidence-based practices (EBPs) that will have the greatest impact on preventing substance abuse in their community. Expected Problem Identification and Referral strategies include:
-Promotion of policies and procedures that align with best-practices of employee assistance programs that address common risk and protective factors to provide substance abuse prevention framework in the workplace
-Driving while under the influence/driving while intoxicated education programs

e) Community-Based Processes:

Our counties have representation from a Community Prevention Specialist (CPS) who works with local coalitions to develop strategic plans and determine evidence-based practices (EBPs) that will have the greatest impact on preventing substance abuse in their community. Expected community-based strategies include:
-Community-based strategic planning through local coalitions, CPSs, and stakeholders
-Prevention training of coalition members and CPS through online webinars, conferences, annual meetings, and technical-assistance
-Community team-building through planned activities and technical-assistance, when needed
-Strengthening coalition capacity by increasing multi-agency coordination and collaboration ensuring that stakeholders are involved

f) Environmental:

Our counties have representation from a Community Prevention Specialist (CPS) who works with local coalitions to develop strategic plans and determine evidence-based practices (EBPs) that will have the greatest impact on preventing substance abuse in their community. Expected environmental strategies include:
-Implementing policies and procedures for alcohol restrictions at community events through increased use of ID scanners, breathalyzers, and other evidence-based tools
-Implementing policies such as social host liability
-Implementing drug-free policies for schools that include extracurricular activities
-Providing technical-assistance to coalitions to implement environmental strategies and policies

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) If yes, please describe.

Block grant dollars in Wyoming are used to supplement prevention services primarily funded through other sources. Wyoming provides funding directly to county governments for the implementation of prevention strategies. Counties must provide a workplan that is approved by the Agency. Wyoming ensures that all SABG funded activities compliments and supplements existing substance use prevention services. Oversight of the SABG funding continues with the contract payment process. The SABG funds are utilized within the county community prevention services contract with multiple funding streams for a variety of prevention services. All expenses are coded as to the prevention service, purpose, and appropriate funding stream is applied.

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

Subrecipients are encouraged to integrate National CLAS standards in implementation.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

Sustainability is an important consideration for subrecipients.

b) If no, please explain in the box below

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
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6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [x] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [x] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** [ ] Other (please list:)
- **g)** [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** [x] Numbers served
- **b)** [x] Implementation fidelity
- **c)** [ ] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [x] Attendance
- **f)** [x] Demographic information
- **g)** [x] Other (please describe):

Collection of county demographics for environmental strategies and media campaigns.

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** [x] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [x] Heavy use

- **c)** ☑ Binge use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ○ Yes ○ No

- **a)** If yes, please explain in the box below.

  CLAS Standards are a consideration in evaluation.
- **b)** If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

- **a)** If yes, please describe in the box below.

  Sustainability is a consideration when we consider evaluation.
- **b)** If no, please explain in the box below.

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 or providers)
CMHCs are able to provide community services to support clients functioning outside of inpatient or residential institutions. CMHCs include mental health and co-occurring outpatient treatment services, individual, group and family therapy, case management, wraparound 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. CMHCs assist individuals to get connected 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 committed under an involuntary hospitalization order 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 Wyoming Department of Health (Agency), Behavioral Health Division (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)
Local hospitals and providers 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. §§ 25-10-101 - 129)
The Division coordinates many activities to address the high number of involuntary hospitalizations in the state. The Division maintains the coordinating role 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.)

Providers work with their local Public Health Nursing offices and are able to receive physical health services through those programs.

Quality of Life funding has been impacted by budget cuts, though this is where medical and dental services can be billed to assist clients in receiving services.

Services provided by local school systems under Individuals with Disabilities Education Act (IDEA) have the ability to provide community resources to those in need. The Early Intervention and Education Program (EIEP), located within the Agency, provides screenings, early intervention, special education and related services through 14 child development centers across Wyoming. EIEP administers the Part C and Part B/619 programs of the IDEA. Part C consists of early intervention services for infants and toddlers with disabilities, ages 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 Division funded providers offer case management services, including 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.

