Section IIa: Community Mental Health Centers – Mental Health Services

This section includes a statewide review of the mental health services delivered by the Community Mental Health Centers (CMHCs) in Wyoming; the criteria for services; data on the number of clients and services; and a description of the types of services delivered. Discussions of relevant issues, gaps in services, and trends in data are highlighted throughout the document.

Who Receives CMHC Mental Health Services?

One of Wyoming's basic principles for CMHCs is that every citizen in Wyoming should have access to mental health services. In addition, a client may receive services anywhere in the state, regardless of his/her place of residence. To meet this directive, each CMHC provides a range of outpatient mental health services to children and adults, primarily delivered in outpatient clinics within each county and region.

Data has been analyzed to examine the number of clients and the types of services delivered by the CMHCs. Clients have been separated into two major age categories: children (ages 0-17) and adults (18 years and older). While the majority of services are delivered at the center's clinic, some CMHCs have developed a variety of services in the community, including community-based consumer wellness centers for adults and outpatient therapy services delivered in the schools for children. There are a limited number of services developed specifically for transition age youth (ages 16-24) and older adults (60 years and older).

The CMHCs offer a range of mental health services to children who have a Serious Emotional Disturbance (SED) and adults who have a Serious and Persistent Mental Illness (SPMI). SED or SPMI clients frequently require more intensive services. The definitions and criteria for SED and SPMI are provided in Appendix C.

In addition, the CMHCs offer mental health services to children who do not have a Serious Emotional Disturbance (Non-SED); and to adults who do not have a Serious and Persistent Mental Illness (Non-SPMI). These are typically persons who need short-term mental health services.

How Many Clients Received Services in FY 2009?

The Wyoming Mental Health and Substance Abuse Services Division (MHSASD) collects data from all CMHCs regarding the clients served and the types of services delivered. The Wyoming Client Information System (WCIS) was used to produce the data in this report. Data is shown for Fiscal Year (FY) 2009 and shows information on the number of clients who received CMHC outpatient mental health services.

Figure 2 illustrates data from FY 2009, which covers July 1, 2008 through June 30, 2009. Statewide, there were 17,946 unduplicated clients who received CMHC services in FY 2009.

Of the 17,946 clients who received mental health services, there were 6,055 (33.7%) clients who met the criteria for either having a Serious Emotional Disturbance (SED) or Serious and Persistent Mental Illness (SPMI). The proportion across age groups was similar; 39% of children met the criteria for SED and 31.5% of adults met the criteria for SPMI. The remaining 11,891 clients (66.3%) represent those who received mental health services from the CMHCs, but did not meet the criteria for SED or SPMI.

Figure 2 Statewide CMHC <u>Clients</u> Served By Age and SED/SPMI Status FY 2009

	Unduplicated Count of Clients for All Services							
	Clients with SED/SPMI	Percent	Non-SED/SPMI Clients	Percent	Total			
Children	2,114	39.0%	3,306	61.0%	5,420			
Adults	3,941	31.5%	8,585	68.5%	12,526			
Total	6,055	33.7%	11,891	66.3%	17,946			

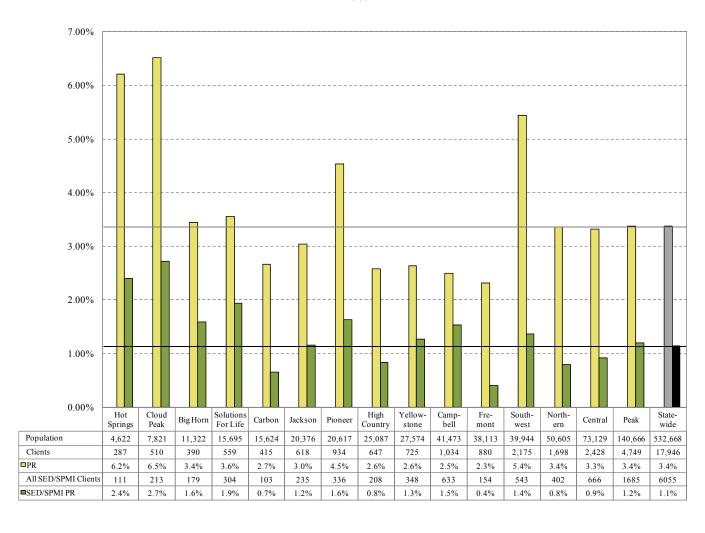
Figure 3 (next page) shows two calculated Penetration Rates for the CMHCs and statewide. This data shows the number of each CMHC's clients who received one or more mental health services in FY 2009 as a proportion of each CMHC's general population. The data is ordered by the size of the CMHC, with the least populated CMHC on the left (Hot Springs) and the most populated CMHC on the right (Peak Wellness). Statewide data is shown on the far right.

The calculation of the total clients into the population provides an overall "Penetration Rate" (PR) for each <u>CMHC</u> and statewide. A client is defined as an individual who received one (1) or more mental health services in the fiscal year. In addition, Figure 3 shows the proportion of SED/SPMI clients out of the general population. This data shows those clients who meet the criteria for SED and SPMI.

The statewide Penetration Rate for *All* clients was 3.4%, showing that 3.4% of the total state population received one or more mental health services in FY 2009. The Penetration Rate for all clients by CMHC varies. Fremont had the lowest Penetration Rate, with 2.3% of the population. Cloud Peak had the highest Penetration Rate, with 6.5%.

The statewide Penetration Rate for *SED/SPMI* clients is 1.1%. This data shows that 1.1 % of the total state population received a service in FY 2009 and met the criteria for either SED or SPMI. The Penetration Rate for SED/SPMI clients by CMHC varies. Fremont had the lowest Penetration Rate for SED/SPMI clients, with 0.4% of the population. Cloud Peak had the highest Penetration Rate for SED/SPMI clients, with 2.7% of the population.

Figure 3
Mental Health Penetration Rates (Unduplicated Clients/General Population)
By CMHC and Statewide
All Clients and Clients with SED or SPMI
FY 2009



How Much Service Did Clients Receive in FY 2009?

Figure 4 shows the <u>statewide</u> average number of hours of all WCIS reported mental health services received by each mental health client. Across all clients, each client received an average of 20.49 hours of service in FY 2009. The higher-need clients with SED or SPMI received an average of 37.92 hours of service per year. Children with SED received an average of 29.42 hours per year, which is approximately 2.5 hours per month. Adults with SPMI averaged 42.48 hours per year, or approximately 3.5 hours per month.

By contrast, non-SED/SPMI clients received an average of 11.62 hours of service per year. Children who did not meet the SED definition averaged 16.18 hours per year, and adults who did not meet the SPMI definition averaged 9.86 hours per year.

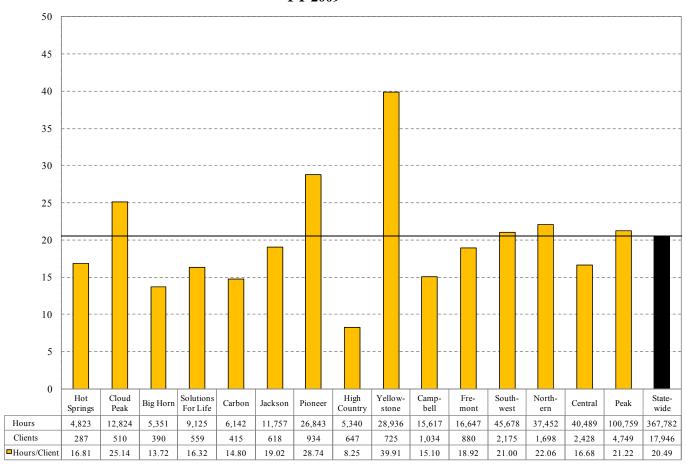
Figure 4
Statewide Average Hours per Client: All Services
By Age and SED/SPMI Status
FY 2009

	All Services - Hours Per Client						
	Hours for Hours Per Hours for Hours Per Clients with Client with SED/SPMI SED/SPMI SED/SPMI SED/SPMI Clients Clients Client Total						
Children	2,114	62,193	29.42	3,306	53,493	16.18	21.34
Adults	3,941	167,407	42.48	8,585	84,689	9.86	20.13
Total	6,055	229,600	37.92	11,891	138,182	11.62	20.49

Figure 5 shows the average number of hours for all mental health services delivered to each client in FY 2009 by <u>CMHC</u> and statewide. The data is ordered by the size of the CMHC, with the least-populated CMHC on the left (Hot Springs) and the most-populated CMHC on the right (Peak Wellness).

Statewide, the average number of hours of service (all services) for each client was 20.49 hours. The average number of hours per client per year varies across the different CMHCs. High Country's clients received the lowest number of hours, with each client averaging 8.25 hours of service per year. Yellowstone's clients had the highest average, with each client averaging 39.91 hours of service per year.

Figure 5
Average Hours per Client per Year (All Hourly Services): All Services
By CMHC and Statewide
FY 2009



Penetration Rate and the average hours per client per year data provide information on how many clients received mental health services, as well as how much service they received. In some CMHCs, there may be a Penetration Rate which is lower than the statewide average, but each client received more hours than the statewide average. Other CMHCs served more clients, but delivered fewer services per person than the statewide average. Access to services and the amount of services are influenced by many factors, including

system values, distance to services, staffing patterns, and the types of services offered for each county/CMHC.

Mental Health Gap: CMHC Average Total Hours per Client. For Total Mental Health Services, the statewide average hours per client (20.49 hours) shows an increase in the average hours per year since FY 2005. However, there is a lot of variability between centers. There are six (6) CMHCs with an average number of hours per client that is above the benchmark: Cloud Peak, Pioneer, Yellowstone, Southwest, Northern, and Peak Wellness. Children with SED averaged 29.42 hours per year, or approximately two and one half (2 ½) hours of service per month. Adults with SPMI received 42.48 hours per year, or approximately three and one half (3 ½) hours per month. Many of these high-need children and adults have many needs and could benefit from additional services to help them meet their treatment goals and achieve positive outcomes.

Mental Health Trends: All Mental Health Services. As shown in Figure 6, there were a total of 16,685 clients who received mental health services in FY 2005. In FY 2009, there were 17,946 clients who received mental health services. This data shows an increase of 7.6%. The total number of hours of mental health services delivered was 280,217 in FY 2005. This number increased to 367,782 hours in FY 2009, which shows a 31.2% increase in mental health service hours. The average hours per client increased from 16.79 hours in FY 2005 to 20.49 hours per client in FY 2009, which shows a 22.0% increase. This increase in access and service utilization clearly shows the positive effects of the expanded funding for mental health services.

Figure 6
Trends in Service Utilization: All Mental Health Services
By Statewide
FY 2009

	FY 2005	FY 2009	Percent Increase
Clients	16,685	17,946	7.6%
Hours	280,217	367,782	31.2%
Hours Per Client	16.79	20.49	22.0%

Overview of All Mental Health Services

CMHCs offer a core continuum of mental health services and specialized mental health services. The core community-based services help the individual function at home or in a supported living situation. These Core Services include a comprehensive clinical assessment to determine the individual's level of functioning and service needs. Outpatient Therapy services include individual and family services. Group Therapy services are delivered to two or more persons. Case Management services help clients access other

services, find a place to live, and/or provide advocacy with other agencies. Day Treatment services are also available in a few centers for persons who need a more intensive level of outpatient mental health services.

All of these Core Services are delivered in the clinic or in the community, depending on the client's needs. Services are coordinated through the development of a service plan, with clients and staff working together to develop a plan of care which identifies goals and outcomes of treatment, as well as the types of services needed to reach these goals. Often, family members are also involved in service planning.

"We have to accept our diagnosis before we can accept the help we need."
- Mental Health Client

Core Services are available in each <u>CMHC</u>. In addition, one or more CMHCs within <u>each region</u> offers a number of Specialized Services, including Rehabilitative services, Recreation and Socialization services, Employment services, Emergency services, and some Housing and Residential services.

Specialized Services are designed to develop skills to help a client learn to live independently. For example, Rehabilitative services are designed to help persons with a serious mental illness live independently (e.g., budgeting, shopping, getting along with neighbors/roommates, and other activities of daily living). Employment services assist in the development of skills to obtain a job (e.g., timeliness, hygiene, getting along with coworkers); and Recreation and Socialization services help an individual develop a social support network. These services also help the individual, the employer, the teacher, and the landlord understand how behavior disorders and psychiatric medications may adversely affect timeliness, social interactions, and the ability to focus on a task. By helping the individual and other persons in their environment understand mental illness, these persons in the client's environment learn to better understand the illness and provide the support to help achieve positive outcomes.

Residential services are also available in each region. These programs provide support services to help clients remain living in the community and develop daily living skills. These services are limited and are usually at capacity. Psychiatric Inpatient services are available across the state, with limited capacity. In addition, the Wyoming State Hospital offers the most intensive, long-term psychiatric services for the most seriously ill.

Core Mental Health Services

What Types of Core Mental Health Services Do Clients Receive?

Through Wyoming Legislative funding, the Wyoming Mental Health and Substance Abuse Services Division leadership and WAMHSAC are working together to transform the mental health system to ensure that there are Core Services in each CMHC and that Specialized Services are available in each of the five regions. All Core Services are required to be available in each <u>CMHC</u>. In addition, <u>each region</u> offers a number of Specialized Services, which will be addressed later in this document.

Core Mental Health Services include:

- Clinical Assessment
- Outpatient Therapy
- Group Therapy
- Case Management
- Day Treatment
- Medication Management
- Outreach and Education (no data available)

With the exception of Day Treatment, these services are currently available in all of the counties/CMHCs. Data is available for the following Core Services: Clinical Assessment, Outpatient Therapy, Group Therapy, Case Management, Day Treatment, and Medication Management. The data presented in this report shows the number of clients receiving these Core Services and the number of service hours received. Data is currently *not* available for Outreach and Education.

Descriptions of Core Service Clients and Service Utilization

A special model for showing Core Services has been developed to illustrate the types of services delivered in Wyoming, the number of clients receiving those services, and the average hours per client. To help the reader understand all components of this complex model, the graph has been divided into three components. Each of the following three figures will describe one component of the model. The third figure in the series displays all of the components.

Figure 7 shows Wyoming statewide data for Core Services (FY 2009). The state population (532,668) is shown on the left. Also shown is the total number of Core Mental Health Services clients (17,460) who received mental health services in the fiscal year. The statewide Penetration Rate across Core Mental Health Services clients was 3.28%.

There were 17,460 clients who received at least one Core Service in FY 2009. Statewide, a total of 284,453 <u>Core Service</u> hours were delivered. Thus, the statewide average number of hours per client across the <u>Core Services</u> was 16.29.

The color bar in Figure 7 shows the breakdown of different Core Services and the number of service hours for each Core Service. In addition, the proportion of hours for each service is provided. For example, there were 15,291 Clinical Assessment service hours delivered in FY 2009. This is 5.38% of the total 284,453 hours of Core Services delivered. Outpatient Therapy hours represent 37.48% of all Core Services, Group Therapy hours represent 17.22%, Case Management hours represent 21.24% of all Core Service hours, Day Treatment hours represent 11.12%; and Medication Management hours represent 7.57% of all Core Service hours.

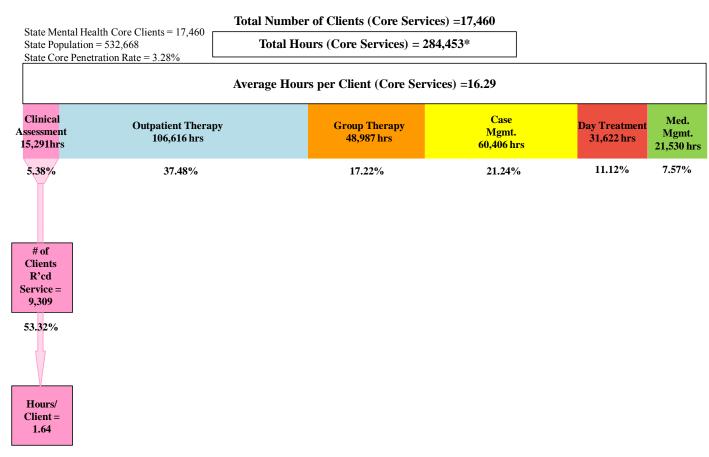
Figure 7 Statewide Mental Health Clients/Hours/Core Services – Color Bar FY 2009

Total Number of Clients (Core Services) =17,460 State Mental Health Core Clients = 17,460 **Total Hours (Core Services) = 284,453*** State Population = 532,668 State Core Penetration Rate = 3.28% Average Hours per Client (Core Services) =16.29 Clinical Case Med. **Outpatient Therapy Group Therapy** Day Treatment Assessment Mgmt. Mgmt. 106,616 hrs 48,987 hrs 31,622 hrs 15.291hrs 60,406 hrs 21,530 hrs 5.38% 11.12% 37.48% 17.22% 21.24% 7.57%

[•]The information in this figure is a subset of all data reported by CMHCs and only includes the Core Services. Specialty services (not shown here) were also delivered in each CMHC. The total number of Mental Health Service hours is 367,782. 77.34% of these hours are Core Service hours (284,453).