Educational services for stakeholders and partnering agencies are activities intended to reduce hospitalizations and hospital stays. The Agency has been assisting in educational training opportunities for law enforcement. The Agency encourages providers to have a working relationship with their local emergency room departments and law enforcement agencies to extend the assistance of the behavioral health workforce to reduce hospitalizations and hospital stays. The Agency also utilizes the 988 Suicide and Crisis Lifeline to assist in the reduction of hospitalizations and hospital stays.

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

None at this time.

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	10057	7303
2.Children with SED	3202	1991

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.

Calculations are determined based on data points gathered in the Behavioral Health Management System (BHMS) previously known as the Wyoming Client Information System (WCIS); data is from SFY2023; FY23 data is not complete until 8/15/2023; and Outpatient and Residential data included.

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

None requested at this time.

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 IDEA	(•) 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 systems	( ) Yes	(•) No

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

None requested at this time.

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

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. **See SAMHSA's Rural Behavioral Health page for program resources**

Wyoming is a rural and frontier state by nature. All services are individually based on availability and accessibility. Each county in Wyoming has a Community Mental Health and Substance Use Treatment Center (provider). The provider may be specific to a single county or multiple, all providers work together to offer services to those in need within their community(ies).

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

The Wyoming Department of Health (Agency), Behavioral Health Division (Division) receives the SAMHSA Projects for Assistance in Transition from Homelessness (PATH) Grant. The PATH subrecipients are encouraged to interact and refer their clients to providers as needed. PATH subrecipients are not allowed to utilize PATH funds for treatment services in regards to providers that receive block grant dollars. There are four PATH subrecipients within the state - one in the most populated counties, one serving native americans, one serving youth and adolescents, and one serving the general MH/SUD population in/around their county. Currently there are no block grant funds going towards the PATH program. Block grant providers are required to have a sliding fee scale, and utilize the MHBG for the populations they serve. Several block grant providers participated in the learning opportunity to support homeless individuals and assist eligible clients in receiving Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits through the SSI/SSDI Outreach, Access, and Recovery (SOAR) program.

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

Currently there are no mental health and substance use services targeted to the older adult population. The older adult population do fall into the response from Criterion 4.a. 'Wyoming is a rural and frontier state by nature. All services are individually based on availability and accessibility. Each county in Wyoming has a provider. The provider may be specific to a single county or multiple, all providers work together to offer services to those in need within their community(ies).' The resources above will be passed to leadership for further discussion; and to providers for their knowledge.

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

None requested at this time.

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.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

The emergency management systems and functions are the responsibility of local communities. Community Mental Health Centers (providers) are contractually obligated to have policies and procedures, including action plans and training documents, in regards to emergency management directly impacting individuals with SMI and SED. Providers will have the opportunity to apply for Bipartisan Safer Communities Act (BSCA) funding to enhance and strengthen community response efforts.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Providers and patients in Wyoming have the ability to use telehealth services, and are encouraged when treatment would be difficult to obtain in-person. Telehealth can be used in a variety of different forms such as telephones, smartphones, tablets, and laptops; and can be synchronous (real-time) or asynchronous (non-urgent communications). Providers are allowed to use telehealth services for screening and assessment, medication management, case management, recovery support, and crisis services. Collaboration efforts with local community resources has allowed use of telehealth services in private settings for clients, such as a private library study room with access to WiFi, allowing the client to receive telehealth services privately. Current PATH providers are encouraged to host a private accessible location for telehealth services for the SMI/SED homeless population with block grant providers and/or other related health service providers.

Telehealth has improved healthcare treatment especially during winter months, as Wyoming's interstates and highways close, sometimes for long periods of time due to large amounts of snow and hazardous traveling conditions. Most cities are two to three hours away from each other. As a rural and frontier state, Wyoming does have internet accessibility issues. Another barrier for telehealth is the client's ability to use the technology, access to technology, or access to private accommodations to complete telehealth services.

Wyoming recognizes these barriers and continues working on enhancing efforts to reduce the needs and gaps of access to service. Three resources of efforts include the Wyoming Department of Transportation (WYDOT), Wyoming State Broadband Program, and the Wyoming Telehealth Network (WyTN). For a short video clip, please view 'Wyoming working to bridge the Digital Divide across the state' (https://www.youtube.com/watch?v=x7tKI1DLRC4).

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

None requested at this time.

Footnotes:

Criterion 3 Footnote: Though there are no 'established defined geographic areas for the provision of services of such system', there are collaboration efforts and attempts between all the listed systems of care to work side-by-side to ensure the client receives the necessary integrated services. Collaboration efforts are also available outside of the above agencies through systems like 211.

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

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/residential)	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:

i)	Prioritized services for veterans?	Yes / No
ii)	Adolescents?	Yes / No
iii)	Older Adults?	Yes / No

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 data and contract deliverables in the Behavioral Health Management System (BHMS) and by the Wyoming Department of Health (Agency), Behavioral Health Division (Division). The Division reviews the contract deliverables and has the capability to pull provider-reported de-identified individual information and determine if the client is receiving PWWDC services according to the requirements of the block grant. With the redesign efforts, PWWDC will be separated from the Medicaid Wyoming Integrated Next Generation System (WINGS) data entry and remain within the BMHS and through separate treatment contracts from the primary treatment contracts. To date, the Division has not had any compliance issues or corrective actions regarding PWWDC.

Note: The Agency does identify a need for (e) Health navigators to assist clients with community linkages and (f) expanded capabilities for family services, relationship restoration, and custody issues.

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, LGBTQI+, 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 Wyoming Department of Health (Agency), Behavioral Health Division's (Division) contract monitoring process. Each contracted Substance Use Disorder Treatment Center (provider) is required to comply with the PWID requirements set forth in the contract and attachments. The Division monitors the contract requirements. The Division has the ability to pull provider-reported de-identified individual information and determine if the client is receiving PWID services according to the requirements of the block grants. The Division has not had any compliance issues or corrective actions regarding PWID, though there is a formal process that can be viewed through the Wyoming Administrative Rules in regards to Mental Health and Substance Use Disorder Services and Complaints.

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 Department of Health (Agency), Public Health Division (Public Health) in each of the 23 counties. If the Behavioral Health Division (Division) identifies a client in need of TB services, the client is referred to the closest provider. Providers are required to have a policy in place for TB services; including where to provide referrals to local Public Health offices for testing and treatment, or provide dual treatment, along with information and educational materials regarding TB. Further, it is a requirement that all providers share TB policies with the Division upon submission of their request for application.

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 such 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 SUPTRS BG 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 SUPTRS BG 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 - Due to challenges within the Wyoming statutes SSPs are currently not legal in Wyoming. There will be no funding going towards the SSP using block grant dollars based on this challenge.

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)** MOUD — (●) 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.

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

Two (2) providers are reviewed, two (2) are reviewers. A total of four (4) providers involved out of ten (10). An overall of approximately twenty (20%) of providers are reviewed annually; approximately ten percent (10%) from each block grant. Process to determine which provider will be next is based off the last few years reviews, major changes, data reviews, etc.

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) ☑ Commission on the Accreditation of Rehabilitation Facilities

ii) ☑ The Joint Commission

iii) ☑ Other (please specify)

The rules allow for other accreditation by other organizations; historically 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/

If the answer is No to any of the above, please explain the reason.

The Wyoming Department of Health (Agency), Behavioral Health Division (Division) contracts with Community Mental Health Centers and Substance Use Treatment Centers (providers), but does not provide a revolving loan to participants. Wyoming has one recovery community organization (RCO) and they provide a small recovery community center allowing individuals a social acceptance atmosphere, which includes a meeting space, lounge area, small kitchen, kid zone, and computer/internet access. Recover Wyoming does not have group homes available, but does also provide Projects for Assistance to Transition from Homelessness (PATH) services.

Waivers - Wyoming is not a designated HIV state.

Footnotes:
Criterion 2 is blank.
Criterion 4,5,&6 - Wyoming is not an HIV designated State.

Wyoming is not a designated state.

HIV Designated States 2019-2022[1]

	2019	2020	2021	2022[2]
DC	✓	✓	✓	✓
Florida	✓	✓	✓	✓
Georgia	✓	✓	✓	✓
Lousiana	✓	✓	✓	✓
Maryland	✓	✓	Δ[3]	Δ
Mississippi	✓		✓	Δ
South Carolina		✓	Δ	Δ

[1] The term "designated state" means any state whose rate of cases of acquired immune deficiency syndrome (AIDS) is 10 or more such cases per 100,000 individuals (as indicated by the number of such cases reported to and confirmed by the Centers for Disease Control and Prevention (CDC) for the most recent calendar year for which the data are available (See 45 CFR 96. 128(b)).