Figure 8 shows the same information described in Figure 7. In addition, it provides more information on Clinical Assessment services which were delivered statewide. The Clinical Assessment "column" shows that 53.32% of all clients that received Core Services received a Clinical Assessment in FY 2009. Dividing the total number of Clinical Assessment hours by the number of unique clients who received a Clinical Assessment produces an average number of Clinical Assessment hours per Clinical Assessment client. As shown in Figure 8, each client averaged 1.64 hours of Clinical Assessment services in the year.

Figure 8
Statewide
Mental Health Clients/Hours/Core Services – Color Bar with One Service Type
FY 2009



[•]The information in this figure is a subset of all data reported by CMHCs and only includes the Core Services. Specialty services (not shown here) were also delivered in each CMHC. The total number of Mental Health Service hours is 367,782. 77.34% of these hours are Core Service hours (284,453).

Figure 9 (next page) shows the full graphic display of statewide Core Services, building upon the information shown in Figures 7 and 8. Following Clinical Assessment services, the next column of data shows information on Outpatient Therapy services. There were 106,616 hours of Outpatient Therapy services delivered. These services represent 37.48% of all Core Services. There were 12,362 clients who received Outpatient Therapy. This shows that 70.80% of all clients who received Core Services received Outpatient Therapy. Each client who received an Outpatient Therapy averaged 8.62 hours of service.

The next column of data in Figure 9 shows Group Therapy services. There were 48,987 hours of service delivered. These Group Therapy services represent 17.22% of all Core Services. There were 2,086 clients who received Group Therapy. This represents 11.95% of clients receiving Core Services. Each client who received Group Therapy averaged 23.48 hours of service.

Case Management services are also shown in Figure 9. There were 60,406 hours of Case Management services (21.24% of all Core Service hours). There were 9,028 clients who received Case Management services. This was 51.71% of all Core Services clients. Each client who received Case Management services averaged 6.69 hours of service.

Day Treatment services are also shown in Figure 9. There were 31,622 hours of Day Treatment delivered in FY 2009. This was 11.12% of all Core Service hours. There were 902 clients who received Day Treatment (5.17%). Four (4) CMHCs delivered the majority of these Day Treatment hours: Campbell, Northern, Central, and Peak. Each client who received Day Treatment averaged 35.06 hours of service.

Medication Management services are also shown in Figure 9. There were 21,530 hours of Medication Management delivered in FY 2009. This was 7.57% of all Core Service hours. There were 6,207 clients who received Medication Management (35.55%). Each client who received Medication Management averaged 3.47 hours of service.

In summary, the Core Mental Health Service hours (284,453) represent 77.34% of all mental health services delivered to clients. The total number of mental health service hours, with Core Services and Specialized Services combined, was 367,782 hours. The Specialized Services are discussed later in this report.

Figure 9 Statewide Mental Health Clients/Hours/Core Services FY 2009

Total Number of Clients (Core Services) =17,460

State Mental Health Core Clients = 17,460 State Population = 532,668

Total Hours (Core Services) = 284,453*

State Core Penetration Rate = 3.28% Average Hours per Client (Core Services) =16.29 Clinical Case Med. **Outpatient Therapy Group Therapy** Day Treatment Assessment Mgmt. Mgmt. 106,616 hrs 48,987 hrs 31,622 hrs 15,291hrs 60,406 hrs 21,530 hrs 5.38% 37.48% 17.22% 21.24% 11.12% 7.57% # of # of # of # of # of Clients Clients Clients Clients Clients Clients R'cd R'cd R'cd R'cd R'cd R'cd Service = Service = Service = Service = Service= Service= 9,309 12,362 2,086 9,028 902 6,207 53.32% 70.80% 11.95% 51.71% 5.17% 35.55% Hours/ Hours/ Hours/ Hours/ Hours/ Hours/ Client = Client = Client = Client = Client = Client = 1.64 8.62 23.48 6.69 35.06 3.47

NOTE: Each client may receive <u>more</u> than one (1) type of service in a year. The number of clients shown in the middle box of each column shows the unique number of clients receiving that specific service. One client may be counted in more than one service. Therefore, the sum of clients across services is greater than the total unduplicated count of clients.

[•]The information in this figure is a subset of all data reported by CMHCs and only includes the Core Services. Specialty services (not shown here) were also delivered in each CMHC. The total number of Mental Health Service hours is 367,782. 77.34% of these hours are Core Service hours (284,453).

While all of the Core Services are valuable to persons with SED and SPMI, two (2) of these Core Services are key to helping many of the highest-need clients achieve successful outcomes. These services are Medication Management and Case Management.

Medication Management Services

Medication Management services, delivered by a psychiatrist, Advanced Practitioner of Nursing (A.P.R.N.), and/or a Physician Assistant, are available at all of the CMHCs. In addition to receiving an assessment and a prescription for medication, Medication Management services offer an important service to help the client, and many times, the family, to understand potential medication side effects. These services are also critical in helping the client follow the prescribed medication regimen.

Legislative funding has helped to improve the availability of Medication Management services in Wyoming. This funding was effective in recruiting and hiring psychiatrists and other medication practitioners. As a result, access to psychiatrists has improved in Wyoming. Many centers reported that they have a psychiatrist available, on-site or through Telemedicine, at least once a week. Some centers utilize an Advanced Nurse Practitioner to deliver medication services. Many centers also have part- or full-time nurses to support the psychiatrists and help with Medication Management. Some clients and family members were very pleased with the accessibility of psychiatrists and/or Advanced Nurse Practitioners; however, some clients and family members expressed concern over the lack of psychiatrists in their region.

Medication Management services also includes services delivered through Telemedicine. Smaller centers have expanded access through the use of Telemedicine. These services provide an alternative model for delivering psychiatric services and allow CMHCs to expand the availability of psychiatrists and other personnel. In addition, the state hospital offers psychiatric consultation to CMHCs by utilizing Telemedicine when local psychiatrists are not available. Clients receiving Telemedicine reported satisfaction with their treatment. Continued use and expansion of this technology into all CMHCs could enhance services. It will also be useful in strengthening the service delivery system as health care and mental health care are integrated through Health Care Reform.

While there has been an increase in psychiatric and nursing availability, there is a need for additional resources. The average client receives 3.47 hours of Medication Management services per year. Clients could benefit from additional time from both the psychiatrist and nurse to their improve health outcomes.

As Health Care Reform is developed, there will also be an expanded need to create Health Care Homes. Nurses will need to work closely with clients to help manage psychical health care conditions and provide education on medication, nutrition, and symptom management. Nurses will also need to provide leadership to the patient assistance programs to help clients get funding to pay for medications.

Mental Health Trends: Medication Management Services. As a result of additional funding for psychiatrists and nurses, there has been a dramatic increase in the number of clients who are receiving Medication Management services and the number of hours delivered. As shown in Figure 10, there were 4,053 clients who received Medication Management services in FY 2005 and 6,207 in FY 2009. This data shows an increase of 53.1%. The number of Medication Management hours increased from 11,785 to 21,530 hours, which shows an 82.7% increase in Medication Management service hours. The average hours per client increased from 2.91 hours per client in FY 2005 to 3.47 hours per client in FY 2009, which shows a 19.3% increase.

Figure 10
Trends in Service Utilization: Medication Management
By Statewide
FY 2005 and FY 2009

	FY 2005	FY 2009	Percent Increase
Clients	4,053	6,207	53.1%
Hours	11,785	21,530	82.7%
Hours Per Client	2.91	3.47	19.3%

Medication Management services includes a Medication Evaluation and Medication Management services delivered by a physician, Advanced Nurse Practitioner, Physician Assistant, and/or Registered Nurse. There has been a dramatic increase in the number of persons receiving Medication Management services and the total number of hours delivered as a result of additional funding and expansion of Telemedicine. However, persons interviewed reported an ongoing need for additional Medication Management services, as the average client received 3.47 hours of Medication Management services across the year. The implementation of Health Care Reform will require the system to link clients with primary care services to help expand access and coordinate health-related services.

Case Management Services

Case Management services provide supporting services to clients to help them live independently and achieve positive outcomes. Case Managers are the unsung heroes of the mental health services system for adults with SPMI and families with children with SED. Case Managers work with clients to help them access food, clothing, and shelters (homes). They provide advocacy for the client and help with budgeting, financial issues, housing assistance, and paperwork to receive benefits. They assist clients in applying for funding to pay for medications and providing transportation to get clients appointments with doctors and therapists. Case Managers teach clients how to shop, prepare meals, make nutritious choices, and link them to other services.

Case Managers work closely with therapists and doctors to help keep the clients stable and out of the hospital. When the Case Manager visit the home and sees that the client is not taking his/her medication, or are unable to get to an appointment, the Case Manager can ameliorate the situation before the client decompensates.

Case Managers also are invaluable in coordinating services for families with children with SED. They provide supportive assistance to families, help link them to services, and help advocate for them in court. They teach parenting skills and work with teen parents, as needed. They also support youth to go to school, help link youth to needed services (e.g. dental and medical), and promote positive family communication.

Some centers have hired Case Management staff who are unlicensed but trained to deliver comprehensive care to meet the client's needs. Many of these Case Managers have case loads of 60 - 100 clients. Other centers do not have dedicated Case

underutilized across the state for substance abuse clients.

Management staff, but utilize clinical staff to offer Case Management services.

Many persons interviewed reported that having Case Management services available in each center is the biggest need in the state. They also felt that Case Management is

"I have over 100 clients on my caseload, but I try to call each client at least every two weeks to check in with them. This way they feel that they have one person in their life that cares about them."

- Case Manager

Figure 11 shows the statewide average hours per client for Case Management services, by age and SED/SPMI status. There were 1,580 children with SED in FY 2009. These children received 12,129 hours of Case Management services. This calculates into 7.68 hours per year per child with SED, or approximately 30 minutes per month. Children with SED, and their families, could greatly benefit from additional Case Management services. There were also 1,923 children who were not reported to be SED, and received Case Management services. This may reflect the centers' reluctance to "label" a child as SED. There were 6,966 hours of Case Management services delivered to children who were not SED, for an average of 3.62 hours per year. There is a need to review how children with SED are identified and determine if there is a different method for obtaining this valuable information.

Figure 11 also shows that there were 2,722 adults with SPMI who received Case Management services. These individuals received 32,631 hours per year, or approximately one (1) hour per month of Case Management services. Adults with SPMI could also greatly benefit from additional hours of Case Management services. For adults who are not SPMI, they averaged 3.10 hours of Case Management services per year.

Figure 11
Statewide Average Hours per Client: Case Management
By Age and SED/SPMI Status
FY 2009

	Case Management - Hours Per Client						
	Hours for Hours Per Clients with Client with Non-SED/SPMI Non-SED/SPMI Non-SED/SPMI SED/SPMI SED/SPMI SED/SPMI Clients Clients Client Total						Total
Children	1,580	12,129	7.68	1,923	6,966	3.62	5.45
Adults	2,722	32,631	11.99	2,803	8,680	3.10	7.48
Total	4,302	44,760	10.40	4,726	15,646	3.31	6.69



Mental Health Trends: Case Management Services. As shown in Figure 12, there has been a slight increase in the number of clients receiving Case Management services (6.6%). The total hours of Case Management services has increased 28%, from 47,200 hours in FY 2005 to 60,406 hours in FY 2009.

The average hours per client has increased 20%. This percentage calculates into 6.69 hours of Case Management services per year for each Case Management client.

Figure 12
Trends in Service Utilization: Case Management
By Statewide
FY 2005 and FY 2009

	FY 2005	FY 2009	Percent Increase
Clients	8,468	9,028	6.6%
Hours	47,200	60,406	28.0%
Hours Per Client	5.57	6.69	20.0%

Mental Health Gap: Expanding Case Management Services. Case

Managers support clients to live independently and access services. Some centers have hired Case Managers to support clinicians and deliver Case Management services. Other centers have clinicians deliver Case Management services to their clients. The centers that have a Case Manager on staff report that they are highly effective in helping clients access services and are critical to keeping clients stable at home. These centers also noted that there is a demand for additional Case Managers to meet the needs of their clients. Hiring additional Case Managers can be a cost-effective approach to meeting the needs of children with SED and their families, and adults with SPMI.

Children's Outpatient Mental Health Services

The CMHC children's mental health service delivery system primarily provides services to persons younger than 18 years of age, although some youth ages 18-22 also receive services from the children's program. The children's service delivery system offers both Core Services and Specialized Services. Across <u>all</u> children's Outpatient Mental Health Services (both Core Services and Specialized Services), a total of 5,420 children (ages 0-17) were served in FY 2009. This number represents a Penetration Rate of 4.7% of the total Wyoming children population of 128,457. A total of 115,686 hours of service was delivered to children.

The next set of data shows the array of Core Services delivered to all children (Figure 13), children with SED (Figure 14), and Children without SED (Figure 15). Figure 13 (next page) shows data for all children receiving Core Services (Clinical Assessment, Outpatient Therapy, Group Therapy, Case Management, Day Treatment, and Medication Management). There were a total of 5,375 children who received Core Services in Wyoming in FY 2009. This number represents a Penetration Rate of 4.18% of the state's total child population of 128,457 children. Children received a total of 105,371 Core Service hours

The Core Service hours represent 91.08% of all mental health services delivered to children. The total mental health service hours, Core Services and Specialized Services combined, delivered to children were 115,686 hours. The average Core hours per child were 19.60 hours, or approximately 1 ½ hours of service per month for each child.

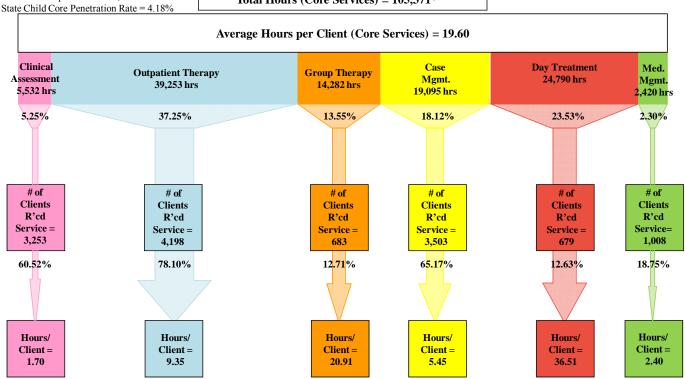
Across all Core Services, there were 39,253 hours of Outpatient Therapy delivered to children (see Figure 13). This was 37.25% of all Core Service hours delivered to children. The majority of children (N=4,198) received Outpatient Therapy (78.10% of all children). The average hours per child for Outpatient Therapy were 9.35 hours per year, or approximately less than one (1) hour per month for each child.

Figure 13 Statewide All Children **Mental Health Clients/Hours/Core Services** FY 2009

Total Number of Children (Core Services) = 5,375

State Mental Health Child Core Clients = 5,375 State Child Population = 128,457

Total Hours (Core Services) = 105,371*



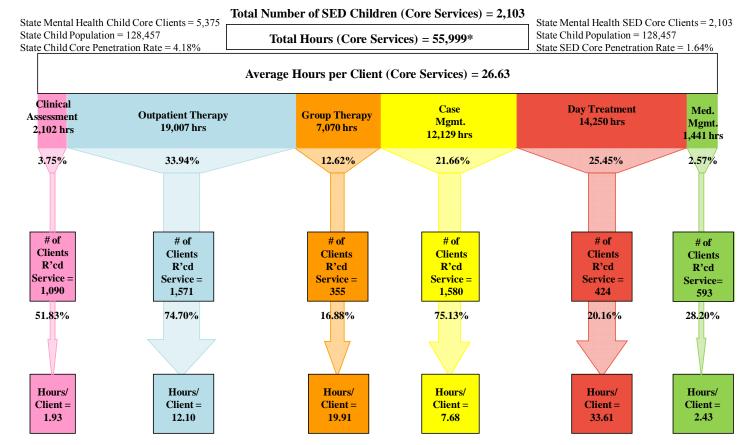
[•]The information in this figure is a subset of all data reported by CMHCs and only includes the Core Services. Specialty services (not shown here) were also delivered in each CMHC. The total number of Child Mental Health Service hours is 115,686. 91.08% of these hours are Child Core Service hours (105,371).