[2] Centers for Disease Control and Prevention. *HIV Surveillance Report, 2019*; vol.32. http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021.
CDC NCHHSTP AtlasPlus Results for SABG HIV "Designated States" as follows, in accordance with SABG §96.128 (AtlasPlus Results published by CDC 5/27/21):

- DC 19.9
- FL 10.9
- GA 12.0
- LA 11.1

Generating States' AIDS Case Rates Per 100,000 Table

In order to generate the table reflecting the most current States' AIDS Case Rate per 100,000 take the following steps:

- Click on this link, **https://gis.cdc.gov/grasp/nchhstpatlas/charts.html** or copy and paste the URL in the browser address line.
- "Charts" will already be selected
- Locate the "Select Data" column on the left-hand side of the web page
- Select "Single" under the "Compare charts" section
- Select "HIV" from the "Disease & SDOH dropdown menu
- Select "AIDS diagnoses" from the "Indicator" dropdown menu
- Select United States" from the "Geography" dropdown menu
- Select "2018" from the "Year" dropdown menu
- Select "Ages 13 years and older" from the "Age Group" dropdown menu
- Select "All races/ethnicities" from the "Race/Ethnicity" dropdown menu
- Select "Both sexes" in the "Sex" section
- Select "All transmission categories" from the "Transmission Category" dropdown menu
- Select "Rate"
- Once the charts are generated, scroll down until you come to the chart titled "AIDS diagnoses | 2018 | Ages 13 years and older | All races/ethnicities | Both sexes | All transmission categories | United States – Rate per 100,000," then either click on the Table icon located in the upper right-hand corner of the chart to generate a table or click on the download icon that will generate an MS Excel CSV file.

[3] Δ indicates a state fell out of designation but has indicated its intention to use SABG funds for EIS.

HIV Designated States 2019-2022[1]

	2019	2020	2021	2022[2]
DC	✓	✓	✓	✓
Florida	✓	✓	✓	✓
Georgia	✓	✓	✓	✓
Lousiana	✓	✓	✓	✓
Maryland	✓	✓	Δ	Δ
Mississippi	✓		✓	Δ
South Carolina	✓	✓	Δ	Δ

Δ: state fell out of designation but has indicated its intention to use SABG funds for EIS/HIV

CDC NCHHSTP AtlasPlus Results for SABG HIV "Designated States"[3] as follows, in accordance with SABG §96.128 (AtlasPlus Results published by CDC 5/27/21):

- DC 19.9
- FL 10.9
- GA 12.0

[1] The term "designated state" means any state whose rate of cases of acquired immune deficiency syndrome (AIDS) is 10 or more such cases per 100,000 individuals (as indicated by the number of such cases reported to and confirmed by the Centers for Disease Control and Prevention (CDC) for the most recent calendar year for which the data are available (See 45 CFR 96. 128(b)).

[2] Centers for Disease Control and Prevention. *HIV Surveillance Report, 2019*; vol.32. **http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published May 2021**

[3] **Generating States' AIDS Case Rates Per 100,000 Table**

In order to generate the table reflecting the most current States' AIDS Case Rate per 100,000 take the following steps:

1. Click on this link, **https://gis.cdc.gov/grasp/nchhstpatlas/charts.html** or copy and paste the URL in the browser address line.
2. "Charts" will already be selected
3. Locate the "Select Data" column on the left-hand side of the web page
4. Select "Single" under the "Compare charts" section
5. Select "HIV" from the "Disease & SDOH dropdown menu
6. Select "AIDS diagnoses" from the "Indicator" dropdown menu
7. Select United States" from the "Geography" dropdown menu
8. Select "2018" from the "Year" dropdown menu
9. Select "Ages 13 years and older" from the "Age Group" dropdown menu
10. Select "All races/ethnicities" from the "Race/Ethnicity" dropdown menu
11. Select "Both sexes" in the "Sex" section
12. Select "All transmission categories" from the "Transmission Category" dropdown menu
13. Select "Rate"

Once the charts are generated, scroll down until you come to the chart titled "AIDS diagnoses | 2018 | Ages 13 years and older | All races/ethnicities | Both sexes | All transmission categories | United States – Rate per 100,000," then either click on the Table icon located in the upper right-hand corner of the chart to generate a table or click on the download icon that will generate an MS Excel CSV file.

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 2022-FFY 2023? ○ Yes ◉ No

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

None requested at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. 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 and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their 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 how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, 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 with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] 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.*

[2] *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 guides 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 provide training on trauma-specific treatment and interventions for M/SUD providers?	○ Yes ◉ No
4.	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
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	◉ Yes ○ No
6.	Does the state use an evidence-based intervention to treat trauma?	◉ Yes ○ No

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 requested at this time.

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Footnotes:

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [ ] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [ ] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

( ) Yes (•) No

N/A

3. 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

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

https://wyoleg.gov/Legislation/2020/HB0031
The Wyoming Department of Health (Agency), Behavioral Health Division (Division) continues efforts and collaboration with the Department of Corrections to improve standards of care for mental health and substance use services available to those within the justice involved population. The local community jail systems and State prisons have access to Community Mental Health Centers and the State Hospital to provide necessary services and evaluations.

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

None requested at this time.

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14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

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 offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

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. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

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

Please respond to the following items:

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

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

3. Does the state purchase any of the following medication with block grant funds?

- **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 treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? ( ) Yes (●) No

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

The Wyoming Department of Health (Agency), Behavioral Health Division (Division) does not utilize block grant funding for the purchases of the above medications, but does use other sources of funding, such as SOR, for MAT.

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15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

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-intervention 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, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

The Wyoming Department of Health (Agency), Behavioral Health Division (Division) contracted with the National Council of Wellbeing (MTM Services) to provide a needs and gap assessment for the Wyoming crisis system. In short, the conclusion was that Wyoming needs to bolster the current programs to achieve success in providing true crisis services in the state. The Agency is under a Behavioral Health Redesign (redesign), these recommendations were included in the efforts of the redesign. Additional and major changes are placed on hold until the redesign implementation has commenced.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis lifeline network

ii. Not in the suicide lifeline network

b. Number of Crisis Call Centers with follow up protocols in place

c. Percent of 911 calls that are coded as BH related

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of first responder structures (police, paramedic, fire)

b. Integrated with first responder structures (police, paramedic, fire)

c. Number that employs peers

3. Safe place to go or to be:

a. Number of Emergency Departments

b. Number of Emergency Departments that operate a specialized behavioral health component

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☑	☐	☐	☐	☐	☐
Safe place to go or to be	☐	☑	☐	☐	☐	☐

b. Briefly explain your stages of implementation selections here.

Program sustainment for "Someone to talk to" is in direct relation to 988 and the crisis call centers providing 24/7 call coverage to the state. There are two call centers in the Wyoming lifeline network. Exploration planning for "Someone to respond" and "Safe place to go or to be". Chat and text implementation are underway, and are in progress of making necessary changes. 911 calls can be coded as behavioral health related, and all public-safety answering points have been trained in utilizing 988. Law enforcement with behavioral health professions partner with several local crisis intervention teams to respond to crisis situations. Currently no communities reported having a mobile crisis response independent of law enforcement. Crisis centers are currently in planning stages, but are not

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

The Division contracted with MTM Services for a gaps and needs assessment on the Wyoming crisis system. The assessment reported that the current crisis system in Wyoming is lacking resources to successfully offer a full crisis continuum of care. The report provided the Division with a recommended continuum for crisis care. Implementation of the recommendations have been included in the efforts to redesign the entire public behavioral health system that was mandated by the Wyoming Legislature in 2021.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

Crisis 5% for the original block grant and the COVID and ARP supplemental funds, the set aside will be utilized for subacute residential payments for appropriate and contracted providers.
BSCA 5% set aside will be utilized for approved activities as reported in the Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH] section.

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

No requests at this time.

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

No requests at this time.

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16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining 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- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

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, 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)	Use 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.