Of the children who received one or more mental health service in FY 2009, there are two (2) groups of children. One group includes children with a Serious Emotional Disturbance (SED) (see Figure 14). The second group includes all other children who received services but did not meet the criteria for SED (see Figure 15). Figure 14 shows data for children with SED who received the Core Services of Clinical Assessment, Outpatient Therapy, Group Therapy, Case Management, Day Treatment, and Medication Management. There were 2,103 children with SED who received Core Mental Health Services in FY 2009. Of all children in the state, this represents a Penetration Rate of 1.64%. These children with SED received a total of 55,999 Core Service hours. The average hours per child with SED were 26.63 hours, or an average of two hours per month for each child.

Children with SED received 2,102 hours of Clinical Assessment, which is 3.75% of all Core Service hours. Figure 14 also shows that Outpatient Therapy was 33.94 % (19,007 hours), Group Therapy was 12.62% (7,070 hours), and Case Management was 21.66% (12,129 hours) of all Core Service hours. Day Treatment comprised 25.45% of the service hours (14,250 hours). Four (4) CMHCs delivered the majority of these Day Treatment hours: Campbell, Northern, Central, and Peak. Medication Management represented 2.57% of the Core hours, with 593 children receiving these services (28.20% of all children with SED). Across the six (6) services, the average hours per child varied: 1.93 Clinical Assessment hours, 12.10 hours of Outpatient Therapy, 19.91 hours of Group Therapy, 7.68 hours of Case Management, 33.61 hours of Day Treatment, and 2.43 hours of Medication Management.

Figure 14 Statewide hildren with Serious Emotional

Children with Serious Emotional Disturbance (SED) Mental Health Clients/Hours/Core Services FY 2009



[•]The information in this figure is a subset of all data reported by CMHCs and only includes the Core Services. Specialty services (not shown here) were also delivered in each CMHC. The total number of Child Mental Health Service hours is 115,686. 91.08% of these hours are Child Core Service hours (105,371).

This array of services shows that children with SED receive a minimal amount of services. For example, the services for children with SED show that 75.13% of the children received Case Management services, which help link children and their families to needed resources. The children who received Case Management received less than one (1) hour per month; this amount of service is inadequate to meet the multiple needs of these highneed children

Mental Health Gap: Children with SED. Children with SED have a need for comprehensive services for themselves and their families. These are the highest-need children and youth in our system. These children and youth received an average of 26.49 hours per year, or approximately two (2) hours of Core Services per month. For these complex children and families, this amount of services may not be sufficient to provide comprehensive services to achieve optimal outcomes.

Mental Health Gap: Hours of Core Service per Child with SED. Children with SED are individuals with multiple needs. Across the state, each child with SED received an average of 26.63 hours of Core Services in the year. This represents an average of two (2) hours per month. This data breaks down to 1 hour per month of Outpatient Therapy; 1.7 hours of Group Therapy; 30 minutes of Case Management; approximately 3 hours of Day Treatment (for a few children); and approximately 15 minutes of Medication Management. These are the highest need children in the system, and they would greatly benefit from intensive treatment services for the child, supportive services for the family, and a collaborative multiagency approach. An average of 26.63 hours per year may not be sufficient to meet all of the needs of these highneed children and their families.

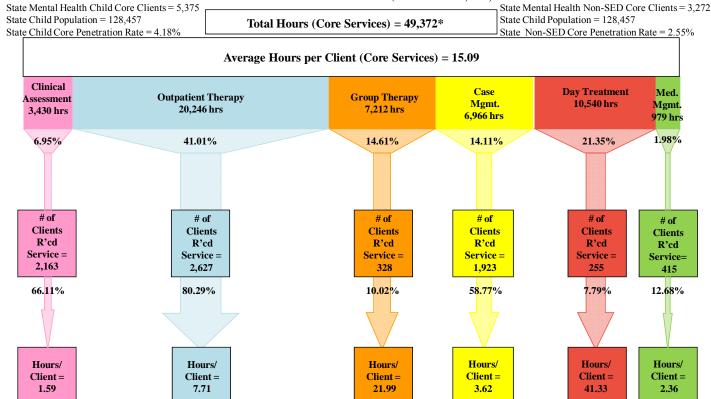
Figure 15 (next page) shows children who received Core Services and did not meet the criteria for SED. There were 3,272 children who did not meet the SED criteria in FY 2009. Of all children in the state, this represents a Penetration Rate of 2.55%. These children received a total of 49,372 Core Service hours. The average number of hours per child per year was 15.09 hours.

These children received 3,430 hours of Clinical Assessment (see Figure 15). This represents 6.95% of all Core Service hours. The remainder of the Core Service array for these children shows: Outpatient Therapy was 41.01% (20,246 hours), Group Therapy was 14.61% (7,212 hours), and Case Management was 14.11% (6,966 hours). Day Treatment comprised 21.35% of the service hours (10,540 hours). There were 255 children who did not meet the SED criteria, but received Day Treatment services. Four (4) CMHCs delivered the majority of these hours: Campbell, Northern, Central, and Peak.

Medication Management represents 1.98% (979 hours) of the Core Service hours. There were 415 children who did not meet the SED criteria, but received Medication Management services. While Medication Management services may be appropriate for children, it is unclear why they did not meet the criteria for SED. Across the six (6) services, the average hours per child varied: 1.59 Clinical Assessment hours, 7.71 hours of Outpatient Therapy, 21.99 hours of Group Therapy, 3.62 hours of Case Management, 41.33 hours of Day Treatment, and 2.36 hours of Medication Management.

Figure 15 Statewide Non-SED Children Mental Health Clients/Hours/Core Services FY 2009

Total Number of Non – SED Children (Core Services) = 3,272



[•]The information in this figure is a subset of all data reported by CMHCs and only includes the Core Services. Specialty services (not shown here) were also delivered in each CMHC. The total number of Child Mental Health Service hours is 115,686. 91.08% of these hours are Child Core Service hours (105,371).

Mental Health Discussion: Services for the Non-SED Child. There were a number of children who did not meet the criteria for SED but received intensive Day Treatment and/or Medication Management services. This information may indicate that there is a need to refine the definition and criteria for a Serious Emotional Disturbance and/or review how Day Treatment services are utilized. Medication Management services may be appropriate for children who are not diagnosed with SED, in some instances.

Figures 16 and 17 show the trends and changes in <u>Core Service</u> access and utilization across all children and children with SED for FY 2005 and FY 2009.



Mental Health Trends: Children Core Services. As shown in Figure 16, there were a total of 5,319 children who received Core Services in FY 2005

There was a small increase in the total number of children served by FY 2009, to 5,375. This data shows a 1.1% increase. However, the total number

"There would be a huge change in how staff serve children if each staff member envisioned each child as having [the staff person's] last name."
- Family Member

of Core Service hours for children's services increased by 13.3%, from 93,007 hours in FY 2005 to 105,371 in FY 2009. Similarly, the average Core Service hours per child increased 12.1%, from 17.49 hours per client in FY 2005 to 19.60 hours per client in FY 2009. This data calculates into approximately 1.6 hours of service per month for each child in FY 2009.

Figure 16
Trends in Core Service Utilization: All Children
By Statewide
FY 2005 and FY 2009

	FY 2005	FY 2009	Percent Increase
Clients	5,319	5,375	1.1%
Hours	93,007	105,371	13.3%
Hours Per Client	17.49	19.60	12.1%

Mental Health Trends: Children with SED Core Services. As shown in Figure 17, there were a total of 1,922 children with SED who received Core Services in FY 2005. In FY 2009, there were 2,103 children with SED served. This data shows an increase of 9.4% for children with SED. Core Service hours for children with SED increased 10.0%, from 50,917 hours to 55,999 hours. However, the average Core Service hours per child with SED remained stable, with 26.49 hours per client in FY 2005 and 26.63 hours per client in FY 2009.

Figure 17
Trends in Core Service Utilization: SED Children
By Statewide
FY 2005 and FY 2009

	FY 2005	FY 2009	Percent Increase
Clients	1,922	2,103	9.4%
Hours	50,917	55,999	10.0%
Hours Per Client	26.49	26.63	0.5%

Mental Health Promising Practice: Hot Springs Mobile Family Partnership Team. Hot Springs CMHC has created a Mobile Family Partnership Team, comprised of staff from mental health, substance abuse, the Department of Family Services, education, law enforcement, and county attorneys. The team goes out to the homes of families involved in Child Protective Services, then delivers services to the family, and comes out with a plan. The family identifies what they need and the agencies outline how they can help. This model has brought the agencies together to build a coordinated plan that meets the needs of the child and family. Mental health clinicians have received extensive training in attachment and trauma, and work to develop services that reduce the negative consequences of being removed from the home. The extensive clinical training and the Mobile Family Partnership Team provide a strong clinical best practice model for other communities.

Early Intervention Services

Early Intervention services were funded through HB 91 and SF 76. Early Intervention services are delivered in all regions and by all CMHCs. These services are focused on interrupting patterns of behavior that could lead to serious problems as the child develops. Each CMHC has developed services to provide Outreach and Early Intervention services to local preschools, Head Start programs, and teen pregnancy centers, as well as other services for young children and their parents. Services may include observation of the child, consultation with the parent and/or teacher, and direct service delivery. Consultation and education are an important component of this service. Many of the families receiving these services are not enrolled in ongoing mental health services, but receive supportive services to address and/or ameliorate the identified problem.

Early Intervention therapists spend time with the children; consult with preschool staff, helping them understand disorders and disabilities, and teaching them behavior management techniques; and meet with parents. During their phone interviews, CMHC staff and family members reported high satisfaction with these services. Some of the centers have assigned additional staff to meet the demand for services, and others noted that this service could be further expanded to meet the needs of the communities. Early Intervention services have been implemented in a variety of ways across the state. Some CMHCs serve adults who have young children with this funding, while other CMHCs provide Early Intervention consultation, education, and treatment to young children and their schools and/or families.

Some centers have been effective at coordinating services with Child Development Centers (CDC) in the region to maximize services and prevent duplication. Other communities have some difficulty in getting referrals and coordinating Early Intervention services with the local CDC.

Unfortunately, client-specific data is not available for Early Intervention services. Many of the services are offered to preschools, teachers, parents, and are not directly delivered to individual children. As a result, the services are not reported to the WCIS data system.

Mental Health Discussion: Early Intervention Services. Early Intervention services have been successfully implemented and have provided an important service in all communities. Every community voiced their request for additional Early Intervention services to meet the needs of young children and their families. Early Intervention services are not clearly defined by the Division, and the services are delivered to different populations in some CMHCs. A clear definition of Early Intervention services and the population to be served would promote a more consistent application of this funding statewide, while still recognizing the need for some flexibility at each center. Early Intervention services are at capacity in each CMHC. Directors and staff reported that these services have been well received and there is a continued increase and demand for services for children who are 0-5 years old and their families.

Mental Health Treatment Services for Young Children

Mental health treatment services for young children (ages 2-6) address behavior problems and develop skills in both the child and the parent. The children served in this age group are likely to show one or more of the following indicators: failure to thrive; history of abuse and/or neglect; behavioral problems including aggression and/or opposition; eating and/or feeding problems; attachment disorders; separation anxiety; and/or withdrawn behavior

In addition, there are several family risk factors which often contribute to young children needing mental health services. These include household income; inadequate, unsafe, or unstable housing; domestic abuse; substance abuse; and parental history of abuse as a child. For this age group, it is important to provide mental health and supportive services to both the child and the parent(s).

Several mental health services are effective at meeting the needs of young children and their parent(s). A few CMHCs have staff trained to deliver Parent Child Interactive Therapy (PCIT). This is an evidence-based practice which is highly effective. PCIT requires intensive staff training across a six- to twelve-month period, as well as a specially equipped room. Through systematic parent coaching, the clinician shapes positive behavior management skills with the parent. Through the use of a one-way mirror and a small hearing device worn by the parent as he/she plays with the child, the clinician coaches the parent to reinforce appropriate behavior and ignore other behaviors. While this program requires significant set-up costs and staff training, it has been found to obtain excellent results.

PCIT is an excellent example of services which help prevent and or treat behavior problems in young children. Expanding these services to other regions could help meet the needs of young children and their families, and potentially prevent future mental health problems.



Mental Health Gap: Continue to Expand Mental Health Services for Young Children. The development of services for young children and their families, as well as utilization of promising practices and/or evidence-based practices, would further enhance the existing children's mental health system.

Additional funding has expanded services to this young population, and a few CMHCs have developed evidence-based practices to serve young children and their parent(s). The continual implementation of evidence-based practices for this age group in all regions would further develop these important treatment services to meet the needs of young children and families.

Children's Mental Health Waiver

In 2006, the Department of Health, Wyoming Mental Health and Substance Abuse Services Division, and Office of Health Care Finance (Medicaid) developed the Children's Mental Health Waiver program. In 2009, the Children's Waiver was renewed for an additional five (5) years by the Centers of Medicare and Medicaid Services (CMS). This program provides individualized services and support to children and youth with a Serious Emotional Disturbance and their families. The goal of the services is to reduce the length of stay and/or prevent psychiatric hospital stays, when possible. The Children's Waiver services are directed through the child's Individual Service Plan (ISP). Waiver services are considered to be non-clinical services which support and enhance mental health services provided by local/regional practitioners, both public and private. They include family care coordination, youth and family training and support, and respite services (to be developed).

The Children's Waiver services are available in each region and county in Wyoming. Of the current 54 providers, there are four (4) CMHCs currently enrolled in Medicaid to provide Children's Waiver services. Some CMHCs reported being involved with activities related to the Children's Waiver, while others reported that they were not yet involved. Many voiced their hope that these services become strong and well staffed, with close coordination with CMHC staff and services. Some of the families that were interviewed were overwhelmed with the number of forms and the need to provide the same information several times. In 2009, the paperwork and forms for the Children's Waiver were streamlined and simplified. In addition, much of the paperwork is being reduced as part of the program's high fidelity wraparound process updates that are occurring in 2010.

The values of the Children's Waiver are consistent with promoting a system of care and wrapping services around children and families. This program is helping to give families a voice and be involved in their children's services. When a child is receiving mental health services from a CMHC, or a private provider, it is important for the services to be integrated and collaborative with Children's Waiver services.

Voice, Choice, and Involvement for Children and Families

A number of different programs have been funded and/or expanded in the past few years to promote voice, choice, and involvement. These programs include UPLIFT, the National Alliance for the Mentally Ill (NAMI), and WYSAAG.

UPLIFT, Federation of Families for Children's Mental Health, is an organization with offices in all five regions of the state. Uplift's vision is to promote hope, health, and well-being for all Wyoming children and families. Their mission is to encourage success and stability for children and youth with or at risk of emotional, behavioral, learning, developmental, or physical disorders at home, school, or in the community.

UPLIFT delivers services in a culturally and linguistically appropriate manner for each individual family and community by providing advocacy, support, referral, education, prevention, and intervention. UPLIFT offers a Family Support Program which works with families of children with an emotional or behavioral disorder. By hiring staff who often are also family members of children with emotional disorders, families feel supported and are able to get the additional guidance they need to address the needs of their child.

UPLIFT promotes family voice and supports families in advocacy and accessing services. UPLIFT also provides training to promote family involvement and voice, and helps families utilize wraparound services. By promoting and integrating family voice into the CMHC service delivery system, family members will be able to "sit at the table" and have a voice in planning, service delivery, and evaluation of mental health services. In addition, through the development of Parent Partner positions in CMHCs and expanded collaboration between CMHCs and the family advocates, families can receive the support and services needed to improve outcomes for their children. This strategy can also help create a welcoming environment at the CMHCs by offering a wide range of services to families. Staff can provide advocacy and mentoring, help parents develop positive parenting skills, and support families as they try to navigate through the mental health service delivery system.