Contracts are in place with Recover Wyoming to provide training and support to individuals seeking and in recovery. Recover Wyoming will secure the coordination of peer specialist training and support services to advance recovery for Wyoming citizens and advance the peer specialist profession. Along with coordinating Wellness Recovery Action Plan (WRAP) training to current certified peer specialists, and will address substance use disorders and mental health through the implementation and further development of a telephone recovery support.

Community Mental Health and Substance Use Disorder Treatment Centers include 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. Providers assist individuals in connection to primary health care, educational resources, and other various community resources.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

Wyoming has one recovery community organization (RCO), Recover Wyoming.

Recover Wyoming is made up of volunteers, staff, a board, and includes individuals in long-term recovery and family members/allies of people affected by addiction. Services include recovery coaching, referrals to existing services, special events, and a safe place to be and to volunteer.
Recover Wyoming provides a small recovery community center allowing individuals a social acceptance atmosphere, which includes a meeting space, lounge area, small kitchen, kid zone, and computer/internet access. Recover Wyoming does not have group homes available, but does provide Projects for Assistance to Transition from Homelessness (PATH) services.

Recover Wyoming's mission is "to advocate for persons in recovery and mobilize resources to aid them, their families, & allies to increase the occurrence and quality of long-term recovery from addiction." Through recovery promotion and education, Recover Wyoming will work with communities and organizations to advocate that all people, seeking treatment and in recovery, are treated with dignity and respect.

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

None at this time.

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

None requested 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:

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

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The Wyoming Department of Health (Agency) is currently under a Behavioral Health Redesign (redesign). During the 2021 General Session of the Wyoming Legislature, House Enrolled Act No. 56 was passed and signed by the Governor. This legislation specifies and prioritizes persons to receive state-funded mental health and substance use disorder treatment services. The legislation directs the Agency to prioritize the contracted Community Mental Health and Substance Use Disorder Treatment Centers (providers) for state-funded services. The purpose of the redesign is to create incentives for treatment in the most appropriate and integrated setting, as the priority populations of the redesign are focused on individuals who have been institutionalized. Redesign efforts started in summer 2021 and the work will continue until the prescribed implementation date of July 1 , 2024 and beyond.

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

None requested at this time.

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18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG 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.[1]. 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.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

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.[4].

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.[5].

According to data from the 2017 Report to Congress[6] 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).

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

[2]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.

[3]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.

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

[5]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**

[6] **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 of children and youth with SED?	○ Yes	◉ No
b) The resilience of children and youth with SED?	○ Yes	◉ No
c) The recovery of children and youth with SUD?	○ Yes	◉ No
d) The 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) Health care?	◉ Yes	○ No
c) Juvenile justice?	◉ Yes	○ No
d) 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
c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?	○ Yes	◉ No
d) Does the state have an established FEP program?	◉ Yes	○ No
Does the state have an established CHRP program?	○ Yes	◉ No
e) Is the state providing trauma informed 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.)

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

The Wyoming Department of Health (Agency), Behavioral Health Division (Division) continues efforts and collaboration with the

Department of Corrections to improve standards of care for mental health and substance use services available to those within the justice involved population. The local community jail systems and State prisons have access to Community Mental Health Centers and the State Hospital to provide necessary services and evaluations.

The Division holds a contract with Volunteers of America Northern Rockies (VOANR) to provide transitional substance use disorder (SUD) residential and case management services to young adults transitioning from the Department of Family Services (DFS) custody into the community. A second contract between the Division and VOANR is to provide SUD residential treatment services and support to individuals referred to the Division by the Wyoming Department of Corrections (DOC) through the Adult Community Corrections or Sanctions program. The Division has adult and child policies for discharge and coordination of care policies related to state-supported facilities or correctional institutions.

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 requested 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 a leading cause of death overall, with over 47,000 people dying by suicide in 2021 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:

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.

The Public Health Division (PHD) is working on the 5-year strategic plan and it will be finalized by end of 2023. PHD utilize the Community Prevention Grant to expend funds to each Wyoming county to implement local suicide prevention programming under the advisory of the Injury and Violence Prevention Program (WIVPP). The WIVPP takes part in the Governor's Challenge to Prevent Suicide in Service Members, Veterans, and their Families, and leads the statewide suicide prevention coalition to coordinate prevention activities across the state. WIVPP promotes best practices, explores current trends, and shares up-to-date data via technical assistance provided to stakeholders. Wyoming is also working on a data collection project to investigate the intersect of mental health and substance use.

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

If yes, please describe how barriers are eliminated.

Through the Governor's Challenge partnership, the Wyoming Department of Health, PHD, Wyoming Injury and Violence Prevention Program will be promoting Caring Contacts to focus on improving care for suicidal patients after being discharged and ensuring barriers to seek further care are diminished.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? ◉ Yes ○ No

If so, please describe the population of focus?

Veterans, Middle-Age Males, Youth

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

None at this time.

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Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG 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 State Medicaid Authority 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's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

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?

N/A

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Wyoming Department of Health (Agency), Behavioral Health Division (Division), collaborates efforts with the following partners:
- Attorney General's Office
- Department of Corrections (DOC)
- Department of Education (WDE)

- Department of Family Services (DFS)
- Department of Health (Agency)

The Division continues efforts and collaboration with the DOC to improve standards of care for mental health and substance use services available to those within the justice involved population. The local community jail systems and State prisons have access to contracted Community Mental Health and Substance Use Disorder Treatment Centers and the State Hospital to provide necessary services and evaluations.

In a most recent contract the Division provided support to the Department of Family Services (DFS) through a contract with Volunteers of America Northern Rockies (VOANR). VOANR did provide transitional substance use disorder (SUD) residential and case management services to young adults transitioning from the Department of Family Services (DFS) custody into the community. At this time, the contract has concluded and no extension has been implemented.

The Division provides necessary assistance with the Wyoming Department of Education (WDE) through the AWARE Grant. The Division also supports and participates in the Attorney General's Office, Violence Against Women Act (VAWA) Committee, and partners on multiple efforts with Safe2Tell.

The Division also hosts the Wyoming Governor's Behavioral Health Advisory Council which includes multiple agencies such as Vocational Rehabilitation, WDE, DOC, and multiple staff members from DFS and the Agency.

The Division and the Division of Healthcare Financing are in partnership to advance behavioral health services for providers and Wyomingites through the Behavioral Health Redesign efforts, which includes future updates to the Olmstead plan. Further, the Division has volunteered to be on a stakeholder group revolving around the planning stages of a Clubhouse Model.

Currently, the Division is working on 988 partnerships and strategies to incorporate stakeholders in continued advertisements and education efforts. 988 was previously housed under the Public Health Division (Public Health). Public Health houses the Public Health Preparedness and Response unit, and the Community Prevention unit, consisting of the Substance Use and Tobacco Prevention Program and the Injury and Violence Prevention Program. The Division and Public Health collaborate on several efforts and each provide necessary support.

Services provided by local school systems under Individuals with Disabilities Education Act (IDEA) have the ability to provide community resources to those in need. The Early Intervention and Education Program (EIEP), located within the Division, provides screenings, early intervention, special education and related services through 14 child development centers across Wyoming. EIEP administers the Part C and Part B/619 programs of the IDEA. Part C consists of early intervention services for infants and toddlers with disabilities, ages 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.

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

None requested at this time.

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21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder 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 SUPTRS BG, 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.**[1]

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.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

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? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The Wyoming Governor's Behavioral Health Advisory Council (BHAC) is involved in the final review of the combined block grant application. The BHAC meets at a time period in August before the submission of the block grant application. The meetings are recorded through Zoom and available on the BHAC Google Site, which can be found through the Wyoming Department of Health (Agency), Behavioral Health Division's (Division) website. Following review and agreement, the Chair will write a letter of support that will be attached in the block grant prior to submission.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

The Division requests participation of one individual from Community Mental Health Centers (providers) and one from the Substance Use Disorder Treatment Centers (providers). Providers have the ability to take the discussion topics from the BHAC to the Wyoming Association of Mental Health and Substance Abuse Centers (WAMHSAC) to discuss between the other treatment facilities.

In regards to individuals in recovery, the Division takes inquiries and encourages individuals to apply to be members. The membership process does not go through the Division. The application for the BHAC goes through the Governor's Boards and Commissions page and the members are then appointed by the Governor. The Division is not involved in the selection of members, but offers support, if requested.