Mental Health Gap: Hiring Consumers and Family Members. Hiring family members to be Parent Partners and work on child teams would strengthen services. These Parent Partners would help promote family voice, as well as help promote the collaboration of services across agencies.

Mental Health Discussion: Voice, Choice, and Involvement for Children and Families. Some CMHCs utilize the family services and resources provided through the Children's Waiver Program and UPLIFT. A few CMHCs have hired family members as Parent Partners/Family Advocates to support families who are receiving mental health services. Statewide training on family voice, choice, and involvement would help include families in all aspects of the service delivery system, from initial assessment to service delivery, and providing mentoring and support to other family members. Developing paid family positions would also promote collaboration across systems, provide advocacy for families, help family members access services through the Children's Waiver and UPLIFT, and engage families in treatment. This strategy will help to maximize child and family outcomes.

Other programs that promote voice, choice, and involvement are discussed in the Adult Outpatient Mental Health Services section below.

Services for Transition Age Youth

Transition Age Youth (TAY) are typically defined as young people with serious emotional disorders and emerging serious mental illnesses during the crucial developmental window between the ages of 16 and 25. Across all persons who participated in phone interviews, it was clear that there are very few CMHCs which have developed a specific program component for TAY. The majority of these youth are underserved, usually due to a lack of coordination across child- and adult-serving agencies or because services are not offered in a manner that meets the needs of these young adults.

There are several critical issues in understanding the scarcity of services for TAY. While there are traditional mental health support services for children and adults, the service systems typically act as two separate systems of care. Neither system is designed to accommodate the unique needs of young people entering adulthood (i.e., those who are struggling to further their education, live independently, find and keep jobs, and develop social relationships). Once a child turns 18, the children's system is "done" with the child. Children are released from foster care when they turn 18. If they do not have a home to return to, and many do not, these young adults often do not seek services. In many instances, these young adults may not access the adult mental health system because services are not relevant for this young adult population.

For TAY with SED, this lack of a continuous service system often leaves them without the support that they need to develop into functioning adults. As a result, they are at high risk for and vulnerable to unemployment, homelessness, substance abuse, unplanned pregnancies, arrests and incarceration, and dropping out of school. In recent years, the system of care has worked to strengthen the safety net for these high-risk youth. For example, in many centers, Probation, Department of Education, Department of Family Services, and the CMHCs have been working collaboratively to improve outcomes for these Transition Age Youth.

Developing an SOC specifically for TAY helps youth thrive. Developing youth voice and providing youth-guided services through a TAY program creates a welcoming environment where they can connect with and mentor other youth; develop and co-lead high interest youth groups and events; provide input for SOC leadership activities; and create a positive, credible image of how to transition into adulthood.

Youth Voice is the perspectives, ideas, experiences, knowledge, and actions of young people. Youth voice doesn't mean talking loudly or shouting to be heard, and it is not about drowning out other people's voices, including adults. Youth voice is about considering the perspectives and ideas of youth people, respecting what everyone has to say, taking risks, listening, sharing, and working together.

Youth Guided means that young people have the right to be empowered, educated, and given a decision-making role in the care of their own lives, as well as the policies and procedures governing care for all youth, the community, state, and nation. This includes giving young people a sustainable voice and the focus should be towards creating a safe environment enabling a young person to gain self-sustainability in accordance to the cultures and beliefs they abide by. Further, through the eyes of a youth-guided approach, we are aware that there is a continuum of power and choice that young people should have based on their understanding and maturity in this strength-based change process. Youth guided also means that this process should be fun and worthwhile. (Youth M.O.V.E. National, 2009).

All supports and services must be responsive and have cultural relevance to meet the youths' unique needs. It is important that TAY staff communicate hope and develop resiliency skills for the youth, while creating an array of informal and formal supports to promote positive outcomes. In addition, expectations and goals need to accommodate the changing developmental needs of youth as they develop confidence in themselves and their skills.

A program for TAY also helps to identify these high-risk individuals across agencies and provides opportunities to develop youth-friendly services. Staff who work with TAY are willing to do "whatever it takes" to help these youth obtain positive outcomes, and help them stay at home, in school, out of trouble, and healthy. TAY require a number of supports in order to succeed. These may include financial and emotional supports, services designed for youth and young adults, positive role models, and timely health care (physical, dental, mental health, substance abuse management).

Mental Health Gap: Develop Transition Age Youth Services. At the present time, there are few services developed specifically for Transition Age Youth in Wyoming. This population is high-need, as evidenced by the growing substance abuse population, escalating youth crime rates, increasing jail populations, and a high suicide rate among youth ages 16-25. Age-appropriate services are needed for youth to develop independent living skills, get jobs, and avoid substances. Also, creating positions within the CMHC organization to hire youth as Peer Mentors would help develop youth-oriented services to improve access and retain youth in services as they develop skills to become functional young adults.

Adult Outpatient Mental Health Services

The CMHC adult mental health service delivery system provides services to persons 18 years of age and older. The service delivery system offers both Core Services and Specialized Services. Across <u>all</u> adult Outpatient Mental Health Services (both Core Services and Specialized Services), a total of 12,526 adults were served in FY 2009. This represents a Penetration Rate of 3.1% of the total Wyoming adult population of 404,211. A total of 252,096 hours of service was delivered to adults.

The next set of data shows the array of Core Services delivered to all adults (Figure 18), adults with SPMI (Figure 19), and adults without SPMI (Figure 20). Figure 18 shows data for all adults receiving Core Services (Clinical Assessment, Outpatient Therapy, Group Therapy, Case Management, Day Treatment, and Medication Management). There were 12,085 adults who received Core Services in FY 2009. Of all adults in the state population, this represents a Penetration Rate of 2.99%. Adults received a total of 179,082 Core Service hours. The average Core Service hours per adult was 14.82 hours. The Core Service hours represent 71.04% of all mental health services delivered to adults.

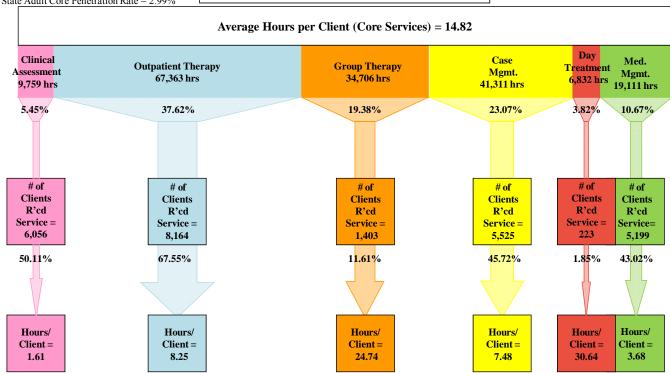
Across all Core Services, the majority of adults received Outpatient Therapy (67.55% of all adults). There were 67,363 hours of Outpatient Therapy delivered to adults, which was 37.62% of all Core Service hours delivered to adults. This data calculates into an average of 8.25 hours per year of Outpatient Therapy. There were 41,311 hours of Case Management services delivered to adults. Nearly half of all adults (45.72%) received Case Management services. This data calculates into an average of 7.48 hours of Case Management per year. Forty-three percent (43.02%) of adults (5,199) received Medication Management services, with an average of 3.68 hours per year per person.

Figure 18 Statewide All Adults Mental Health Clients/Hours/Core Services FY 2009

Total Number of Adults (Core Services) = 12,085

State Mental Health Adult Core Clients = 12,085
State Adult Population = 404,211
State Adult Core Penetration Rate = 2.99%

Total Hours (Core Services) = 179,082*



[•]The information in this figure is a subset of all data reported by CMHCs and only includes the Core Services. Specialty services (not shown here) were also delivered in each CMHC. The total number of Adult Mental Health Service hours is 252,096. 71.04% of these hours are Adult Core Service hours (179,082).

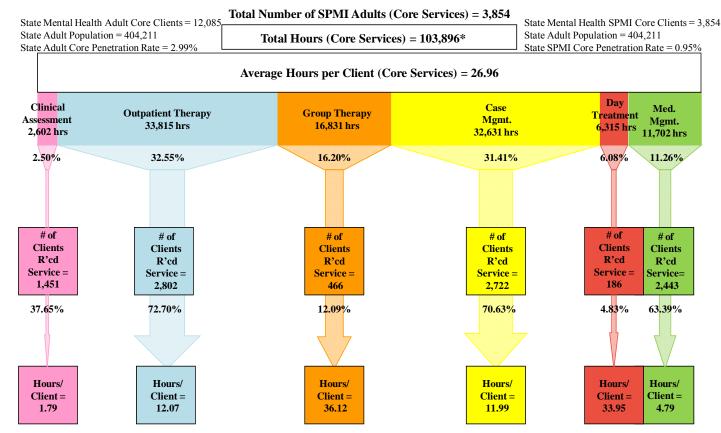
Of the adults who received one or more mental health services in FY 2009, there are two groups of adults. One group includes adults with Serious and Persistent Mental Illness (SPMI). The second group includes all other adults (non-SPMI) who received mental health services, but did not meet the criteria for SPMI.

Figure 19 (next page) shows data for adults with SPMI who received the Core Services of Clinical Assessment, Outpatient Therapy, Group Therapy, Case Management, Day Treatment, and Medication Management. There were 3,854 adults with SPMI who received Core Services in FY 2009. Of all adults in the state, this represents a Penetration Rate of 0.95%. These adults with SPMI received a total of 103,896 Core Service hours. The average hours per adult with SPMI were 26.96 hours, representing an average of two (2) hours per month per client.

Adults with SPMI received 2,602 hours of Clinical Assessment, representing 2.50% of all Core Service hours. The remainder of the Core Service hours for adults with SPMI shows that Outpatient Therapy was 32.55% (33,815 hours), Group Therapy was 16.20% (16,831

hours), and Case Management was 31.41% (32,631 hours). Day Treatment comprised 6.08% of the service hours (6,315 hours). Two (2) CMHCs delivered the majority of these hours: Campbell and Peak. Medication Management represents 11.26% of the Core Service hours, with 2,443 adults receiving these services (63.39% of all adults with SPMI). Across the six (6) services, the average hours per adult varied: 1.79 hours for Clinical Assessment, 12.07 hours for Outpatient Therapy, 36.12 hours for Group Therapy, 11.99 hours for Case Management, 33.95 hours for Day Treatment, and 4.79 hours for Medication Management.

Figure 19
Statewide
Adults with Serious and Persistent Mental Illness (SPMI)
Mental Health Clients/Hours/Core Services
FY 2009



[•]The information in this figure is a subset of all data reported by CMHCs and only includes the Core Services. Specialty services (not shown here) were also delivered in each CMHC. The total number of Adult Mental Health Service hours is 252,096. 71.04% of these hours are Adult Core Service hours (179,082).

Adults with SPMI primarily received Outpatient Therapy (72.70% of the clients), Case Management (70.63%), and Medication Management (63.39%). The average service utilization for these services shows that adults with SPMI received an average of one (1) hour of Outpatient Therapy per month, one (1) hour of Case Management per month, and 30 minutes of Medication Management.

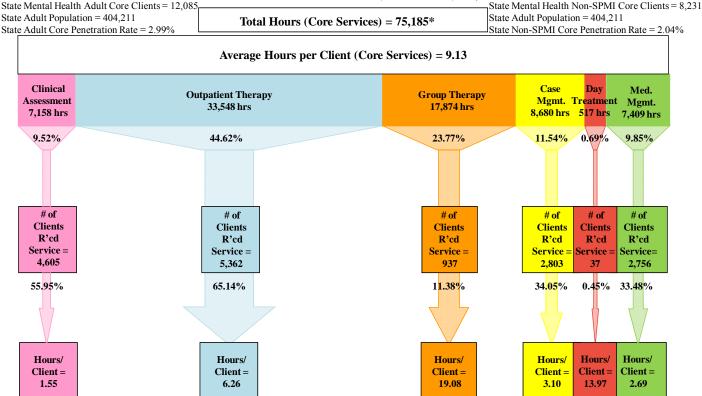
Mental Health Gap: Hours of Core Service per Adult with SPMI. Adults with SPMI are individuals with multiple needs. Across the state, each adult with SPMI received an average of 26.96 hours of Core Services in the year. These are the highest need adults in the system, and they would greatly benefit from intensive and collaborative multiagency services. An average of 26.96 hours per year, or 2 hours per month, is not sufficient to meet all of the needs of these high-need adults.

Figure 20 (next page) shows adults who received Core Services, but did not meet the criteria for SPMI. There were 8,231 adults who did not meet the SPMI criteria in FY 2009. Of all adults in the state, this number represents a Penetration Rate of 2.04%. These adults received a total of 75,185 Core Service hours. The average number of hours per adult with SPMI was 9.13 hours.

Adults who did not meet the SPMI criteria received 7,158 hours of Clinical Assessment. This represents 9.52% of all Core Service hours. The remainder of the Core Service hours for adults who did not meet the SPMI criteria shows that Outpatient Therapy was 44.62% (33,548 hours), Group Therapy was 23.77% (17,874 hours), and Case Management was 11.54% (8,680 hours). Day Treatment comprised 0.69% of the service hours (517 hours). There were 37 adults who did not meet the SPMI criteria who received Day Treatment services. Two (2) CMHCs delivered the majority of these hours: Campbell and Peak. Medication Management represented 9.85% of the Core Service hours (7,409 hours). There were 2,756 adults who did not meet the SPMI criteria who received Medication Management services. Across the six services, the average hours per adult varied: 1.55 hours for Clinical Assessment, 6.26 hours for Outpatient Therapy, 19.08 hours for Group Therapy, 3.10 hours for Case Management, 13.97 hours for Day Treatment, and 2.69 hours for Medication Management.

Figure 20 Statewide Non - SPMI Adults Mental Health Clients/Hours/Core Services FY 2009

Total Number of Non - SPMI Adults (Core Services) = 8,231



[•]The information in this figure is a subset of all data reported by CMHCs and only includes the Core Services. Specialty services (not shown here) were also delivered in each CMHC. The total number of Adult Mental Health Service hours is 252,096. 71.04% of these hours are Adult Core Service hours (179,082).

Mental Health Discussion: Mental Health Services for Adults. There are 3,854 adults with SPMI and 8,231 adults who do not meet the SPMI criteria who received mental health services. Some persons with mental health needs may be effectively treated by a primary care physician. As Wyoming beings to implement Health Care Reform, it will be important for CMHCs and local physicians to integrate and coordinate treatment services. Short-term mental health conditions may be treated by primary care physicians who have access to psychopharmological consultation opportunities. This approach would help focus the efforts of mental health clinicians to coordinate and integrate services for adults with SPMI to help them live in the community, reduce inpatient hospitalizations, recover, and achieve optimal outcomes.

Figures 21 and 22 below show the trends and changes in Core Service access and utilization for adults and adults with SPMI in FY 2005 and FY 2009.



Mental Health Trends: Adult Core Services. As shown in Figure 21, there were a total of 11,366 adults who received Core Services in FY 2005. There was an increase in the total number of adults served by FY 2009, to 12,085.

This data shows a 6.3% increase. The total number of hours for adult's Core Services increased by 16.2%, from 154,106 hours in FY 2005 to 179,082 in FY 2009. Similarly, the average hours per adult increased 9.3%, from 13.56 hours per client in FY 2005 to 14.82 hours per client in FY 2009. This number calculates into approximately 1.2 hours of service per month for each adult in FY 2009.

Figure 21 **Trends in Core Service Utilization: All Adults** By Statewide FY 2005 and FY 2009

	FY 2005	FY 2009	Percent Increase
Clients	11,366	12,085	6.3%
Hours	154,106	179,082	16.2%
Hours Per Client	13.56	14.82	9.3%



Mental Health Trends: Adults with SPMI Core Services. As shown in Figure 22, there were a total of 3,790 adults with SPMI who received Core Services in FY 2005. In FY 2009, there were 3,854 adults with SPMI served. This data shows an increase of 1.7% for adults with SPMI. Core Service hours for adults with SPMI increased 15.1%, from 90,250 hours in FY 2005 to 103,896 hours in FY 2009. The average hours per adult with SPMI increased 13.2%, with 23.81 hours per client in FY 2005 and 26.96 hours per client in FY 2009.

Figure 22 Trends in Core Service Utilization: SPMI Adults **By Statewide** FY 2005 and FY 2009

	FY 2005	FY 2009	Percent Increase
Clients	3,790	3,854	1.7%
Hours	90,250	103,896	15.1%
Hours Per Client	23.81	26.96	13.2%

Mental Health Discussion: Services for Veterans. Veterans returning to their home community may experience mental health problems that need supportive mental health services. These may include Posttraumatic Stress Disorder (PTSD); depressive disorders; and military sexual trauma (MST), which the Department of Veterans Affairs uses to refer to sexual assault or repeated, threatening sexual harassment that occurred while the Veteran was in the military. The MHSASD has identified veterans has a high priority population. These returning veterans could greatly benefit from additional mental health services.

Voice, Choice, and Involvement for Adults

A number of different programs have been funded and/or expanded in the past few years to promote voice, choice, and involvement. These programs include UPLIFT, the National Alliance for the Mentally Ill (NAMI), and WYSAAG. In addition, many of the centers have hired Peer Specialists to promote consumer and family voice.

The goal of mental health services is to work together to create healthy futures for our clients and communities. Research has shown that people with a mental illness have the ability to recover. Recovery may mean that the person does not experience physical or emotional symptoms as much as they used to, or it may mean that the symptoms go away completely. Recovery may also mean that relationships with others improve. Clients can live on their own, have a job, and be active participants in their services. "Recovery is

"Client
involvement and
client advocacy is
very important
since we know
better than the
therapists how our
treatment is
working."
- Client

described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness."

According to the National Consensus Statement on Mental Health Recovery, "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."

Recovery is a journey that involves developing hope, self-direction, empowerment, respect and peer support. Promoting recovery on a system-wide level can have a lasting impression. However, it requires a change in how the organization views mental illness and recovery. Leaders must have a vision of recovery and wellness, rather than problems, disabilities, and illness. Recovery is possible when services and staff have the goal of promoting hope, healing, empowerment, and connection. This includes hiring consumers and family members alongside clinical staff, and the service team. Volunteer work is one of the most powerful methods for helping a client recover. Several of the CMHCs have developed drop-in centers, outreach centers, and employed consumers to deliver services, and have experienced excellent results from these programs. Other CMHCs can use these effective programs as models for developing similar programs in their communities.

Mental Health Promising Practice: Consumer and Family Leadership and Involvement. The National Alliance for the Mentally Ill (NAMI) Chapter in Casper has expanded services and provides support and linkage to consumer and family members across the state. The statewide consumer organization, WYSAAG, provides leadership and support to mental health and substance abuse consumers across the state. The MHSASD supports this group by funding a consumer advocate position. Janet Jares has been instrumental in helping this organization gain momentum. Their annual conference was held in August 2010, and had over 300 people in attendance. This clearly illustrates that consumer voice and participation is being strengthened and promoted across the state.

Older Adult Services

An analysis of the census illustrates that the older adult population is growing rapidly throughout the nation. Seventy-six million baby boomers will reach the age of 65 between 2010 and 2030. By 2030, it is projected that older adults will account for 20% of the total population – up from 13% in 2000. Population data for Wyoming shows that there are a high proportion of older adults in the state.

Few older adults access services from the mental health system. Over half of the older persons who do receive mental health care receive it from their primary care physician. Of concern with older adults, especially in rural areas, is the under-diagnosis and undertreatment of mental illness, especially depression. Nationally, older Americans account for only 7% of all inpatient mental health services; 6% of community-based mental health services; and 9% of private psychiatric care, despite the fact that older adults comprise 13% of the population. Reasons cited for this underutilization include: stigma; denial of problems; barriers to access; funding issues; lack of collaboration and coordination between mental health and older adult systems; and shortages of persons trained to address the needs of this age group. Health coverage for mental health services is also an issue for this population. Medicare coverage is not comprehensive. It requires substantial cost sharing for many covered services and only covers 50% of the cost of mental health services. However, this issue may be resolved as Health Care Reform is implemented in the next few years.

Studies also show that mental disorders in older adults are under-reported. The rate of suicide is highest among older adults compared to any other age group. The suicide rate for persons 85 years and older is the highest of all: twice the overall national rate. Often these suicides are not reported as such, but are listed as accidental deaths. Many are committed by isolated, lonely, older people. In some cases, there are no friends or family members who are involved with the individual; in other cases, friends and family may be too afraid to inquire because of the stigma attached to this kind of death. Also, suicides are often mistaken for natural deaths, especially in cases of medicinal overdosing, as many older people take several medications each day.

² Institute on Aging: Elderly Suicides. http://www.ioaging.org/programs/cesp/sfacts.html.

¹ Discussion found at http://www.aagpgpa.org/prof/facts mh.asp

Several issues may contribute to an older adult needing mental health services:

- 1. <u>Isolation</u>: Many older adults have limited mobility and become isolated and home bound.
- 2. <u>Independent Living</u>: Many older adults need varying levels of assistance to remain living independently. These services may not be available, which creates the need for these individuals to be placed in a nursing home or other assisted care facility.
- 3. <u>Substance Abuse</u>: Many older adults are prescribed a number of different medications. An individual may choose to self-medicate to alleviate symptoms of mental illness rather than seeking treatment. These behaviors can contribute to substance abuse problems in the elderly. There has been a rapid increase in addictions to prescription drugs, pain medications, and antidepressants among older adults.

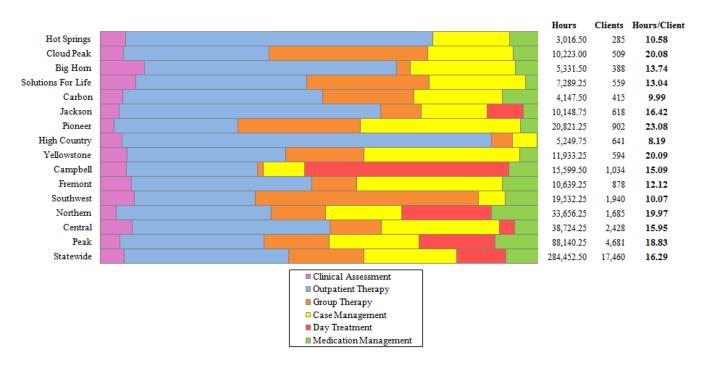
As noted above, there are very few programs in Wyoming that offer mental health services specifically designed for older adults. Two (2) of the older adult programs (offered by Peak Wellness and Central Wyoming Counseling Center) have recently been closed because the centers lost their "special project" funding. This loss is significant to this vulnerable population.

Mental Health Discussion: Services for Older Adults. Mental health services for older adults are extremely limited, with some specialized programs closing due to limited funding. During their phone interviews, many CMHC Directors noted the lack of outreach and mental health services for this population. The development of targeted funding for services specifically designed to meet the unique needs of the older adult population would help to reduce stigma, improve access, and assist individuals to live independently and achieve positive outcomes. In addition, there is a need to improve collaboration between physical health, mental health, and substance abuse services to improve coordination of services to meet the needs of older adults.

Summary of Core Mental Health Services

Figure 23 summarizes the array of Core Mental Health Services across CMHCs and statewide. The Core Mental Health Services include Clinical Assessment, Outpatient Therapy, Group Therapy, Case Management, Day Treatment, and Medication Management. Also, the total hours of Core Services, total number of clients, and the average hours of Core Services per client is shown on the right. The statewide average is 16.29 hours per client. Across the CMHCs, the average number of Core Service hours per client ranges from 8.19 hours in High Country to 23.08 hours in Pioneer.

Figure 23
Proportion of Service Hours for Mental Health Core Services
All Core Clients
By CMHC and Statewide
FY 2009



Figures 24a and 24b provide an overview of the Core Services provided by each CMHC. All CMHCs offer each of the Core Services, except for Group Therapy and Day Treatment services. The information is shown by the CMHC population, with the smallest on the left.

To help understand this service delivery system, the Penetration Rate is also included. The statewide Core Services Penetration Rate is 3.28%. The hours per client helps to standardize this information across services and the CMHCs. For example, the average number of hours per client for Outpatient Therapy ranges from 5.37 hours per client in Southwest to 10.31 hours per client in Yellowstone. The statewide average is 8.62 hours per client for Outpatient Therapy. For Group Therapy clients, the average number of hours per client is 23.48. For Case Management, the average number of hours per client is 6.69.

Figure 24a Summary of Core Mental Health Services All Core Clients FY 2009 (Table 1 of 2)

	_	Hot Springs	Cloud Peak	Big Horn	Solutions For Life	Carbon	Jackson	Pioneer	Statewide
al	Clients	129	181	194	341	151	318	519	9,309
Clinical Assessment	Hours	174.25	536.75	533.00	589.25	212.00	425.50	644.50	15,291.00
As	Hours/Client	1.35	2.97	2.75	1.73	1.40	1.34	1.24	1.64
.aby	Clients	249	420	327	393	256	549	681	12,362
OP Therapy	Hours	2,110.25	3,390.75	3,070.00	2,835.25	1,893.75	6,055.00	5,896.50	106,616.00
	Hours/Client	8.47	8.07	9.39	7.21	7.40	11.03	8.66	8.62
Group Therapy	Clients	-	145	17	143	91	63	151	2,086
up Th	Hours	-	3,698.00	168.75	2,041.25	856.50	938.50	5,803.50	48,987.00
	Hours/Client	-	25.50	9.93	14.27	9.41	14.90	38.43	23.48
Day Treatment	Clients	-	-	-	-	-	15	-	902
Treat	Hours	-	-	-	-	-	839.50	-	31,622.00
Day	Hours/Client	-	-	-	-	-	55.97	-	35.06
nent	Clients	185	310	245	166	221	371	556	9,028
Case Management	Hours	531.75	1,990.00	1,275.00	1,598.50	839.25	1,526.75	7,594.25	60,406.25
Ma	Hours/Client	2.87	6.42	5.20	9.63	3.80	4.12	13.66	6.69
ion	Clients	92	138	148	108	76	210	195	6,207
Medication Management	Hours	200.25	607.50	284.75	225.00	346.00	363.50	882.50	21,530.25
Ma	Hours/Client	2.18	4.40	1.92	2.08	4.55	1.73	4.53	3.47
ore	Core Clients	285	509	388	559	415	618	902	17,460
Total: Core Services	Core Hours	3,016.50	10,223.00	5,331.50	7,289.25	4,147.50	10,148.75	20,821.25	284,452.50
Tol	Hours/Client	10.58	20.08	13.74	13.04	9.99	16.42	23.08	16.29
Penetration Rate	General Population	4,622	7,821	11,322	15,695	15,624	20,376	20,617	532,668
Penet R	Penetration Rate	6.17%	6.51%	3.43%	3.56%	2.66%	3.03%	4.38%	3.28%

Figure 24b Summary of Core Mental Health Services All Core Clients FY 2009 (Table 2 of 2)

		High Country	Yellow- stone	Camp- bell	Fre- mont	South- west	North- ern	Central	Peak	Statewide
al ient	Clients	196	334	550	508	1,090	859	1,704	2,266	9,309
Clinical Assessment	Hours	258.25	735.00	918.25	756.50	1,519.75	1,231.50	2,833.25	3,923.25	15,291.00
As	Hours/Client	1.32	2.20	1.67	1.49	1.39	1.43	1.66	1.73	1.64
apy	Clients	579	418	795	634	999	1,353	1,865	2,888	12,362
OP Therapy	Hours	4,419.25	4,308.75	4,667.00	4,371.00	5,367.25	11,874.50	17,433.50	28,923.25	106,616.00
	Hours/Client	7.63	10.31	5.87	6.89	5.37	8.78	9.35	10.01	8.62
Group Therapy	Clients	22	119	31	89	182	214	217	609	2,086
up Th	Hours	253.75	2,126.25	218.00	1,098.75	9,952.75	4,169.25	4,516.00	13,145.75	48,987.00
	Hours/Client	11.53	17.87	7.03	12.35	54.69	19.48	20.81	21.59	23.48
Day Treatment	Clients	1	-	215	-	-	137	54	480	902
/ Trea	Hours	1.00	-	7,275.75	-	-	6,882.50	1,379.75	15,243.50	31,622.00
Day	Hours/Client	1.00	-	33.84	-	-	50.24	25.55	31.76	35.06
nent	Clients	152	470	496	268	585	758	1,340	2,951	9,028
Case Management	Hours	298.00	4,240.50	1,454.75	3,531.00	1,198.25	5,836.25	10,445.00	18,047.00	60,406.25
	Hours/Client	1.96	9.02	2.93	13.18	2.05	7.70	7.79	6.12	6.69
Medication Management	Clients	12	143	487	242	875	606	541	2,352	6,207
ledica	Hours	19.50	522.75	1,065.75	882.00	1,494.25	3,662.25	2,116.75	8,857.50	21,530.25
M _Z	Hours/Client	1.63	3.66	2.19	3.64	1.71	6.04	3.91	3.77	3.47
ore	Core Clients	641	594	1,034	878	1,940	1,685	2,428	4,681	17,460
Total: Core Services	Core Hours	5,249.75	11,933.25	15,599.50	10,639.25	19,532.25	33,656.25	38,724.25	88,140.25	284,452.50
	Hours/Client	8.19	20.09	15.09	12.12	10.07	19.97	15.95	18.83	16.29
Penetration Rate	General Population	25,087	27,574	41,473	38,113	39,944	50,605	73,129	140,666	532,668
Penel R	Penetration Rate	2.56%	2.15%	2.49%	2.30%	4.86%	3.33%	3.32%	3.33%	3.28%

The services provided in each CMHC follows, with a brief analysis of the information.

Hot Springs served a proportionately high number of clients, with a Penetration Rate of 6.17%. This CMHC provided an array of services, with most clients receiving Outpatient Therapy and Case Management.

Cloud Peak provided the full range of Core Services except Day Treatment. Cloud Peak had the highest Penetration Rate of 6.51%. Most clients received Outpatient Therapy and Case Management.

Big Horn also provided the full range of Core Services except Day Treatment. Their Penetration Rate of 3.43% was similar to the statewide rate.

Solutions for Life offered the full range of Core Services except Day Treatment. Their Penetration Rate of 3.56% was similar to the statewide rate.

Carbon also offered the full range of Core Services except Day Treatment. Their Penetration Rate of 2.66% was lower than the statewide rate.

Jackson provided the full range of Core Services including Day Treatment. The Penetration Rate was 3.03%, slightly below the statewide rate. Jackson's average hours per client for Outpatient Therapy was the highest in the state at 11.03 hours per year; the statewide average was 8.62 hours per year.

Pioneer provided the full range of Core Services except Day Treatment. Their Penetration Rate of 4.38% was higher than the statewide rate. Pioneer's average hours per client for Group Therapy was the highest in the state at 38.43 hours per year; the statewide average was 23.48 hours per year.

High Country provided the full range of Core Services including Day Treatment (one person). The Penetration Rate of 2.56% was lower than the statewide rate. High Country's average hours per client for Case Management was the lowest in the state at 1.96 hours per year; the statewide average was 6.69 hours per year. High Country also had the lowest average hours per client across all Core Services (8.19 hours per year). The statewide average was 16.29 hours per client per year.

Yellowstone provided the full range of Core Services except Day Treatment. The Penetration Rate was 2.15%, which was lower than the statewide rate. Yellowstone's average hours per client for all Core Services was 20.09 hours per year, which was higher than the statewide average of 16.29 hours per year.

Campbell provided the full range of Core Services including Day Treatment. The Penetration Rate was 2.49%, lower than the statewide rate. Campbell's average hours per client for Core Services was 15.09 hours per year, which was similar to the statewide average of 16.29. Campbell had a high number of clients receiving Day Treatment.

Fremont provided the full range of Core Services except Day Treatment. The Penetration Rate was 2.30%, which was lower than the statewide rate of 3.28%. Fremont's Case Management clients received an average of 13.18 hours per year, which was double the state average of 6.69 hours per year.

Southwest also provided the full range of Core Services except Day Treatment. The Penetration Rate was 4.86%, which was higher than the statewide rate of 3.28%. Southwest's Group Therapy clients received an average of 54.69 hours per year, which was double the statewide average of 23.48 hours per year. Southwest's average hours per client for all Core Services was 10.07 hours per year, which was lower than the statewide average of 16.29.

Northern provided the full range of Core Services including Day Treatment. The Penetration Rate was 3.33%, which was similar to the statewide rate of 3.28%. Northern's average hours per client for all Core Services was 19.97 hours per year, which was slightly higher than the statewide average of 16.29.