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

4. 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

5. 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 adequacy of behavioral health services;
- To advocate for people with behavioral health needs.

The Council currently meets approximately four times a year; two annually is the minimum flexibility to have meetings every two months in a twelve-month consecutive period. It is the goal of the BHAC to meet six times a year, but due to summer vacations, holidays, winter, and other obligations such as legislation session, the BHAC meets at minimum two times a year as required.

These meetings focus on addressing concerns identified by membership. The BHAC membership reflects populations as critical to the work: LGBTQI+, persons recovering from substance abuse, experiencing mental issues, and family members affected concerns. Members and others are encouraged to share "what is happening in their community or group they represent'' at each meeting. Discussions drive agendas for future meetings.

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

None requested at this time.

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	2	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	2	
Parents of children with SED	1	
Vacancies (individual & family members)	8	
Others (Advocates who are not State employees or providers)	7	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**20**	**62.50%**
State Employees	8	
Providers	2	
Vacancies	2	
Total State Employees & Providers	**12**	**37.50%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	7	
Individuals/Family Members from LGBTQI+ Populations	7	
Persons in recovery from or providing treatment for or advocating for SUD services	1	
Representatives from Federally Recognized Tribes	2	
Youth/adolescent representative (or member from an organization serving young people)	1	
Total Membership (Should count all members of the council)	**32**	

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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:

Public Comment: https://health.wyo.gov/behavioralhealth/mhsa/about-us/grants/
Public Meeting: https://health.wyo.gov/behavioralhealth/mhsa/about-us/bhac/

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://health.wyo.gov/behavioralhealth/mhsa/about-us/grants/

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

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

Request defined expectations of how many years are visible, how many versions should be available, and does a link to Web BGAS with the citizen login count as meeting this expectation?

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Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

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.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.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 not currently legal in Wyoming. There will be no funding towards the SSP using 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

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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%

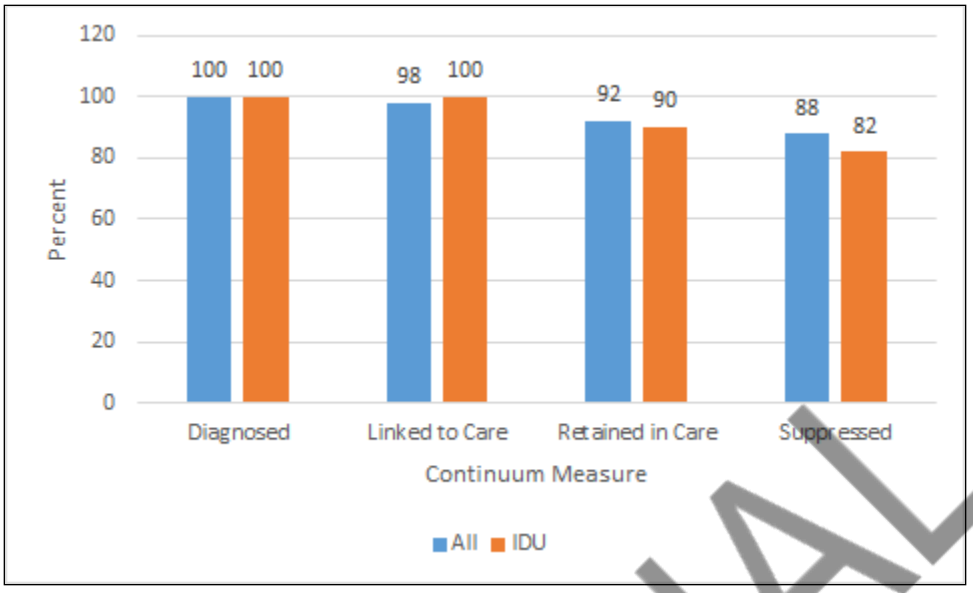
The Wyoming Department of Criminal Investigations compiles statewide crime data through the Uniform Crime Reporting system. Meth and heroin related arrests have increased significantly since 2011.

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 Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes:
Due to challenges in Wyoming statutes, SSPs are not currently legal in Wyoming. There will be no funding towards the SSP using block grant dollars based on this challenge.