Central provided the full range of Core Services including Day Treatment. The Penetration Rate was 3.32%, which was similar to the statewide rate of 3.28%. Central's average hours per client for all Core Services was 15.95 hours per year, which was similar to the statewide average of 16.29.

Peak provided the full range of Core Services including Day Treatment. The Penetration Rate was 3.33%, which was similar to the statewide rate of 3.28%. Peak's average hours per client for all Core Services was 15.95 hours per year, which was similar to the statewide average of 16.29. Peak's average hours per client for all Core Services was 18.83 hours per year, which was higher than the statewide average of 16.29

Specialized Mental Health Services

A number of Specialized Services are available from the CMHCs to help clients achieve positive outcomes. Whenever possible, these services are available in each CMHC. When there are limited services and/or funding, the Specialized Services are available within each region. These regions were initially developed to assure that these Specialized Services were accessible to all persons in the state. The regions are outlined below.

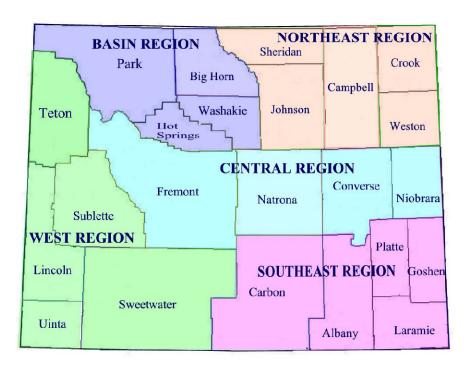


Figure 25 Wyoming State by Five Regions

In 2006, House Bill 91 and Senate File 76 provided additional funding to expand and strengthen several Specialized Services. As these services have been implemented, some of them are now available in each CMHC and funded within the CMHC's contract. Other services are available on a regional basis. These Specialized Services, and related data as available, are described below:

- Rehabilitative Services (described below)
- Employment Services (described below)
- Recreation and Socialization (described below)
- Emergency Services (described below; partial data available)
- Prevention/Early Intervention/Community Education is available in all CMHCs (described above in the Children's Services section; no data available)

- Housing and Residential Services (described below)
- Crisis Stabilization (described below)
- Acute Inpatient Care (described below; no data available)
- Wyoming State Hospital (described below; no data available)

Mental Health Promising Practice: Drop-In Centers to Promote Wellness and Recovery. Mountain House and Hope House are two excellent examples of drop-in centers for adults. Mountain House is operated by Jackson Hole Community Counseling Center and Hope House is a part of Yellowstone Behavioral Health Center. These programs offer a safe, warm, comfortable environment where community members may "drop in" to relax, read, work on the computer, visit with others, or meet with staff members who can help them address their issues and improve the quality of their lives. Services offered include individual and group therapy, Crisis Intervention, social and recreational opportunities, vocational and career support through job coaching and a working relationship with the Division of Vocational Rehabilitation, Case Management services, and psychiatric medication clinics. The clients work with the staff to create a team approach to provide the comprehensive network of support and care. These two programs are excellent models for other CMHCs to use in developing drop-in centers for their clients.

Rehabilitative Services

Rehabilitative services link a skilled trainer to the client for the purpose of developing and restoring the basic skills necessary to function independently in the home and the community. The client acquires skills for using community resources (e.g., riding the bus, shopping, budgeting).

Rehabilitative services are effectively delivered by Case Managers, as well as by consumers hired as Peer Specialists/Coaches, family members as Parent Partners, and youth as Peer Mentors. Persons with mental illnesses have found Rehabilitative services to be highly effective in teaching basic living skills, helping access physical and mental health care, and offering support during stressful events. In many states, these services are reimbursed by Medicaid through a 1115 or 1915b waiver and are available for children with SED and adults with SPMI.



Mental Health Trends: Rehabilitative Services. As shown in Figure 26, the number of clients receiving Rehabilitative services has increased over the past four years. In FY 2005, 380 clients received Rehabilitative services. That has increased to 1,040 clients in FY 2009. This data shows a 173.7% increase.

Similarly, the total number of hours of Rehabilitative services has increased from 10,404 in FY 2005 to 38,071 in FY 2009. Nearly half of these Rehabilitative services (15,885) were delivered by Yellowstone.

Figure 26
Trends in Specialized Service Utilization: Rehabilitative Services
By Statewide
FY 2005 and FY 2009

	FY 2005	FY 2009	Percent Increase
Clients	380	1,040	173.7%
Hours	10,404	38,071	265.9%
Hours Per Client	27.38	36.61	33.7%

Figure 27 shows the average <u>hours per client</u> for Rehabilitative services. Clients in all four groups average a small number of hours for Rehabilitation services. Four (4) centers delivered the majority of these services: Pioneer, Yellowstone, Northern, and Peak. Yellowstone delivered nearly half of all Rehabilitative service hours by delivering 15,885 hours to 82 clients. Statewide, there were 1,040 out of the total 17,460 clients that received these services. Of the clients who received these services, the average number of hours per client was 36.61 hours per year. Children with SED averaged 30.18 hours and adults with SPMI averaged 49.66 hours.

NOTE: Additional information on the number of clients receiving these services and the number of hours of services is shown in Appendix B.

Figure 27
Statewide Average Hours per Client
Rehabilitative Services
By Age and SED/SPMI Status
FY 2009
N=1.040

Rehabilitative Services - Hours Per Client								
	Hours Per Client with SED/SPMI	Hours Per Non-SED/SPMI Client	Total					
Children	30.18	23.05	26.94					
Adults	49.66	14.45	41.12					
Total	44.75	18.46	36.61					

Mental Health Gap: Rehabilitative Services. Rehabilitative services are important for children with SED and adults with SPMI. There were 1,040 clients in the state that received Rehabilitative services. The average client receives only 37 hours per year, which calculates into 3.08 hours per month. This amount of services may not be adequate for developing the skills necessary to live independently in the community. It would be helpful to clearly define Rehabilitative services to ensure that all centers are delivering and reporting a similar array of services.

Employment Services

Employment services include a broad range of services that help clients to acquire the skills necessary for obtaining and maintaining employment. Employment services may include assessing clients' individual skills, attitudes, behaviors, and interests relevant to work; supporting the client to attend vocational rehabilitation services and/or other training; assisting individuals in finding work; and promoting employment opportunities. Once a client is hired, these services may include job coaching, working with the employer to help the client maintain employment, and providing follow-up with the client to address ongoing issues in the work place.



Mental Health Trends: Employment Services. As shown in Figure 28, Employment services offered by the CMHCs have decreased over the past four years. In FY 2005, there were 429 clients receiving Employment services. In FY 2009, these services were offered to 367 clients. Similarly, the total hours decreased from 12,118 hours of Employment services offered in FY 2005 to 5,433 in FY 2009. This data shows a 55.2% decrease.

Figure 28 Trends in Specialized Service Utilization: Employment Services **By Statewide** FY 2005 and FY 2009

	FY 2005	FY 2009	Percent Increase
Clients	429	367	-14.5%
Hours	12,118	5,433	-55.2%
Hours Per Client	28.25	14.80	-47.6%

Figure 29 shows the average hours per client for Employment services. There were 367 clients that received these services. The average number of hours per client per year was 14.80. The 295 adults with SPMI averaged 14.87 hours while the 71 non-SPMI adults averaged 14.71 hours. There was an additional child client who received 0.25 hours of Employment services. Eight (8) of the 15 CMHCs reported this service.

Figure 29 Statewide Average Hours per Client Employment Services By Age and SED/SPMI Status FY 2009 N=367

Employment Services - Hours Per Client								
	Hours Per Client with SED/SPMI Client Client Total							
	SED/SPMI	Client	Total					
Children	-	0.25	0.25					
Adults	14.87	14.71	14.84					
Total	14.87	14.51	14.80					

Mental Health Promising Practice:
Washakie Works. Washakie Works continues to provide an excellent model for creating employment opportunities for clients with SPMI. This Cloud Peak program mentors and trains adult clients to develop skills. Washakie Works advertises in the community and receives contracts from community members to build porches, construct additional rooms, paint, and complete maintenance activities. These skills

"Washakie Works is a group of small miracles." - Peer Specialist

create the opportunity for clients to earn money and, more importantly, develop marketable and employable skills. As a result, clients can "graduate" from Washakie Works and successfully find employment with other companies. Clients who have worked for Washakie Works have confidence and the ability to work as team members, while successfully managing their mental health symptoms.

Mental Health Promising Practice: Central Wyoming Counseling Center's Supported Employment Program. Central Wyoming Counseling Center's Supported Employment program has been successful in helping clients with SPMI obtain and maintain competitive employment. This program was developed in 1994 through a joint cooperative effort with the Division of Vocational Rehabilitation. In FY 2008, there were 4,435 clients served in the Supported Employment Program. This program has been recognized as one of the best practice models in the nation by the President's Committee on Employment of People with Disabilities.

Mental Health Discussion: Expanding Rehabilitative and Employment **Programs.** Many CMHCs have developed some Rehabilitative and Employment programs and are helping clients to obtain employment. This strategy is an important first step in developing employment opportunities for clients. Training for staff and expansion of services to include a variety of Employment services in each region is encouraged. A few CMHCs work closely with the local Department of Vocational Rehabilitation (DVR); however, in most locations, DVR does not have adequate staffing to serve mental health clients. Frequently, clients must wait six months or longer to receive DVR services. In addition, the high employment benchmarks in the DVR accountability model are not compatible with mental health clients' need for ongoing supported employment and are not accommodating to a serious mental illness. As the mental health system measures employment as one of the key client outcomes, it is critical that the system helps clients learn and practice skills that are marketable. There is a need to fund and develop supported employment programs specifically designed for persons who are SPMI. Washakie Works provides a strong model for other centers.

Recreation and Socialization Services

Group and individual recreational outings and social activities are a service component that helps clients to develop the appropriate skills to recover and function independently in the community. These services are provided to clients by one or more mental health professionals as one part of a client's individual treatment plan. These services are provided to children who are SED and adults who are SPMI. During the phone interviews, many clients and family members reported that these services were helpful, and some reported that they would like to see Recreation and Socialization services expand. There were 513 clients who received Recreation and Socialization services in FY 2009; there were 35,269.75 hours of Recreation and Socialization services delivered. Nearly two-thirds of these services were delivered by Southwest Counseling (24,936 hours).



Mental Health Trends: Recreation/Socialization Services. As shown in Figure 30, the number of clients receiving Recreation/Socialization services increased from 420 clients in FY 2005 to 513 clients in FY 2009. This data shows an increase of 22.1%. The number of hours of Recreation and

Socialization services increased from 10,584 hours in FY 2005 to 35,270 hours in FY 2009. This data shows a 233.2% increase. Most of the hours (24,936) were delivered by Southwest Counseling to adult clients.

Figure 30
Trends in Specialized Service Utilization: Recreation/Socialization Services
By Statewide
FY 2005 and FY 2009

	FY 2005	FY 2009	Percent Increase
Clients	420	513	22.1%
Hours	10,584	35,270	233.2%
Hours Per Client	25.20	68.75	172.8%

Figure 31 shows the average hours per client for Recreation and Socialization services. Across the 513 clients who received these services, the average number of hours per client was 68.75. Children with SED averaged 7.64 hours and adults with SPMI averaged 94.07 hours.

NOTE: Additional information on the number of clients receiving these services and the number of hours of services is shown in Appendix B.

Figure 31 Statewide Average Hours per Client Recreation/Socialization By Age and SED/SPMI Status FY 2009 N=513

Recreation/ Socialization Services - Hours Per Client								
	Hours Per Client with SED/SPMI	Hours Per Non-SED/SPMI Client	Total					
Children	7.64	6.95	7.28					
Adults	94.07	71.07	90.49					
Total	79.66	36.28	68.75					

Mental Health Gap: Recreation and Socialization Services. Recreation and Socialization services are important for children with SED and adults with SPMI. The average child with SED receives 7.64 hours per year. The average adult with SPMI receives 94.07 hours. For adults with SPMI, this figure calculates into 7.84 hours per month. This amount of services may not be adequate for developing the social skills necessary to live successfully within a community environment.

Mental Health Discussion: Reporting Recreation and Socialization Services. Recreation and Socialization services are often available as a component of a CMHC's drop-in center activities. Some CMHCs record and report data on Recreation and Socialization services; others do not collect data on these activities. As a result, the data for these services are not consistently reported across the state. It would be helpful to more clearly define these services and outline how to consistently report them to WCIS.

Emergency Services

Emergency services are provided by each CMHC, and are partially funded by the Division as of FY 2007. These services provide a direct contact with an individual in crisis and an intervention to prevent the escalation of the crisis. A staff person triages each individual into needed services, determining the appropriate level of services based on each client's unique needs. Each CMHC has staff that are on-call 24 hours a day, seven (7) days a week to provide crisis response services. These on-call Emergency services are available to any person in an acute mental health crisis. The response timeframes that began in FY 2007 are outlined below.

- A telephone response by an appropriate licensed professional is required <u>within 15</u> minutes;
- An onsite response by an appropriate licensed professional within the community is required within one hour; and
- An onsite response by an appropriate licensed professional within the county is required within two hours.

The purpose of Emergency services is to provide Crisis Intervention services which enable the individual, family members, and friends to cope with the emergency while maintaining the individual's status as a functioning community member to the greatest extent possible. These services are effective at helping to de-escalate the crisis, resolve the crisis, and reduce the number of persons who are admitted to psychiatric inpatient services. The CMHCs also offer consultation and education outreach services, which may include offering outreach to homeless shelters; crisis counseling at schools or job sites after a critical incident; and training on recognizing depression, suicidal behavior, and other indicators of mental illness. During the phone interviews, many CMHC Directors and staff reported high satisfaction with these services.

Figure 32 shows the average hours per client for Emergency services. Clients in all four (4) groups average a small number of hours of Emergency services. Across all 1,737 clients who received these services, the average number of hours per client was 2.62 hours. Children with SED averaged 1.87 hours and adults with SPMI averaged 3.73 hours. Not all Emergency services are reported to the WCIS system. Many of the Emergency services delivered by CMHC staff are for persons who have not been previously served; therefore, the client is not enrolled and not reported to WCIS.

Figure 32 Statewide Average Hours per Client Emergency Services By Age and SED/SPMI Status FY 2009 N=1,737

Emergency Services - Hours Per Client								
	Hours Per Client with	Hours Per Non-SED/SPMI						
	SED/SPMI	Client	Total					
Children	1.87	1.82	1.85					
Adults	3.73	2.03	2.74					
Total	3.42	2.01	2.62					

Emergency services are one of the essential components to individuals with suicidal thoughts and behaviors. The Center for Disease Control and Prevention reported that Wyoming has the highest suicide rate in the nation, with 22.6 persons committing suicide per 100,000 population (2006 data). Figure 33 shows the suicide rate in Wyoming compared to other surrounding states. This data shows that Montana is ranked second with a rate of 20 per 100,000 population, South Dakota is ranked seventh, and Colorado is ranked ninth. This is an area of concern and is being addressed as a high priority by CMHCs across the state.

Figure 33
Suicide Rates in Wyoming and Surrounding States
CDC Data (2006)

Suicide Rate (per 100,000 population) Wyoming vs Surrounding States							
State	Rate	Rank (out of 50)					
Wyoming	22.6	1					
Montana	20.0	2					
South Dakota	15.9	7					
Colorado	15.3	9					
Idaho	15.2	10					
Oklahoma	15.0	11					
Utah	14.0	16					
Nebraska	11.5	31					

Mental Health Promising Practice: Yellowstone Behavioral Health's Brief Intervention Treatment. Yellowstone Behavioral Health in Park County has a Brief Intervention Therapist on staff who provides intensive, brief outpatient therapy and follow-up services to suicidal individuals, and their families. By remaining in the home and receiving intensive therapy services (3 to 15 hours per week) in the community, the therapist and individual are able to immediately work on the psychological stressors that trigger the suicidal response and develop effective coping strategies. These brief intervention therapy and Case Management services incorporate many natural supports (family, friends, etc.) to promote the individual's recovery and prevent future suicidal attempts. This intense level of service decreases the need for hospitalization while effectively delivering services within the individual's home environment.

Summary of Specialized Mental Health Services

Figures 34a and 34b show a summary of the Specialized Mental Health Services by CMHC. These tables show the additional services offered by the CMHCs which are reported to the WCIS data system. These tables show data on the number of clients, service hours, and hours per service. Please note that there are other specialized regional services that are discussed in this report, but are not shown on this table.

Rehabilitative services are available in each region, but on a limited basis. Rehabilitative services provide supportive services to clients to help them develop daily living skills. These services promote wellness and recovery. Expanding these services in all regions would promote positive outcomes.

Employment services are available in eight (8) of the CMHCs, and in each region except the Northeast. As noted above, there are a few exemplary employment programs available. These services are critical to helping clients recover and live independently. The development and expansion of these services in every region would promote positive outcomes.

Recreation and Socialization services are available in each region on a very limited basis. These services are important to individuals who are SED or SPMI to help them develop appropriate social skills within a community setting.

Throughout all CMHCs/counties, there is a need to develop consistent standards for documenting services. This practice will help to assure that there is uniform access to services across the state and that data reported for each service is comparable.

The availability and expansion of Specialized Services for SED children and SPMI adults is critical for assisting our highest-need clients to live successfully in the community, attend school and successfully graduate, obtain and maintain employment, and achieve positive outcomes. Training staff to offer evidence-based services that are targeted to the needs of clients with SED and SPMI is an important component of delivering Specialized Services.

Figure 34a Summary of Mental Health Specialized Services FY 2009 (Table 1 of 2)

		Hot Springs	Cloud Peak	Big Horn	Solutions For Life	Carbon	Jackson	Pioneer	Statewide
- 9 S	Clients	10	41	1	87	26	54	152	1,040
Rehab- ilitative Services	Hours	1,772.75	578.25	0.50	1,758.75	553.50	134.75	5,740.00	38,070.50
	Hours/Client	177.28	14.10	0.50	20.22	21.29	2.50	37.76	36.61
Employment Services	Clients	-	12	-	3	-	41	2	367
mployme	Hours	-	2,007.75	-	2.00	-	525.00	2.50	5,432.75
	Hours/Client	-	167.31	-	0.67	-	12.80	1.25	14.80
Recreation/ Socialization Services	Clients	4	-	-	16	27	64	-	513
Recreation/ socialization Services	Hours	34.00	-	-	74.50	1,421.25	876.75	-	35,269.75
Soc S	Hours/Client	8.50	-	-	4.66	52.64	13.70	-	68.75
ency	Clients	-	6	19	-	12	25	99	1,737
Emergency	Hours	-	14.75	19.00	-	19.75	71.50	279.50	4,556.25
Er S	Hours/Client	-	2.46	1.00	-	1.65	2.86	2.82	2.62
Total Spe	Total Specialty Hours		2,600.75	19.50	1,835.25	1,994.50	1,608.00	6,022.00	83,329.25

Figure 34b Summary of Mental Health Specialized Services FY 2009 (Table 2 of 2)

		High	Yellow-	Camp-	Fre-	South-	North-			Statewide
		Country	stone	bell	mont	west	ern	Central	Peak	State Wide
b- es	Clients	4	82	-	45	30	114	-	396	1,040
Rehab- ilitative Services	Hours	3.75	15,885.00	-	1,212.25	171.75	2,258.25	-	8,001.00	38,070.50
	Hours/Client	0.94	193.72	-	26.94	5.73	19.81	-	20.20	36.61
Employment Services	Clients	-	-	-	36	8	-	183	83	367
mployme	Hours	-	-	-	911.75	10.00	-	1,764.25	209.50	5,432.75
Em	Hours/Client	-	1	-	25.33	1.25	ı	9.64	2.52	14.80
ion/ ation es	Clients	1	27	-	82	47	107	1	139	513
Recreation/ Socialization Services	Hours	2.00	476.50	-	3,846.75	24,936.00	1,458.75	-	2,143.25	35,269.75
Re Soc S	Hours/Client	2.00	17.65	-	46.91	530.55	13.63	-	15.42	68.75
ncy es	Clients	53	228	20	29	471	62	1	715	1,737
Emergency	Hours	84.25	641.50	17.50	37.00	1,027.75	79.00	1	2,264.75	4,556.25
En	Hours/Client	1.59	2.81	0.88	1.28	2.18	1.27	1	3.17	2.62
Total Spe	cialty Hours	90.00	17,003.00	17.50	6,007.75	26,145.50	3,796.00	1,764.25	12,618.50	83,329.25

Other Community Mental Health Center Mental Health Services

In addition to Core and Specialized Services, CMHCs deliver an array of other services and/or link clients to needed services. These services include Supported Independence Projects (SIP), and Housing and Residential services (including group homes and supported apartments for adults). CMHCs also offer Crisis Stabilization services. Acute Inpatient Psychiatric services are available from local hospitals in each region, as well as private organizations, such as Wyoming Behavioral Institute and Cheyenne Regional Medical Center. Many centers utilize Quality of Life Funds to help them live independently. Finally, many CMHCs offer consultation and education services to local community organizations and the public. Each of these services are described below.

Supported Independence Projects (SIP)

The Supported Independent Project (SIP) is a regional service which consists of community living arrangements and other supportive services that assist the client in living successfully in the community and integrating into community activities. SIP services include supported living arrangements which provide varying levels of support and supervision. Residential placements in the community are based on a client's needs and preferences. The SIP also provides education and vocational opportunities to help the client achieve employment.

Quality of Life Funds

CMHCs utilize Quality of Life funds to help pay for 'whatever it takes' to support clients and help them remain independent and live in the community. They are also used to pay for prescription medications which are not covered by insurance and/or Medicaid, to cover health and medical expenses, and to establish an independent living situation (e.g., pay for the client's first and last month's rent, basic kitchen supplies, bedding). These funds are a very small percentage of the CMHC budget, but make a significant difference in the lives of clients. During their phone interviews, CMHC Directors, staff, and clients commented on the importance of these flexible funds to help clients when all other resources have been exhausted

Quality of Life funds provide non-clinical supports which are necessary elements for successful community living. These funds were first made available in FY 1999. There have been some increases in funding over the years as a result of demonstrated life successes for many clients throughout Wyoming. These funds are an important part of helping clients with SPMI live independently and avoid higher levels of care.

Housing and Residential Services

Adult Group Homes and Supported Apartments

Safe and stable housing provides the foundation for delivering services to persons with a mental illness. If a client is homeless, or living in an unstable living arrangement, the client will be unable to fully benefit from mental health services.

Housing and Residential services assist clients in finding and maintaining appropriate housing arrangements. Some CMHC communities have developed community-based housing opportunities for adults with SPMI which include multiple levels of support, ranging from group homes and residential living arrangements, to supported apartments. Persons who utilize housing services move from one level of support to another, depending on need and skills. Housing services may include therapeutic activities or interventions to develop daily living skills, including self-care, meal preparation, shopping, and budgeting proficiency to help the client successfully remain in the independent living situation.

There are different types of housing services for mental health clients. These Residential services provide short-term, intensive, transitional services, as well as long-term, facility-based treatment programs designed to prevent hospitalization or ease transition from an inpatient facility to independent or supported living environments. CMHCs have secured funding from local and state services to develop and maintain these residential options. During phone interviews, some of the Directors from the larger CMHCs reported that their centers offer supported housing options. Most persons interviewed reported that these programs are extremely limited and are always filled to capacity.

House Bill 91 and Senate File 76 provided funding to expand the number of mental health supervised apartments (\$194,150) and mental health group homes (\$2,015,750). This funding helped to develop programs and hire staff to deliver these supportive services.

Figure 35 shows the total number of beds for supported apartments available in each CMHC and region. The CMHCs are ordered from smallest population to largest. The ten smallest CMHCs do not have any beds available, with the exception of Pioneer. In FY 2009, there were a total of 117 beds across all CMHCs, and 145 unduplicated clients utilized these beds. The average number of bed days per client was 265 days. Many of the clients stayed in the apartment for the entire year. Others had shorter lengths of stay.

Figure 35 Supported Apartments Data By CMHC and Statewide FY 2009

RESIDENTIAL SERVICES SUPPORTED APARTMENTS (BEDS)	Number of Beds	Total Bed Days Available	Unduplicated Number of Clients	Total Bed Days Used	Average Days per Client Days
Hot Springs					
Cloud Peak					
Big Horn					
Solutions for Life					
Carbon	4	1,460	6	1,421	237
Jackson Hole					
Pioneer	18	5,110	20	4,847	242
High Country					
Yellowstone					
Campbell County					
Fremont Counseling	21	7,665	23	7,314	318
Southwest Counseling	8	2,920	10	3,128	313
Central Wyoming					
Northern Wyoming	10	3,650	14	3,588	256
Peak Wellness	56	18,910	72	16,154	224
TOTAL	117	39,715	145	36,452	265

Some CMHCs reported that they provide rent subsidies as part of their SIP Program services. As a result, they have not implemented supported apartments in their county. SIP staff work with clients to help them live independently. Along with rent subsidies, many CMHCs also provide group homes for clients.

Housing and Urban Development (Section 8)

In addition to the residential programs offered by some of the CMHCs, adult clients also utilize Section 8 Housing, when available. The United States Department of Housing and Urban Development (HUD) helps low-income families and individuals receive subsidized housing. This is commonly known as Section 8 Housing. In Wyoming, a limited number of Section 8 Housing properties are available for families, elderly persons, and disabled persons.

The map in Figure 36a shows where the Section 8 Housing properties are located within each CMHC. Across CMHCs, the number of available properties ranges from 23 in Peak to none in Jackson and Big Horn. The federal government allocates only a few Section 8 Housing options to states each year. Last year, Wyoming did not receive any additional Section 8 Housing.

Mental Health Gap: Low-Income Housing Apartments/Section 8 Housing.

One of the core outcomes for mental health services is to help clients live independently. With the limited number of residential programs and limited availability of Section 8 Housing properties in Wyoming, mental health clients have few low income housing opportunities. There are very few low-income housing and/or expanded Section 8 Housing opportunities in Wyoming. There is a need for the Division to develop additional options for low-income housing and/or advocate for additional Section 8 Housing.

Figure 36a
Number and Location of Section 8 Housing Properties
By CMHC
FY 2009
N=74

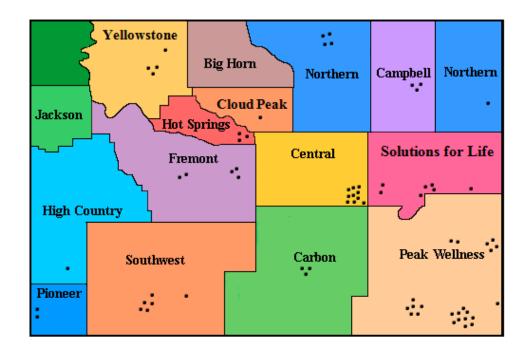


Figure 36b shows the number of available Section 8 Housing properties in Wyoming. There are a total of 74 available properties in the state. Thirty (30) properties are available for families, 26 properties are available for elderly persons, 14 properties are available for disabled persons, and 4 properties did not specify their 'targeted' group. Some properties may be one (1) bedroom apartments; other properties may be three (3) bedroom houses.

Figure 36b Number and Location of Section 8 Housing Properties By Type of Housing FY 2009 N=74

	Number of Available	Number of Properties for	Number of Properties for	Number of Properties for	Number of Other
СМНС	Properties	Families	Elderly	Disabled	Properties
Hot Springs	3		2		1
Cloud Peak	2	1	1		
Big Horn					
Carbon	3	2	1		
Solutions for Life	7	4	3		
Jackson Hole					
Pioneer	2	1		1	
High Country	1		1		
Yellowstone	4	2	2		
Fremont	5	2	2	1	
Southwest	6	2	1	3	
Campbell	3	2			1
Northern	5	2	2	1	
Central	10	4	3	2	1
Peak	23	8	8	6	1
TOTAL	74	30	26	14	4

Mental Health Discussion: Expanding Residential Apartments.

Supported living options and low cost apartments create the opportunity for clients with SPMI to achieve success in living independently in the community. The development of safe, affordable living options in each region would provide an excellent foundation for helping clients reduce dependence on the mental health system. Residential data shows that in most apartments, the same client stays in a unit for one (1) year or longer. With such a low turnover, this limited resource is not available for other clients who could also benefit from this resource. Some clients interviewed reported that it is extremely difficult to find low-income housing in Wyoming and that there is a need for additional group homes. For persons on a limited income, there are few housing options. This difficulty adds to the stress and, in some cases, exacerbates their mental illness.

Mental Health Promising Practice: Affordable, Safe Housing for SPMI Clients. Peak Wellness, Cloud Peak, Pioneer, Southwest, Fremont, and Northern CMHCs have built and/or purchased apartments for use by clients who are SPMI. These apartments are available to clients who are living on disability and have limited incomes. Affordable, safe housing provides the foundation for a person to live independently; combining these apartments with supportive services helps clients to successfully live in the community. As the client develops the skills to live independently without supports, he/she can then "graduate" to a fully independent living situation. These apartments have been an important component in helping clients recover and achieve their life goals and provide an excellent model for other CMHCs to use in developing this service in other regions.

Residential Services for Clients with Co-Occurring Disorders

It is estimated that approximately 40-60% of the clients receiving mental health services have co-occurring mental health and substance abuse diagnoses. Programs that offer outpatient and/or residential treatment packages for cooccurring disorders have been found to be more effective in achieving positive outcomes. Several of the CMHCs offer mental health services and substance abuse services to a client with a co-occurring disorder; however, there are only a few that provide an outpatient treatment program for persons with a co-occurring disorder. In addition, only one (1) of the substance abuse residential programs in the state is specifically designed to treat persons with a co-occurring disorder. There is a program at WSH that voluntarily serves persons with a co-occurring disorder; this program is operated by Peak Wellness. Several programs across the state are in the process of developing services to address the needs of clients with co-occurring substance abuse and mental health disorders.

"Clients with cooccurring
disorders are
getting treatment,
but it is hard to
tell whether it is
better to address
the substance
abuse first or the
mental health
first."
- Peer Specialist

Mental Health Promising Practice: Haven Residential Treatment Program for Co-occurring Disorders. Peak Wellness operates a Residential Treatment program for persons with co-occurring disorders (mental health and substance abuse) in Laramie County. It is an eight (8) bed, long-term, Residential program for men and women who have a serious and persistent mental illness and a substance use disorder. The program uses a Therapeutic Community Model with a length of stay in the program between 12 to 18 months. The treatment model has four (4) phases, and the clients progress through the program when they learn key components of the dual issues. As the clients successfully move through the treatment phases, they also develop employment skills, activities of daily living, and money management. This program has been successful and provides an excellent model for replication in other regions.

Mental Health Gap: Coordinated Services for Individuals with Co-Occurring Mental Health and Substance Abuse Disorders. There is a need to fund and develop additional programs to meet the complex needs of persons with co-occurring substance abuse and mental health disorders. These programs would be staffed by appropriately credentialed mental health professionals with training in substance abuse treatment. Individuals with a co-occurring substance abuse and mental health disorder enrolled in these specially designed programs would have access to such services as Intensive Outpatient Substance Abuse Services, Intensive Case Management, Psychotropic Medication Management, and mental health therapy. In addition, there is a need to develop additional residential programs which specifically serve persons with co-occurring substance abuse and mental health disorders.

Residential Crisis Stabilization Services

In 2006, House Bill 91 and Senate File 76 provided additional funding to pilot the development of Crisis Stabilization programs to help reduce psychiatric inpatient hospitalizations and admissions to the Wyoming State Hospital. Crisis Stabilization services are a comprehensive array of services designed to stabilize the conditions of acute or severe psychiatric symptoms, for individuals with a mental health emergency or severe emotional disturbance. Crisis Stabilization services include a 24-hour supervised non-secure living environment, psychiatric services, a nursing assessment, supportive counseling, and group therapy. Services are provided at a physical residence (building and location) where staffing is available 24 hours a day, seven (7) days a week. Treatment services are immediate and short-term (typically less than 30 days), and individualized for each person to help stabilize acute symptoms of mental illness and/or other emotional distress.

Casa de Paz was developed by Peak Wellness Center and is located in Cheyenne. In addition, Carbon County developed an intensive community Case Management program to help respond to clients in crisis. Both pilot projects were extremely effective. In 2008, additional funding created a Crisis Stabilization in Evanston. Foundations was developed by Pioneer Counseling Services and is located on Wyoming State Hospital property. These Crisis Stabilization programs have been successful at diverting over 90% of their clients from higher levels of care by resolving the client's crisis in a community setting. Clients report that their experiences at these programs are very positive and vastly superior to an involuntary emergency detention or inpatient hospitalization. In addition, the Directors reported that the programs have been very effective at resolving the crisis and helping clients receive services in the community and, in most cases, avoid hospitalization.

The impact of the Crisis Stabilization programs on Wyoming State Hospital utilization is difficult to measure, but indicators show that the vast majority of clients who received Crisis Stabilization services were not admitted to a psychiatric hospital and/or the state hospital. Other factors also influence state hospital utilization, including changes in policy; the use of designated hospitals to serve clients when the state hospital is at capacity; and the variety of treatment services available (i.e., geriatric services, substance abuse services).

Mental Health Promising Practice: Crisis Stabilization Programs. Casa de Paz (Peak Wellness) and Foundations (Pioneer Counseling) are two Crisis Stabilization Programs which have been successful at diverting over 90% of their clients from higher levels of care by resolving the client's crisis in a community setting. Data shows that only 10 out of 157 Casa de Paz clients needed to be hospitalized while receiving crisis stabilization services. Foundations experienced similar success in its first months of operation. Clients report that their experiences at these programs are very positive and vastly superior to an involuntary emergency detention and inpatient hospitalization.

Casa de Paz and Foundations provide models which could be replicated in other counties and centers in Wyoming which have similar available resources. The Carbon County Assertive Case Management Program provides an effective model for smaller county programs. A Crisis Stabilization program is currently being planned in the Basin region. The development of Crisis Stabilization services and/or intensive Case Management services in Basin and other regions would significantly enhance the capacity of the mental health system to respond quickly to crises, de-escalate acute behavior, and prevent the need for hospitalization. Overall, the needs and local resources of each community must be considered when developing Crisis Stabilization services.

Mental Health Discussion: Medicaid Payment for Adult Residential Crisis Stabilization Services. Residential Crisis Stabilization services for adults are an important component in the full system of care continuum. These costeffective, community-based services help to reduce inpatient hospitalizations and provide a safe environment for helping adult clients resolve a crisis. There is an immediate need for Residential Crisis Stabilization services in all regions. In some states, Crisis Stabilization services are reimbursed by Medicaid as a 'bundled' day rate. In Wyoming, Medicaid does not have a day rate for Crisis Stabilization services. Instead, centers are able to receive Medicaid reimbursement for some of the Outpatient Services delivered to clients in Crisis Stabilization programs through Medicaid (e.g., Medication Management services, Individual Therapy, and Group Therapy). However, the current Medicaid Waiver does not include a Crisis Stabilization Day Rate Payment for the bundled program. The Division may wish to investigate the advantages of revising the Medicaid Waiver to include payment for Crisis Stabilization services.

Psychiatric Residential Inpatient Services and Wyoming State Hospital

Psychiatric Residential Inpatient services and Wyoming State Hospital (WSH) services are also available for persons with an acute mental illness. These services are extremely limited and for the highest-need individuals; only the most acutely ill are admitted to the state hospital. The state hospital does not accept persons who are willing to be admitted on a voluntary basis. All clients admitted to the state hospital are involuntarily detained under Title 25, except for persons who are admitted to the Co-Occurring Disorder Program.

Title 25 provides a foundation and structure for the state of Wyoming to evaluate, detain, and hospitalize persons who are acutely mentally ill. Several different county, state, and private agencies and organizations are involved in the Title 25 process in order to ensure

that client's rights are protected and that there is consistency in the treatment of persons when they are the most vulnerable. The Title 25 process requires that these agencies collaborate and coordinate services to ensure timely and humane services for individuals who are a danger to self, danger to others, or unable to meet basic needs as a result of a mental illness.

A Title 25 study was conducted in 2009 by Carol Day, M.P.A., Facility and Community

Service Systems Coordinator from the Wyoming Department of Health, and Nancy M. Callahan, Ph.D. and John K. Whitbeck, Ph.D. from I.D.E.A. Consulting. Over 260 persons from all 23 counties were interviewed as a part of this study in order to review the Title 25 process and identify areas for strengthening the system to promote a stronger, more coordinated system of care for persons experiencing an acute psychiatric episode.

Stakeholders provided several recommendations for improving the Title 25 process. Recent legislation has been proposed which addresses the key recommendations from the study, including a revised definition of the terms "mental illness" and "mentally ill"; an expansion of the Title 25 statute language to describe standard treatment guidelines; and specifications for establishing a Single Point of Responsibility within each CMHC. Other recommendations in the Title 25 study, such as the need to develop Crisis Stabilization programs, are currently being implemented.

The Title 25 study addresses the involuntary commitment

process and the placement of adults who need the highest

level of services. There is a need to conduct a study on the Title IX process for children and the residential placement practices for high-need children with a serious emotional disturbance.

The Wyoming State Hospital provides a broad range of services for people who have complex psychiatric problems and require an intensive psychiatric hospital setting. Individuals who have complex problems that cannot be effectively treated by local psychiatric hospitals are referred to the state hospital. Length of stay may be a few days or several months, depending on the needs of the client.

WSH primarily serves persons with mental health disorders. However, as noted above, the state hospital operates one (1) program that is dedicated to persons with a co-occurring diagnosis of mental health and substance abuse. The Co-Occurring Disorders Program (CDP) is a residential treatment program for individuals 18 years of age and older who have a co-occurring disorder. This program accepts referrals for other units at the WSH and is a voluntary treatment program. Persons remain in this from for 30-90 days, or

"We can't get clients admitted to the state hospital. We have given up. Unless we have a severely acute, involuntary client, there is no hope of getting them access to the state hospital. This puts our SPMI clients at an even greater risk of being harmed." - Director

longer. At the time of discharge, clients are referred back to their home community. This program helps to improve the clients' quality of life so they are more likely to achieve optimal outcomes.

Persons attending the program live on the WSH campus and attend the program. Treatment activities include group services, didactic videos, homework assignments, and individual therapy sessions. The program staff work with each client to develop their treatment, empower the client, and promote wellness. The focus of treatment is to help clients overcome the effects of chemical dependency, learn to live sober, manage symptoms of mental illness, and work toward improving their quality of life.

Mental Health Staff and Consumer Empowerment

The ability of the mental health system to successfully deliver services to the most seriously mentally ill, achieve positive outcomes, and transform the system depends on a competent, trained, and experienced work force. The mental health workforce is comprised of licensed and paraprofessional staff who deliver a variety of services and supports to help clients and families, including managing their symptoms; developing activities of daily living; attending school or gaining employment; and recovering from their mental illness. Skilled and licensed clinicians, psychiatrists, and nurses provide the core foundation of mental health services. Paraprofessional staff, such as Case Managers and Peer Specialists, are effective team members that provide supportive services to help retain clients and promote positive outcomes. These positions, when filled by clients and family members, especially empower individuals to recover and thrive. In turn, the mental health system is strengthened and supported when it hires consumers as Case Managers and Peer Specialists; family members as Case Managers and Parent Partners; and youth as Peer Mentors

This section provides a brief discussion on the challenges the CMHCs have in hiring, retaining, and licensing clinical staff. In addition, there is a discussion on recovery and wellness; drop-in centers; hiring consumers, youth, and family members; and the importance of ongoing training to continually strengthen the entire service delivery team.

Staffing

In order to close the service gaps, help clients reduce symptoms so they can live independently, and manage resources in a cost-effective manner, the system must be able to hire staff that are skilled and understand the mental health service delivery system. The legislative funding that increased staff salaries in 2006 was effective at increasing the pay scales and enabled centers to hire qualified staff. Unfortunately, four (4) years later, Wyoming salaries have failed to keep up with surrounding states. As a result, CMHCs are again having difficult recruiting and retaining qualified staff.

There are several strategies for meeting the current mental health services staffing shortage. These strategies include hiring more staff; increasing salaries and benefits; timely processing of clinical license applications; expanding the workforce through the

development of mental health staff positions for consumers and family members; and staff training.

Increasing Salaries and Benefits

Wyoming salary ranges are lower than surrounding states. Salaries at CMHCs for mental health clinicians are also lower in comparison to similar positions in other local agencies

"We see a lot of

people leave these

agencies because

of salary issues. I don't think you're

going to keep

people if you can't

be competitive in

(i.e., Department of Education and private hospitals). Low salaries create significant barriers to attracting qualified staff to accept positions in this state. Low compensation also contributes to the CMHCs losing staff to other states and local agencies, where experienced staff can perform the same job with higher pay.

Currently, CMHCs are primarily able to hire inexperienced clinicians who have recently graduated from college. These new graduates need to obtain supervision and hours of experience to complete their clinical license. Once fully licensed, many of these clinicians leave for higher paying positions.

refused job offers because of limited benefits.

In addition, staff from different CMHCs noted that the CMHC position benefits are often extremely limited. For example, some clinicians noted that they have health benefits for themselves but do not receive benefits for family members, including their children. Many applicants have

Until Wyoming salaries and benefits are competitive with surrounding states and other local agencies, staff turnover will remain high, positions will remain vacant, and CMHCs will continue to hire less experienced staff to meet the needs of mental health programs.

Mental Health Licensing Reciprocity and Dual Credentialing

Skilled, trained, and licensed clinical mental health staff are the foundation for delivering excellent mental health services. Every state has comprehensive standards and requirements for assuring that licensed individuals have had the proper training and education prior to obtaining a clinical license. Most states have a reciprocal agreement with surrounding states and accept clinical licenses from these states. This creates the opportunity for a licensed person to move across state lines and more easily obtain employment. The timely approval of clinical licenses also allows programs to expand recruitment activities to attract qualified, experienced staff from across the country.

The Wyoming Licensing Board has extremely strict and comprehensive licensing requirements, which are mandated by current legislative language. These licensing standards require a large amount of documentation in order to retain licensing or certification and can be very time consuming for persons requesting re-certification or relicensing. Each specific skill or category of licensure or certification has separate requirements and separate procedures which must be fully met with documentation and

time requirements. The overall investment in time to become or remain licensed is considerable.

Individuals who have been licensed, practicing mental health clinicians in other states and are seeking employment in Wyoming do not automatically receive reciprocity. Individuals must meet all Wyoming requirements before being granted a provisional license by the board. In many cases, this requires an individual to successfully finish one or more college classes before being allowed to practice without provisional supervision. In other cases, individuals have been required to accept lower paid staff positions and not practice therapy until all requirements have been met.

This strict interpretation and application of licensing requirements has a dampening effect on recruitment from outside of Wyoming. Even persons who are well-qualified and working in similar jobs outside of Wyoming may not meet current licensing requirements when recruited to work in Wyoming. While it is important for licensing boards to maintain the integrity of licensing standards, it is equally important to process applications and reapplications in a timely manner. In addition, there is a need for greater responsiveness to out-of-state applicants by allowing persons who are licensed and/or certified in other states to receive a provisional approval from the board and deliver services while completing Wyoming requirements.

Mental Health Discussion: Models for Mental Health Clinical Licensing Reciprocity. Several of Wyoming's neighboring states model efficient programs and procedures for licensing reciprocity and dual credentialing. Nebraska offers core courses statewide which give staff the opportunity to obtain dual credentialing. Most states have a reciprocal agreement with other states and accept clinical licenses from these states. There has been some improvement in the timely approval of clinical licenses, but Directors noted that there are still significant delays in getting approval from the Wyoming Licensing Board. The modification of Wyoming legislation to allow individuals to obtain a provisional license while meeting the educational requirements is encouraged.

Expanding the Work Force: Developing Youth, Client, and Family Member Staff Positions

At the present time, only a few CMHCs reported that consumers have been hired to deliver mental health services. Youth, consumers, and family members are valuable resources for the mental health system and can enrich services by teaching and mentoring clients based upon their personal experiences and life events.

Developing positions and hiring youth, clients, and family members to deliver Case Management and Rehabilitation Services will help expand the work force and help to transform the system to assist clients in recovering and achieving positive outcomes. The development of paid positions for clients (Peer Specialists) and family members (Parent Partners) creates the opportunity to access a valuable resource and expand services to better meet the client's needs.

Youth, consumer, and family involvement can take many forms in a mental health system. Some mental health programs have consumers who are paid to participate in management-level planning activities. Many mental health programs develop paid, benefited positions for consumers to work as Peer Specialists, Rehabilitation Specialists, and/or Case Managers. These positions are highly effective in providing cost-effective, supportive services to other clients. Consumer positions provide mentoring, assistance with daily living skills, and support for clients and family members. In many instances, these individuals help reduce barriers and improve access to needed services.

Youth who are hired part-time as Peer Mentors are able to work effectively with Transition Age Youth to reduce stigma, increase access to services, and develop a supportive environment for youth with SPMI. Peer Mentors are valuable in working with other youth, introducing the client to other youth, clinicians, Case Managers, and other staff. A Peer Mentor provides a 'friendly face' when a youth is first referred to a mental health program and offers ongoing support from another young person, helping to bridge the communication gap with professional staff.

At the present time, utilization of Peer Mentors and Peer Specialists is inconsistent across the CMHCs. In FY 2005, few CMHCs employed or had volunteer Peer Mentors or Peer Specialists. In FY 2007, these positions are being promoted by the MHD. These positions will provide an important role in the development of recovery-based services and are being implemented in most states as a component of the transformation of the mental health system of care.

As a component of this transformation of staff positions, family members hired as Parent Partners provide supportive services to families with SED children. They are effective at reducing stigma and improving access to services for families who are fearful of receiving mental health services. They are also invaluable in helping families access community programs, healthcare, and other needed services. In many instances, they are available to accompany a parent to a school IEP meeting, a court hearing, or doctor's appointment. The Parent Partner provides support to the family member, as well as helping them understand the information discussed during these meetings.

Mental Health Discussion: Hiring Youth, Clients, and Family Members. There were only a few paid staff positions in the state that are filled by consumers or family members in FY 2005 and 06. Promoting the development of youth, consumer, and family member paid positions to utilize the strengths, knowledge, and experience of our clients will benefit the entire system. Creating the opportunity to hire youth as Peer Mentors, adult clients as Peer Specialists, and family members as Parent Partners in each CMHC and at the Division will help transform the system and achieve positive, recovery-oriented outcomes. At the present time, there is no specific funding for hiring clients and family members.

Mental Health Promising Practice: Peer Specialists. Several CMHCs have hired persons who have received mental health services as Peer Specialists. Cloud Peak, Peak Wellness, Jackson Hole, Yellowstone, and other CMHCs have created paid Peer Specialist positions in the past few years. These Peer Specialists have been very effective at providing a positive role model for other consumers. Peer Specialists are active members of the treatment teams and provide valuable information on consumers' strengths, needs, abilities, and outcomes. These paid positions promote wellness and recovery and create opportunities for clients to develop job skills. Peer Specialists support clients in their home and community and are critical to helping clients achieve positive outcomes. Peer Specialist services are Medicaid reimbursable.

Staff Training

All CMHCs provide staff training opportunities at the local, regional, and statewide level. In addition, several CMHCs reported sending staff out of the state to receive specialized training and/or bringing in nationally recognized trainers. According to CMHC staff, these trainings are typically well attended and received, as well as effective at supporting staff, bringing new ideas into the team, and promoting competent service delivery.

Staff from different CMHCs noted that historically the state has held frequent trainings which have been very useful. However, these trainings were discontinued in recent years because of lack of funding. CMHC staff noted that it would be valuable to reinstate these trainings. There are few resources at the state for training. Training dollars go to the most pressing needs (e.g., suicide prevention, Peer Specialists, Wraparound). Some suggested training topics by CMHC staff include:

- Developing Cultural Competence skills in working with consumers of different racial and ethnic backgrounds, including those who are Latino, American Indian, and Asian
- Developing Cultural Competence skills in working with consumers who are lesbian, gay, bisexual, transgender, or questioning
- Strategies for implementing recovery, resiliency, and wellness
- Managing system changes
- Strategies for hiring consumers and family members and incorporating them into the mental health team
- Encouraging functional family involvement
- Developing collaboration between agencies
- Developing and implementing Systems of Care
- Delivering evidence-based practices
- Documenting services to comply with federal funding requirements

Section IIb provides information on service access and service utilization for substance abuse services. Discussions, gaps, and trends provide information on substance abuse services in Wyoming.